

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155659	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/16/2012
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NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-SELLERSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 7823 OLD HWY # 60 SELLERSBURG, IN 47172
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F0000	<p>This visit was for the Investigation of Complaints IN00103698 and IN00103952.</p> <p>Complaint IN00103698 - Substantiated. Federal/state deficiencies related to the allegations are cited at F456, F514, and F9999.</p> <p>Complaint IN00103952 - Substantiated. Federal/state deficiencies related to the allegations are cited at F203, F206 and F9999.</p> <p>Unrelated deficiencies are cited.</p> <p>Survey dates: February 14,15, and 16, 2012</p> <p>Facility number: 010613 Provider number: 155659 AIM number: 200221040</p> <p>Survey team: Jennie Bartelt, RN</p> <p>Census bed type: SNF: 24 SNF/NF: 84 Total: 108</p> <p>Census payor type: Medicare: 51</p>	F0000	<p>This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</p>	
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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>Medicaid: 38 Other: 19 Total: 108</p> <p>Sample: 6</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on February 22, 2012 by Bev Faulkner, RN</p>			
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F0203 SS=D	<p>Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a) (6) of this section.</p> <p>Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.</p> <p>Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days.</p> <p>The written notice specified in paragraph (a) (4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and</p>						

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	<p>telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.</p> <p>Based on record review and interview, the facility failed to ensure a resident received a 30-day notice of the facility's decision to discharge the resident due to the facility's inability to meet the resident's on-going care needs. The deficient practice affected 1 of 3 residents reviewed related to discharge in a sample of 6. (Resident E)</p> <p>Findings include:</p> <p>During the routine phone contact interview on 2/14/12 at 11:55 a.m., the local Long Term Care Ombudsman indicated there was a current problem with the facility's refusal to readmit Resident E. The Ombudsman indicated she had a call from the local hospital's Social Worker "this morning," and the Social Worker told her Resident E was at the hospital ready for discharge, and the facility refused readmission. The Ombudsman indicated she had contacted</p>	F0203	<p>Before a facility transfer or discharge, it is the policy of this facility to notify the resident, a family member or legal representative of the transfer or discharge and the reasons for the move in writing; record the reasons in the resident's clinical record. This notice is made by the facility at least 30 days before the resident is transferred or discharged and the notice may be made as soon as practicable when the health of the individuals in the facility would be endangered, the resident's health improves sufficiently to allow a more immediate transfer of discharge is required by the resident's urgent medical needs, or a resident has not resided in the facility for 30 days. Resident E was an immediate transfer to the hospital due to his urgent medical needs. Resident E is a 48y/o with unstable DM, refuses accuchecks &amp; insulin daily therefore putting him/her self in constant DKA and remains a Full Code. This had a PEG tube placed because he/she</p>	03/05/2012

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	<p>the facility's Administrator by e-mail and was awaiting a response.</p> <p>During a phone call received on 2/15/12 at 12:30 p.m., the Ombudsman indicated she had spoken with the facility's Administrator who told her Resident E was consistently non-compliant with care, and if he was readmitted to the facility, he would just have to be sent to the hospital again. She indicated the Administrator had offered to assist as possible with facilitating the resident's transfer to the corporate long term care hospital in a near-by city.</p> <p>During a phone interview on 2/15/12 at 2:05 p.m., the Social Worker from the local hospital indicated Resident E had been hospitalized six or seven times since November 2011. She indicated the resident refuses to take insulin at the facility, becomes ill, and requires hospitalization. The Social Worker indicated she had been told by the facility the resident would not be readmitted. She indicated she had spoken with the Administrator concerning the readmission, including if the resident had received a 30-day discharge notice to notify him the facility would not readmit. She indicated the Administrator told her, "No, and we don't have to."</p>		<p>was also refusing to eat and then becomes hypoglycemic and unresponsive. On readmission he/she refused to let staff administer his/her tube feed and had orders to give D5W which he/she also refused to let nurses administer via the PICC line, which he/she proceeded to pull out X 2 so they could not administer anything IV. This resident has had several sessions with the SSD about palliative care and wants to remain a full code, however as evidenced by above sited behaviors, will not participate in care. The hospital had inpatient psych evaluation and there were no findings. All residents needing transferred from the facility will received a Transfer/discharge notification indicating the reason for the residents transfer. A thirty day notice will be given unless a more immediate transfer is deemed necessary. Should the facility determine we are unable to meet a the on-going care needs, of a resident who has been discharged to an acute hospital, a 30 day notice will be issued to the resident, family member or legal representative while a patient of the acute care hospital. And should the resident care needs stabilize and become appropriate for SNF placement during the 30 day time frame the resident will be readmitted to the facility. Medical Records and nursing staff have been educated</p>				

