

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15A011	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/22/2015
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NAME OF PROVIDER OR SUPPLIER ESPECIALLY KIDZ HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 2325 S MILLER ST SHELBYVILLE, IN 46176
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F 000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey</p> <p>Survey dates: April 16, 17, 20, 21, and 22, 2015</p> <p>Facility number: 000273 Provider number: 15A011 AIM number: 100267870</p> <p>Census bed type: SNF/NF: 125 Total: 125</p> <p>Census payor type: Medicaid: 124 Other: 1 Total: 125</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 000	<p>Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under and state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey. Due to the low scope and severity of the survey finding, please find the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance, feel free to contact me.</p>	
F 246 SS=D Bldg. 00	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or</p>			

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>safety of the individual or other residents would be endangered.</p> <p>Based on observation, interview, and record review, the facility failed to follow physician's orders, regarding the use of a pommel (device attached to a wheel chair used to abduct the thighs), for 1 of 3 residents reviewed for range of motion. (Resident #77)</p> <p>Findings include:</p> <p>The clinical record for Resident #77 was reviewed on 4/17/15 at 11:00 a.m. The diagnoses for Resident #77 included, but were not limited to: contractures of all extremities and scoliosis.</p> <p>The April, 2015 Physician's Orders for Resident #77 indicated the use of a pommel, effective 1/20/11.</p> <p>The 4/7/15 care plan for Resident #77 indicated, "Adaptive wheel chair with lap/tray belts, shoulder harness and pommel. Needed due to the inability to maintain proper body positioning."</p> <p>An observation of Resident #77 was made on 4/17/15 at 11:26 a.m., in his wheel chair. No pommel was observed.</p> <p>An observation of Resident #77 was made on 4/20/15 at 11:07 a.m., in his</p>	F 246	<p>F246 Requires the facility to will follow physician's orders, regarding the use of a pommel being attached to a wheel chair used toabduct the thighs.</p> <p>1.Resident#77 had a new pommel cushion placed in the wheelchair per physician's order.</p> <p>2.All residents have the potential to be affected. The nursing staff reviewed physician's orders and verified all positioning devices were present on the wheelchairs. No concerns were noted. See below for corrective measures.</p> <p>3.The physician's order policy and procedure was reviewed with no changes made. (See attachment A) The staff was inserviced on the on the above procedure.</p> <p>4.The DON or her designee will utilize the nursing monitoring tool to conduct wheelchair observations to ensure that all adaptive equipment is present on each wheelchair per physician's order. (5 observations a day) These observations will occur daily times for weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of</p>	05/06/2015

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	<p>wheel chair. No pommel was observed.</p> <p>An interview was conducted and observation was made with QMA #3 on 4/20/15 at 2:22 p.m. QMA #3 pointed to the location on Resident #77's wheel chair, where his pommel was previously located. QMA #3 indicated Resident #77's pommel was broken, and had been for at least 2 weeks. She indicated she'd told maintenance staff about the broken pommel, and was told there was no screw for it. QMA #3 indicated she did not put in a work order for Resident #77's broken pommel, because maintenance staff was always around. She indicated Resident #77's knees rub together when he's in his wheel chair without the pommel.</p> <p>An observation of Resident #77 in his wheel chair was made on 4/20/15 at 3:10 p.m. There was no pommel on the wheel chair. His knees were crossed, one knee on top of the other, feet facing outward.</p> <p>An interview was conducted with the DON (Director of Nursing) on 4/20/15 at 3:24 p.m. He indicated he was unaware of how long Resident #77 was without his pommel.</p> <p>A telephone interview was conducted with CNA #4 on 4/22/15 at 10:11 a.m. She indicated Resident #77 did not have</p>		<p>correction will be adjusted accordingly.</p> <p>5.The above corrective measures will be completed on or before May 6, 2015.</p>		

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F 328 SS=E Bldg. 00	<p>his pommel for at least 2 weeks. She indicated Resident #77's limbs were really tight, and without the pommel, his legs would lean to the side.</p> <p>The Physician's Orders policy was provided by the DON on 4/22/15, at 8:45 a.m. It indicated, "Physician's orders are administered upon the clear, complete and signed order of an individual lawfully authorized to prescribe."</p> <p>3.1-3(v)(1)</p> <p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on observation, interview, and record review, the facility failed to provide water flushes to gastrostomy tubes prior to medication administration for 5 of 5 residents observed during medication administrations through gastrostomy tubes. (Resident #2, 17, 69, 73, 114)</p>	F 328	<p>F328 Requires the facility to provide water flushes to gastrostomy tubes prior to medication administration.</p> <p>1.Resident #2, #17, #69, #73 and #114 had flushes provided. RN #1 and LPN #2 was verbally inserviced immediately after the completion of the medication administration regarding the flush order.</p> <p>2.All residents have the</p>	05/06/2015	

