

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/17/2012
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NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122
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F0000	<p>This visit was for Investigation of Complaints IN00101506, IN00102217 and IN00102234.</p> <p>Complaint IN00101506: Substantiated, no deficiencies related to the allegations are cited</p> <p>Complaint IN00102217: Substantiated, no deficiencies related to the allegations are cited</p> <p>Complaint IN00102234: Substantiated, State deficiencies related to the allegation(s) are cited at F9999</p> <p>Dates of survey: January 11, 12, and 17, 2012</p> <p>Facility number: 000057 Provider number: 155132 AIM number: 100266570</p> <p>Survey team: Vanda Phelps, RN</p> <p>Census bed type: 12 SNF 79 SNF/NF 91 Total</p> <p>Census payor type: 14 Medicare</p>	F0000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>68 Medicaid 9 Other 91 Total</p> <p>Sample: 5</p> <p>These state findings are in accordance with 410 IAC 16.2.</p> <p>Quality review completed 1/19/12 Cathy Emswiller RN</p>			
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F9999	<p>3.1-13(g)(1) Administration and Management. Sec. 13.(g)(1) The administrator is responsible for the overall management of the facility ... The responsibilities of the administrator shall include, but are not limited to, the following:</p> <p>(1) Immediately informing the division by telephone, followed by written notice within twenty-four (24) hours, of unusual occurrences that directly threaten the welfare, safety or health of the resident or residents, including, but not limited to, any:</p> <p>(A) epidemic outbreaks; (B) poisonings; (C) fires; or (D) major accidents</p> <p>Based on record review and interviews, the facility failed to report an event when a resident was found in the front parking lot in a stuporous condition unaware a lit cigarette was burning a hole in his coat. This impacted 1 of 5 sampled residents, Resident B.</p> <p>Findings include: On 1/11/12 at 2 p.m., the facility</p>	F9999	<p>Corrective Actions: An incident report was completed on the independent, alert and oriented 31 year old resident on state form 6-04 and sent to ISDH regarding the identified event. Resident B no longer reside in the facility. Other residents having the potential to be affected: All independent residents who are able to sign themselves out for LOA (leave of absence) have the potential to be affected and will be evaluated for safety. Systematic changes: Independent residents who have the ability to sign themselves out for LOA will be evaluated for safety upon admission, quarterly and as indicated. Staff will be educated on residents who have been deemed responsible to go LOA independently. Staff will be educated on policy and procedure for abuse and neglect to include notification of Admn., DON, MD and designated appointees. Any potential reportable event will be brought to the attention of the Regional Director of Clinical Services and Regional Director of Operations (by the Administrator/DON) for review and reported to the ISHD in accordance to Federal Guidelines. An accident/incident report will be completed according to policy and procedure. Accident/incident reports will be reviewed 5 days a</p>	02/16/2012			

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	<p>provided information that Resident B had been issued a 30-day involuntary discharge notice on 12/15/11 which meant he would have to find another dwelling by 1/15/12.</p> <p>Clinical record review for Resident B was completed on 1/11/12 at 4:30 p.m. An accident/incident report dated 12/10/11 indicated the charge nurse was informed "resident passed out in parking lot after having LOA (leave of absence) c (with friend. Res (resident) escorted into building, assessed for injury et (and) neuro - VS (vital signs) WNL (within normal limits). 0 injury. (arrow up-increased) sedation, pupils dilated. Speech slurred." The physician ordered a drug screen to be obtained via a blood draw, neuro checks every shift for 24 hours.</p> <p>A corporate required form titled "SBAR" [situation-background-assessment-recommendation] [a formalized method of communicating with other healthcare practitioners about a critically ill patients condition] dated 12/10/11 added additional information: "...11:30 a.m. writer informed by Maintenance Director res was in parking lot passed out c lit cigarette. Writer immediately went to res. Res aroused easily verbally but displayed s/sx (signs and symptoms) of altered</p>		<p>week (Monday thru Friday excluding holidays and weekends). An investigation will be completed by DON including final disposition. Admn. to sign off on all accident/incident reports. Monitoring: Accidents and incidents will be brought to clinical triage and the daily clinical review 5 days/week (excluding holidays and weekends) for review to ensure investigation and final disposition has been completed in full to determine if there is an injury of unknown origin to ensure timely reporting. DON and/or designee will monitor all accidents and incidents on a daily basis to ensure ongoing compliance. Accidents and incidents will be reviewed during monthly QA on an ongoing basis for at least 6 months to ensure compliance Date of completion: 2-16-12</p>		

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	<p>mental status. Res unaware of lit cigarette burning whole (sic) in res coat. Res escorted inside building. Assessment done. Res displayed (arrow up-increased) s/sx of sedation. Pupils dilated. Res speech slurred. Res unable to keep eyes open. VS WNL. No injury r/t (related to) being in cold or lit cigarette burning whole (sic) in res coat...Received order to hold res 2 p.m. meds r/t (arrow up) sedation. Res cont (continued) to sleep throughout afternoon...Res easily aroused for 5 pm meds. Still presenting c s/sx of (arrow up) sedation. Res ref (refused) dinner at 6:30 pm...For 9 pm med pass...res unable to arouse for medications X 3. 0 s/sx of distress noted."</p> <p>Review of the hospital discharge summary indicated Resident B was admitted on 12/11/11 and discharged back to the facility 12/14/11. The discharge diagnoses were listed as:</p> <ol style="list-style-type: none"> 1. opioid overdose 2. decreased level of consciousness secondary to number one 3. mild aspiration pneumonia 4. hypotension - likely secondary to opioid overdose 5. history of transverse myelitis with bilateral lower extremity paraplegia 6. upper extremity weakness, likely secondary to number one. This is resolved at discharge." 			
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	<p>This document also indicated Resident B's urine screen in the emergency room was "positive for numerous substances." The hospital determined part of the substances were due to prescribed medications Resident B was receiving, but Methadone and Marijuana were also present at high levels and these had not been prescribed. "...I do not think that his normal Fentanyl, Valium and other medications that he has prescribed contributed to his decreased level of consciousness. I believe it was substances that he took outside of the rehab that contributed to his lethargy and hypotension...On hospital day two, the patient was still fairly lethargic, and was also hypotensive, into the 70s and 80s systolic. Because of this he was transferred to the ICU for further monitoring...by the third hospital day, the patient was at his baseline mental status...."</p> <p>Upon review of this information, a request was made on 1/11/12 at 5 p.m. of the Corporate Nurse Consultant for the documentation showing the facility had reported this unusual event to the Indiana state Department of Health as required. Interview with the Nurse Consultant on 1/12/12 at 11:30 a.m. indicated the event had not been reported. Interview with</p>			
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	<p>the Interim Administrator and Director of Nursing on 1/17/12 at the exit conference indicated the event had not been reported because Resident B had signed himself out on LOA prior to finding him sedated in the parking lot. The interim Administrator indicated he had 31 years of experience in interpreting the Indiana State Department of Health's policy and procedure for reporting unusual occurrences and this did not fall into any of the categories which needed to be reported.</p> <p>This state tag relates to complaint number IN00102234.</p> <p>3.1-13(g)(1)</p>				