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	<p>The closed clinical record for Resident E was reviewed on 2/15/12 at 2:35 p.m. The record indicated the resident was readmitted to the facility on 1/30/12 and discharged to the hospital again on 2/2/12.</p> <p>The Resident Transfer Form, dated 2/2/12, indicated "Diagnoses at Time of Transfer: High Blood Sugar, Fall."</p> <p>Resident Progress Notes indicated a Late Entry for 2/1/12 at 6:00 p.m., that indicated, "NP [Nurse Practitioner] here evaluating Res [resident] in regards to refusing care from nurses, refusing accu[check mark]s [blood glucose monitoring], incontinent care, turning &amp; repositioning, IV abt [antibiotics] &amp; fluids, TF [tube feedings] and treatments. Res is his own POA [power of attorney] &amp; this nurse as well as staff nurses attempt education throughout the day on each issue of care.</p> <p>Resident Progress Notes for 2/2/12 at 7:30 a.m., indicated the resident was admitted to the hospital for diabetic ketoacidosis (DKA).</p> <p>On 2/16/12 at 9:25 a.m., upon request, the District Director for Clinical Operations provided the Notice of Transfer and Discharge for Resident E. The Notice of Transfer and Discharge, dated 2/2/12,</p>		<p>in the use of the transfer/discharge notice. All potential facility transfer will be reviewed during the morning meeting to ensure that facility transfers meets with the approval of the residents and the resident's family. Hospitalized residents clinical status will be monitored daily by the Clinical Liaison and should it be determined the facility can no longer meet their on-going care needs, the Executive Director will issue the appropriate 30 day notice. An audit will be performed to determine compliance with the above process. The findings of the audit will be discussed at the monthly PI meeting until compliance has been met. (attachment A) Ongoing random audits will be made by the Executive Director to ensure facility transfers met with approval of the resident and/or resident's family. The Executive Director will be responsible to ensure compliance with this standard.</p>		

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	<p>indicated the resident was being transferred to the hospital emergency room with a check mark next to: "The transfer or discharge is necessary to meet the resident's welfare and the resident's needs cannot be met in the facility."</p> <p>During interview on 2/15/12 at 4:50 p.m., the facility's Admissions Coordinator indicated Resident E would not be readmitted to the facility since the facility could no longer meet his needs. She indicated a clinical determination related to this had been made by the District Director for Clinical Operations.</p> <p>During interview completed on 2/16/12 at 10:15 a.m., the Administrator indicated the facility did not issue a 30-day discharge notice to the resident. He indicated he spoke with the local hospital Social Worker and told her from the beginning of this hospitalization for Resident E that the facility was unable to take the resident back, because the facility was unable to meet his needs. The Administrator indicated the resident's physician, who is also the facility's Medical Director, had documented in the resident's hospital record that the resident should not return to the facility.</p> <p>Review of Resident E's hospital record indicated the following in</p>			

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	<p>"Disposition/Discharge Assessment:"</p> <p>2/3/12 at 11:35 a.m., "Called and spoke with [name of Resident E's physician] per request - states the patient can't make his own decisions and he refuses to take his insulin at the nursing facility. The facility may not take the patient back unless there is someone to make his medical decisions...."</p> <p>2/6/12 at 2:24 p.m., "I spoke with [name of facility's hospital liaison] from Kindred [Kindred Transitional Care and Rehab - Sellersburg] and asked if they have issued pt. [patient] a 30 [sic] discharge notice if they can't accept pt. back. She states she does not think they have but she will check on it. She suggested hospice if pt. continues to refuse everything."</p> <p>2/14/12 at 9:30 a.m., "Order to see where pt is going at discharge and to call [name of resident's physician]. I called [name of facility's hospital liaison] to make sure Sellersburg Health and Rehab [former name of Kindred Transitional Care and Rehab - Sellersburg] still plans on taking pt. back and she states she will have to discuss with her regional supervisor. I explained if they can't accept back, this is a real issue....She will call me back."</p> <p>2/14/12 at 10:58 a.m., "I rec'd [received]</p>						