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	<p>Findings include:</p> <p>1. The clinical record for Resident #69 was reviewed on 4/6/15 at 1:00 p.m. The diagnoses for Resident #69 included, but were not limited to, tracheostomy, and dysphagia. He had a history of gastrostomy with a gastric tube (G-tube) placement.</p> <p>A current physician order dated, (12/2/09 initial order) for Resident #69 was reviewed. It indicated 30 milliliters of water flush per G-tube prior to and following each med pass.</p> <p>An observation was made on 4/20/15 at 9:25 a.m., RN #1 prepared Resident #69's medications in a cup using water to dilute them. She then poured water in a second cup. After RN #1 listened to Resident #69's bowel sounds, she then placed the piston syringe into the G-tube and poured the cup with the medications in the syringe. RN #1 did not water flush prior to pouring the medications in the syringe. After the medication was drained out of the syringe RN #1 then poured 60 milliliters of water into the syringe. The 60 milliliters of water totaled the 30 milliliters of water flush to be given before administrating the medications and the 30 milliliters of water following the medication administration. During this time RN #1</p>		<p>potential to be affected. All nurses did a repeat demonstration of how to properly flush a g-tube during medication administration. No concerns were noted. See below for corrective measures.</p> <p>3. The tube feeding policy and procedure was reviewed with no changes made. (See attachment C) The staff was inserviced on the on the above procedure.</p> <p>4. The DON or his designee will utilize the nursing monitoring tool to conduct observation of G-tube flushes to ensure the nursing staff is providing the flushes per the physician's order. (3 observations a day) The audits will be conducted daily times for weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly.</p> <p>5. The above corrective measures will be completed on or before May 6, 2015.</p>	

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	<p>indicated she was administrating both water flushes.</p> <p>2. The clinical record for Resident #114 was reviewed on 4/6/15 at 1:30 p.m. The diagnoses for Resident #114 included, but were not limited to, tracheostomy, and feeding dysfunction. He had history of gastrostomy with a gastric tube (G-tube) placement and protein calorie malnutrition.</p> <p>A current physician order, (6/5/12 initial order) for Resident #114 was reviewed. It indicated 30 ml (milliliters) flush prior to and following each med (medication) administration.</p> <p>An observation was made on 4/20/15 at 9:44 a.m. After RN #1 crushed medications and placed in water to dilute RN #1 listened to Resident #114 's bowel sounds. She then placed the piston syringe to the G-tube. She then began the administration of the medications. RN #1 did not administer the water flush before she poured the medications into the syringe. She assisted the medications by using the end of the syringe to apply pressure for the medications to drain into the tubing by gravity. After the medications went through the tubing, RN #1 at this time poured 60 ml of water into the syringe.</p>			

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	<p>3. The clinical record for Resident #73 was reviewed on 4/6/15 at 2:00 p.m. The diagnoses for Resident #73 included, but were not limited to, tracheostomy, and dysphagia. He has history of gastrostomy with a gastric tube (G-tube) placement.</p> <p>A current physician order, (12/5/09 initial order) was reviewed. It indicated Resident #73 was to receive 30 ml of water prior to and follow each med pass.</p> <p>An observation was made on 4/20/15 at 10:01 a.m. RN #1 prepared Resident #73's medications in cup and then diluted using water. She then listened to his bowel sounds. RN#1 placed the syringe at this time in the G-tube and poured the medication into the syringe. She did not administer a water flush prior to pouring the medication into the syringe. After the medication was in the tubing RN#1 then poured the 60 ml of water into the syringe.</p> <p>4. The clinical record for Resident #17 was reviewed on 4/6/15 at 1:00 p.m. The diagnosis for Resident #17 included, but were not limited to, decreased gastric mobility. He has a history of gastrostomy with a gastric tube (G-tube) placement.</p> <p>A current physician order, (12/30/09</p>			

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	<p>initial order) was reviewed. It indicated Resident #17 was to receive 30ml of water per G-tube prior to and following each med pass.</p> <p>An observation was made on 4/21/15 at 9:03 a.m. LPN #2 listened to bowel sounds and checked G-tube placement prior to administration of medications. She then placed syringe in the G-tube and poured medication into the syringe. LPN #2 did not administer water flush prior to medication administration. LPN #2 then poured 240ml of water into the syringe after the medication was in the tubing.</p> <p>5. The clinical record for Resident #2 was reviewed on 4/6/15 at 2:15 p.m. The diagnoses for Resident #2 included, but were not limited to, tracheostomy, and dysphagia. He has history of ileus and gastrostomy with a gastric (G-tube) placement.</p> <p>A current physician order, (7/3/14 initial order) was reviewed. It indicated Resident #2 was to receive 30ml of water flush prior to and following each medication pass.</p> <p>An observation was made on 4/21/15 at 9:23 a.m. LPN #2 listened to bowel sounds and checked placement of the G-tube. She then attached syringe to</p>			