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	<p>call from [name], Administrator at Sellersburg Health and Rehab [former name of Kindred Transitional Care and Rehab - Sellersburg] informing me that they will not accept pt. back due to his non-compliance. I asked if they gave a 30 day discharge notice to pt. and he states they do not have to do this because pt. is a danger to himself...."</p> <p>2/14/12 at 3:20 p.m., "[Name of Admissions Coordinator from another long term care facility] and I met with pt. to explain Sellersburg Health and Rehab [former name of Kindred Transitional Care and Rehab - Sellersburg] does not want to accept pt. back and I asked [name of Admissions Coordinator from other facility] to talk to him about going to [name of other long term care facility]...."</p> <p>The hospital's "Physician's Order and Progress Record," dated 2/15/12, indicated the resident was discharged to the other long term care facility on 2/15/12.</p> <p>The hospital's Discharge Summary, dated 2/15/12 and dictated by the resident's physician, who was the facility's Medical Director, included, but was not limited to, "Hospital Course: This patient has been probably in and out of the hospital from Sellersburg [Kindred Transitional Care</p>			
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	<p>and Rehab - Sellersburg] at least 6 to 9 times in the last probably 2 months. He does well in the hospital where actually he is maintained on his medications but once he is in the Sellersburg rehab setting, he immediately begins to refuse treatments and medication and feeds, at which point in time we are not able to force him into taking any of the medications or continuing he PEG [gastrostomy tube] feeds at that facility; hence, he will go into DKA fairly quick and then end up back in the hospital. We are not really able to provide the necessary care with regards to forcing him to take his medications at the rehab setting. It is a little bit different atmosphere in the hospital...."</p> <p>This federal tag is related to Complaint IN00103952.</p> <p>3.1-12(a)(7)</p>			
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F0206 SS=D	<p>A nursing facility must establish and follow a written policy under which a resident whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, is readmitted to the facility immediately upon the first availability of a bed in a semi-private room if the resident requires the services provided by the facility; and is eligible for Medicaid nursing facility services.</p> <p>Based on record review and interview, the facility failed to ensure a resident with Medicaid-pending insurance, who was transferred to the hospital for acute medical care, was allowed to return to the facility when the acute medical need resolved and an appropriate bed was available. The deficient practice affected 1 of 3 residents reviewed related to discharge from the facility in a sample of 6 residents. (Resident E)</p> <p>Findings include:</p> <p>During the routine phone contact interview on 2/14/12 at 11:55 a.m., the local Long Term Care Ombudsman indicated a current problem with the facility's refusal to readmit Resident E. The Ombudsman indicated she had a call from the local hospital's Social Worker "this morning," and the Social Worker told her Resident E was at the hospital ready for discharge, and the facility refused readmission. The Ombudsman indicated she had contacted the facility's Administrator by e-mail and was awaiting</p>	F0206	<p>It is the policy of this facility to establish and follow a written policy under which a resident whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, is readmitted to the facility immediately upon the first availability of a bed in a semi-private room if the resident requires the services provided by the facility; and is eligible for Medicaid nursing facility services. Resident E was an immediate transfer to the hospital due to his urgent medical needs. Resident E is a 48y/o with unstable DM, refuses accuchecks &amp; insulin daily therefore putting him/her self in constant DKA and remains a Full Code. This had a PEG tube placed because he/she was also refusing to eat and then becomes hypoglycemic and unresponsive. On readmission he/she refused to let staff administer his/her tube feed and had orders to give D5W which he/she also refused to let nurses administer via the PICC line, which he/she proceeded to pull out X 2 so they could not administer anything IV. This</p>	03/05/2012			