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F 465 SS=E Bldg. 00	<p>G-tube and at this time poured medication into syringe. LPN #2 did not administer water flush at the beginning of medication administration. After the medication drained into the tubing by gravity LPN #2 then poured 375ml of water into the syringe.</p> <p>A policy titled "TUBE FEEDINGS NASO-GASTRIC OR GASTROSTOMY TUBE" dated, 10/2014 was reviewed on 4/22/15 at 9:00 a.m. It indicated step by step instructions on how to administer medications through a G-tube. It indicated to flush with 30ml of water before and after medication administration.</p> <p>3.1-47(2)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview and record review, the facility failed to maintain wheelchairs in proper condition and a home-like environment for 1 of 40 resident's beds observed and 16 of 92 residents observed for the condition of their wheelchair. (Residents # 9, 10, 25, 28, 30, 38, 44, 50, 60, 61, 62, 78, 85, 103,</p>	F 465	<p>F465 Requires the facility to maintain wheelchairs inproper condition and home-like environment.</p> <p>1.Resident #9, #10, #25, #28, #30, #38, #44 #50, #60,#61, #62, #78, #85, #103, #107 and #118 wheelchairs and beds were repaired.</p> <p>2.All residents have the potential to be affected. A</p>	05/06/2015

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	<p>107, and 118)</p> <p>Findings include:</p> <p>1. The following observations of resident wheelchairs were made on 4/22/15 at 2:30 p.m., with QMA #3:</p> <p>Resident #50's left and right arm rests were loose and wobbly. The lap tray was torn all along the inner seam. Resident #30's left lateral had a tear 6 inches across the seam. Resident #38's chair back had an 8 inch vertical tear along the back, and a 6 inch horizontal tear along the back seam. The right arm was torn at the inner seam. Resident #10's wheelchair was missing a right brake, and the footrest pad was torn along the right seam.</p> <p>The following observations of resident wheelchairs were made on 4/22/15 at 2:45 p.m., with CNA #5:</p> <p>Resident #118's left armrest was torn and had no padding. Resident #103's left armrest had no padding and the right armrest had padding sticking out of the end. Resident #25's left arm was loose, with the fabric completely torn. Resident #25's right thigh support and right armrest was torn. Resident #25 had a left anti-tipper (device attached to wheelchair</p>				<p>complete audit of the resident's wheelchairs and beds were completed to ensure the equipment was in good repair. If a problem was noted, the equipment was repaired. See below for corrective measures.</p> <p>3. The maintenance staff was inserviced on the importance of maintaining equipment in good repair. The staff was instructed if there was a noted concern to submit a work order form for maintenance.</p> <p>4. The administrator or his designee will conduct wheelchair and bed observation to ensure a safe, functional, sanitary and comfortable environment. (5 observations a day) If a concern is noted, the problem will be addressed immediately. The audits will be conducted daily times for weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment D) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly.</p> <p>5. The above corrective measures will be completed on or before May 6, 2015.</p>		

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	<p>to prevent wheelchair from tipping over backwards), but no right anti-tipper. Resident #28's right armrest was attached backwards. Resident #60's left armrest had padding coming out of the end and the right armrest fabric was torn off. Resident #107's tread on the wheels was worn down beneath the rubber of the tire. Resident #107's armrest fabric and padding was torn.</p> <p>An interview was conducted with the Administrator and Social Services Director (SSD) on 4/22/15 at 3:12 p.m. The Administrator indicated it was the goal of the facility to replace all wheelchairs this year.</p> <p>The undated Wheelchair Tracking Log was provided by the Social Services Director on 4/22/15 at 1:00 p.m. The log indicated which residents were identified as being in the process of receiving a new wheelchair. Residents #50, 30, 38, 10, 118, 103, 25, 28, 60, and 107's names were not on the log.</p> <p>On 4/22/15 at 2:09 p.m., during an observation, the wheelchair of Resident #44 was observed to have a seat back frame that was twisted. The wheelchair's right front wheel did not make contact with the floor or ground. The 4 tires on the wheelchair were worn, with the right back tire being worn down beneath the</p>			
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	<p>rubber of the tire. The seat back cushion was torn and frayed.</p> <p>On 4/22/15 at 2:26 p.m., during an interview, QMA #3 indicated Resident #44's wheelchair is difficult to push at times due to the resident's wheelchair having a front tire that does not touch the floor.</p> <p>On 4/22/15 at 3:12 p.m., during an interview, the Administrator and Social Services Director indicated Resident #44's wheelchair should be replaced due to its current condition as described above. The Administrator indicated the facility will be replacing all residents' wheelchairs and the facility has an evaluation process to determine who needs to have a wheelchair replaced. He indicated the facility maintenance staff repaired some residents' wheelchairs and a third party wheelchair vendor would periodically come to the facility to repair wheelchairs as necessary.</p> <p>A facility document, undated and titled "Wheelchair Tracking Log", was provided by the facility Social Services Director on 4/22/15 at 1:00 p.m. The log indicated which facility residents were identified as being in the process of receiving a new wheelchair. Resident #44 was not on the list.</p>			