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	<p>a response.</p> <p>During a phone call received on 2/15/12 at 12:30 p.m., the Ombudsman indicated she had spoken with the facility's Administrator who told her Resident E was consistently non-compliant with care, and if he was readmitted to the facility, he would have to be sent to the hospital again. She indicated the Administrator had offered to assist as possible with facilitating the resident's transfer to the corporate long term care hospital in a near-by city.</p> <p>During a phone interview on 2/15/12 at 2:05 p.m., the Social Worker from the local hospital indicated Resident E had been hospitalized six or seven times since November 2011. She indicated the resident refuses to take insulin at the facility, becomes ill, and requires hospitalization. The Social Worker indicated she had been told by the facility the resident would not be readmitted.</p> <p>The closed clinical record for Resident E was reviewed on 2/15/12 at 2:35 p.m. The record indicated the resident was readmitted to the facility on 1/30/12 and discharged to the hospital again on 2/2/12.</p> <p>The Resident Transfer Form, dated 2/2/12, indicated "Diagnoses at Time of</p>		<p>resident has had several sessions with the SSD about palliative care and wants to remain a full code, however as evidenced by above sited behaviors, will not participate in care. The hospital had inpatient psych evaluation and there were no findings. All hospitalized residents will be readmitted to the facility after determining the residents needs can be met by the facility and the facility has an appropriate bed available. Should the facility determine we are unable to meet a the on-going care needs, of a resident who has been discharged to an acute hospital, a 30 day notice will be issued to the resident, family member or legal representative while a patient of the acute care hospital. And should the resident care needs stabilize and become appropriate for SNF placement during the 30 day time frame the resident will be readmitted to the facility. Medical Records and nursing staff have been educated in the use of the transfer/discharge notice. All potential facility transfer will be reviewed during the morning meeting to ensure that facility transfers meets with the approval of the residents and the resident's family. Hospitalized residents clinical status will be monitored daily by the Clinical Liaison and should it be determined the facility can no longer meet their on-going care</p>		

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	<p>Transfer: High Blood Sugar, Fall."</p> <p>On 2/16/12 at 9:25 a.m., the District Director for Clinical Operations was requested and provided the Notice of Transfer and Discharge for Resident E. The Notice of Transfer and Discharge, dated 2/2/12, indicated the resident was being transferred to the hospital emergency room with a check mark next to: "The transfer or discharge is necessary to meet the resident's welfare and the resident's needs cannot be met in the facility."</p> <p>During interview on 2/15/12 at 4:50 p.m., the facility's Admissions Coordinator indicated Resident E's insurance was Medicaid pending, but now she thought he had been approved for Medicaid. She indicated the resident would not be readmitted to the facility since the facility could no longer meet his needs. She indicated a clinical determination related to this had been made by the Nurse Consultant for Clinical Operations.</p> <p>During interview completed on 2/16/12 at 10:15 a.m., the Administrator indicated the facility had told the local hospital Social Worker from the beginning of this hospitalization for Resident E that the facility was unable to take the resident back, because the facility was unable to</p>		<p>needs, the Executive Director will issue the appropriate 30 day notice. An audit will be performed to determine compliance with the above process. The findings of the audit will be discussed at the monthly PI meeting until compliance has been met. (attachment A) Ongoing random audits will be made by the Executive Director to ensure facility transfers met with approval of the resident and/or resident's family. The Executive Director will be responsible to ensure compliance with this standard.</p>				

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	<p>meet his needs. The Administrator indicated the resident's physician, who is also the facility's Medical Director, had documented in the resident's hospital record that the resident should not return to the facility.</p> <p>Review of Resident E's hospital record indicated the following in "Disposition/Discharge Assessment:"</p> <p>On 2/3/12, the social worker "Called and spoke with [name of Resident E's physician] per request - states the patient can't make his own decisions and he refuses to take his insulin at the nursing facility. The facility may not take the patient back unless there is someone to make his medical decisions...." On 2/6/12, the social worker spoke with the facility's hospital liaison to determine if the facility had issued a 30-day notice of discharge, and the hospital liaison told her she would need to check on it.</p> <p>On 2/14/12, the social worker received a physician's order to find out if the facility would accept the resident back, and she contacted the facility's hospital liaison. The liaison told the social worker she would need to contact her supervisor about readmission. Later on 2/14/12, the social worker received a call from the facility's Administrator who indicated the</p>			
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	<p>facility would not readmit the resident. The social worker made arrangements for another long term facility to accept the resident.</p> <p>The hospital's "Physician's Order and Progress Record," dated 2/15/12, indicated the resident was discharged to the other long term care facility on 2/15/12.</p> <p>During interview on 2/16/12 at 1:10 p.m., the Administrator provided information related to bed availability at the facility. Review of the information indicated a male Medicaid bed was available on 2/13, 2/14, and 2/15/12.</p> <p>This federal tag is related to Complaint IN00103952.</p> <p>3.1-12(a)(27)(A) 3.1-12(a)(27)(B)</p>						

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F0221 SS=D	<p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>Based on observation, record review, and interview, the facility failed to ensure placement of a lap buddy restraint was assessed for need related to medical symptoms and was the least restrictive device to ensure a resident did not rise unassisted from his wheel chair. The deficient practice affected 1 of 1 resident reviewed related to use of restraints in a sample of 6. (Resident D)</p> <p>Findings include:</p> <p>During Initial Tour on 2/14/12 at 11:20 a.m., Unit Manager #9 indicated Resident D was a fall risk and used a lap buddy at the family's request. She indicated the resident could remove the lap buddy.</p> <p>The clinical record for Resident D was reviewed on 2/14/12 at 2:45 p.m. The record indicated the resident was admitted on 1/16/12.</p> <p>Post Fall Evaluations indicated the resident fell onto the floor mat next to the low bed on 1/19/12 at 6:00 a.m., on 1/19/12 at 5:30 p.m., and on 2/4/12 at 7:00 p.m. At the time of the fall on 2/4/12, the alarm used to advise staff of the resident arising unassisted did not</p>	F0221	<p>It is the policy of this facility to follow the residents right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. Resident D had three prior falls from unassisted transfers from the bed in which he had tried to ambulate unsuccessfully. Resident D diagnosis include Alzheimer's Dementia with disturbance of mood; insomnia, Diabetes, GERD, DM, Dysphasia and BPH. Resident D's wife and daughter met with the IDT on 02/10/12 for discussion of current fall interventions utilized to include; Pressure alarm in bed, pull tab alarm in W/C, low bed with soft mats, call light in reach, proper footwear, floor free of spills, use of assistive devices for mobility, PT and OT as ordered, assist with ADL's, toileting Q 2 hours and provide incontinent care as necessary, monitor lab results, and dining in supervised areas. Resident D's wife and daughter did request evaluation of the lap buddy when up in W/C at that time to reduce the risk of accidents and injuries while allowing Resident D to maintain the highest practicable physical and psychosocial well-being. Resident D's physician was</p>	03/05/2012			

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	<p>function and was replaced.</p> <p>Resident Progress Notes for 1/16/12 through 2/9/12 indicated the resident was up in his wheel chair, and no notes indicated the resident attempted unassisted transfers or ambulation. No notes indicated the resident was observed leaning forward in the chair.</p> <p>Resident Progress Notes for 2/10/12 at 6:45 p.m., indicated, "Res [resident's] dgt. [daughter] and wife here at facility &amp; discussed Res. [resident] cont. [continues] poor safety awareness [symbol for with] attempts to self transfer and ambulate. Family requesting safety device in W/C [wheel chair] [symbol for with] alarm also. Discussed a lap buddy in W/C to also assist in upright positioning. Family agreeable. Res. at supper [symbol for with] wife and will trial lap buddy. Notified MD and order received for the lap buddy."</p> <p>The "Acknowledgement of Physical Restraint Use," signed by the resident's family on 2/15/12, indicated, "Restraint: Lap buddy when up in wheel chair. Medical Symptom Treated/Bases for Use: Safety and to prevent falls."</p> <p>Resident Progress Notes for 2/10/12 through 2/12/12 did not indicate the</p>		<p>consulted and an order obtained to implement the lap buddy when up in W/C and release Q 2 hours, PRN, with 1:1 supervision, toileting and in bed as other least restrictive measures have proven to be unsuccessful. An MDS was completed on 02/12/12 and indicated that Resident D did not have a restraint on because resident D was still being assessed for ability to remove the lap buddy upon request and voluntarily. Resident D had been observed removing lap buddy randomly throughout the evaluation period by facility staff and family. Resident D observed to continue and thrust his upper body forward while pushing off the floor to propel himself in his W/C increasing his risk for accidents and injuries. Resident D was assessed for incidence of agitation, depression, withdrawal, reduced social contact, reduced independence, and loss of dignity without findings. All residents requiring the use of restraints will be assessed for the least restrictive and most appropriate restraint when a restraint is initiated. The resident(s) will remain free from any physical restraint imposed for purposes of discipline or convenience and not required to treat the resident(s) medical condition. The facility conducted an audit on 02/29/12 to ensure appropriate restraint assessment to include least restrictive measures had been</p>				