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	<p>Social Services Director (SSD) provided "Wheelchair Tracking Log" on 4/22/15 at 1:00 p.m. The log indicated the residents that were in the process of getting a new wheelchair. This log did not indicate Resident #119 was in the process of receiving a new wheelchair.</p> <p>An observation of Resident #119's wheelchair was made on 4/22/15 at 2:00 p.m. The wheelchair's upholstered headrest, seat, and padding to the lateral sides were torn. There also was grey duct tape wrapped around right and left leg poles.</p> <p>Executive Director on 4/22/15 at 3:12 p.m., indicated all the residents' wheelchairs will be evaluated and replaced this year.</p> <p>An observation, on 4/22/15 at 2:10 p.m., of Resident #85's wheelchair pommel (device to abduct knees) and laterals (device for trunk support) were noted to be fraying and worn at the seams.</p> <p>On 4/22/15 at 2:15 p.m., Resident #62's wheelchair was observed with washcloths taped to the right leg of the footrest.</p> <p>During an interview with Unit Manager #1, on 4/22/15 at 2:16 p.m., she indicated</p>						

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	<p>she was unsure why padding was not placed on the right leg of the footrest, since the washcloths were taped there for protection of Resident #62's skin.</p> <p>Resident #61's wheelchair was observed, on 4/22/15 at 2:20 p.m., with a hand length tear/split in the center of his wheelchair seat. The right armrest was observed to be worn and fraying at the seams.</p> <p>On 4/22/15 at 2:30 p.m., Resident #78's right, wheelchair arm rest was observed to have a hand length tear/split starting at the edge of the cushion.</p> <p>2. During an observation, on 4/21/15 at 1:50 p.m., Resident #9's bed siderails were observed with several fingernail-sized areas, on multiple bars, that were not painted white like the rest of the siderails and metal was showing through.</p> <p>On 4/21/15 at 2:45 p.m. during an observation with the Administrator, the same unpainted areas on the siderails were observed.</p> <p>During an interview with the Administrator, on 4/21/15 at 2:47 p.m., the Administrator indicated Resident #9's bed siderails needed to be repainted to</p>			

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F 502 SS=D Bldg. 00	<p>match the rest of the bed.</p> <p>3.1-19(f) 3.1-19(f)(5)</p> <p>483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. Based on interview and record review, the facility failed to ensure lab draws were performed as ordered for 1 of 3 residents reviewed for tube feeding. (Resident #26)</p> <p>Findings include:</p> <p>The clinical record for Resident #26 was reviewed on 4/20/15 at 10:15 a.m. The diagnoses for Resident #26 included, but were not limited to, spastic quadriplegia due to traumatic brain injury, osteopenia, spasticity, and cerebral palsy with agitation.</p> <p>A Physician's Order, dated 1/17/15, indicated a lab order for vitamin D, calcium, and phosphorus levels to be drawn in 6 weeks. A lab draw for vitamin D, dated 3/10/15, was located in the clinical record. A lab draw for</p>	F 502	<p>F502 Requires the facility to ensure lab draws are performed as ordered.</p> <p>1.Resident #26 had labs drawn for calcium and phosphorus levels. Labs were within normal ranges.</p> <p>2.All residents have the potential to be affected. The nursing staff completed a lab audit ensuring all labs were drawn timely per physician's order. No concerns were noted. See below for corrective measures.</p> <p>3.The nursing staff was inserviced on lab tracking and ensuring that labs are drawn per physician's orders. (See attachment A) The staff was inserviced on the on the above procedure.</p> <p>4.The DON or his designee will utilize the nursing monitoring tool to conduct audits to ensure that labs are drawn timely per physician's order. (3 lab draw reviews a day) These</p>	05/06/2015

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	<p>calcium and phosphorus levels was not located in clinical record.</p> <p>During an interview with Unit Manager #1, on 4/22/15 at 10:35 a.m., she indicated the calcium and phosphorus level labs were not drawn as ordered and the initiated lab order for calcium and phosphorus was not located in the lab tracking binder. Unit Manager #1 indicated she was unsure why the labs were not drawn.</p> <p>3.1-49(a)</p>				<p>observations will occur daily times for weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly.</p> <p>5. The above corrective measures will be completed on or before May 6, 2015.</p>		