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	<p>resident removed the lap buddy.</p> <p>The Occupational Therapy Evaluation, dated 1/17/12, and the Physical Therapy Evaluation, dated 1/17/12, did not address issues with sitting balance specifically.</p> <p>On 2/15/12 at 3:55 p.m., the MDS (Minimum Data Set assessment) Coordinator provided the MDS, dated 2/12/12, for Resident D. The MDS indicated the resident did not have a restraint.</p> <p>During interview on 2/16/12 at 2:15 p.m., the Director of Nursing Services (DNS) indicated none of the resident's falls were from the wheel chair, all were from the bed.</p> <p>During interview on 2/16/12 at 4:30 p.m., the MDS Coordinator indicated the MDS did not indicate a restraint for Resident D, because the MDS was completed when the resident was in the 3-day trial period of using the restraint. She indicated the restraint would be applied and then discussed in the morning meeting. She indicated, "Everyone said he could take it off, and the family was happy with the lap buddy."</p> <p>An undated "Interdisciplinary Physical Restraint Evaluation" indicated the</p>		<p>unsuccessful (see attachment B). The nursing staff was in serviced by the DDCO on the restraint policy and procedure on 02/16/2012. The Director of Nursing/Designee is responsible to monitor and report findings to the Performance Improvement Committee monthly for 90 days then the PI committee will determine if compliance has been achieved and the need for on going monitoring.</p>		

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	<p>resident was at risk of attempting to get out of bed/chair, had conditions that might affect judgement, had alteration in safety awareness due to cognitive decline, had history of falls, had demonstrated poor bed mobility or difficulty moving to a sitting position on the side of the bed, had difficulty with balance or poor trunk control, and was on medications that required increased safety precautions. The "Rationale for Recommendation" of use of the lap buddy indicated, "Res. cont. to demonstrate poor safety awareness [symbol for secondary to] dementia and attempts to self ambulate &amp; transfer. Lap buddy will [arrow pointing down] decrease risk of accidents and injury."</p> <p>The Administrator, Director of Nursing Services, and District Director for Clinical Operations were interviewed on 2/15/12 at 4:20 p.m. The DNS and District Director indicated Resident D's family had requested the lap buddy. They indicated the resident could remove the lap buddy at will, and maybe even upon request. The District Director indicated the lap buddy was assessed and care planned as a restraint. They indicated the resident would lean forward in his wheel chair and push off to get the chair moving.</p> <p>On 2/16/12 at 9:25 a.m., Resident D was</p>			
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	<p>observed in the hallway at the Nurse's Station, seated upright in his wheel chair with hands folded on the lap buddy.</p> <p>On 2/16/12 at the noon meal, Resident D was observed eating his meal at a table in the Restorative Dining Room, seated upright in his wheel chair with lap buddy in place.</p> <p>On 2/16/12 at 1:10 p.m., the DNS provided additional information related the Resident D's lap buddy. Additional information on the "Interdisciplinary Physical Restraint Evaluation" indicated, "2/15/16 [sic] Res. observed through multiple staff &amp; family to be cabable [sic] of removing lap buddy in W/C. res. removes at random and upon request. [Symbol for no] episodes of agitation or anxiety R/T [related to] lap buddy." Additional information on the resident's Physical Restraint Care Plan indicated, "2/15/12, "Trial use of lap buddy decision-making - res is not able to consistently remove on command. Is restraint."</p> <p>On 2/16/12 at 1:30 p.m., the DNS provided a "Rehab Addendum Note," dated 2/16/12 and signed by the Occupational Therapist, indicating, "Pt's [patient's] lap buddy positioning device does not negatively impact pt's w/c seated</p>			
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	<p>positioning. The positioning device does increase safety [symbol for secondary to] pt not aware of his limitations including [arrow pointing down]ed [decreased] balance and impaired judgement/problem solving that could cause falls."</p> <p>On 2/16/12 at 2:55 p.m., Resident D was observed seated in the hallway at the Nurse's Station, seated upright in his wheel chair with his hands folded on the lap buddy. A portion of the lap buddy was unattached from the chair. The Medical Records Supervisor was passing by and asked, "You want this back on?" and the resident replied, "No, I want to get up and go see my neighbor." The Medical Records Supervisor propelled the resident in his wheel chair down the hall toward the front of the building and parked the wheel chair near the door way to the parking lot. The resident was observed looking out the door, and immediately CNA #2 brought the resident to the hallway at the Nurse's Station and parked his wheel chair.</p> <p>3.1-3(w) 3.1-26(o)</p>						

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F0315 SS=D	<p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on record review and interview, the facility failed to ensure the resident with history of urinary retention and benign prostatic hypertrophy had care plans in place related to care of the urinary tract, were assessed for bladder discomfort and distention and that urinary output was accurately assessed when the Foley catheter was discontinued. The deficient practice affected 2 of 2 residents reviewed related to management of care of the urinary tract in a sample of 6. (Residents B and D)</p> <p>Findings include:</p> <p>1. The clinical record for Resident B was reviewed on 2/14/12 at 12:30 p.m. The record indicated the resident was admitted 1/19/12 from a local hospital. Hospital records in the clinical record indicated the resident's diagnoses included urinary retention, benign prostatic hypertrophy, and history of prostate cancer. The hospital records indicated the resident's</p>	F0315	<p>It is the policy of this facility to ensure, based on the resident's comprehensive assessment, that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Resident B completed the antibiotic for UTI, achieved therapy goals and discharged home on 02/17/12. Resident D had a care plan dated 01/23/12 for an indwelling catheter, on 01/20/12 an MD order for Foley Catheter 16 FR/5cc to BSD r/t urinary retention and consult with Metro Urology. Resident D went to Metro Urology consult on 02/02/12 and returned with orders for Cipro 250mg PO BID 1 week prior to TUMT scheduled on 02/28/12. On 02/28/12 Metro Urology re-scheduled TUMT for March 23, 2012 at 3:00PM and</p>	03/05/2012			

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	<p>Foley catheter was discontinued on 1/18/12.</p> <p>Hospital physician's Progress Notes, dated 1/18/12, included, but were not limited to, "A/P [Assessment and Plan]...2. Urinary retention VT [voiding test] today, cysto [cystoscopy] today. 3. H/O [history of] prostate CA [cancer]....Rec [recommendations] per urology."</p> <p>Hospital physician Orders, signed by the urologist and dated 1/18/12, included, "1. D/C [discontinue] Foley. 2. Do bladder scan [symbol for after] voiding X 2. 3. If unable to void str. [straight] cath [catheterize] q [every] 4 - 6 hr [hours] prn [as needed]." Two blanks, numbered 1. and 2. followed the second order. Written on the first blank was: "[Symbol for no] ml [milliliters of urine]" and on the second blank was "53 ml."</p> <p>A physician's Order, signed by the urologist on 1/19/12, indicated, "F/U [follow up] in office for VT &amp; PVR [post void residual] in 1 month [symbol for after] D/C [discharge]."</p> <p>Admission Orders, dated 1/19/12, included, but were not limited to, "F/U [follow-up] [symbol for with] [name of urology group] in one month for VT &amp; PVR [voiding trial and post void</p>		<p>Dr. Rosenbaum gave the following orders: D/C Foley catheter and all orders associated with it, In/Out cath. Q 4 hours to monitor residual, Monitor pain/bladder distention, if resident is voiding, but is difficult or too painful then anchor Foley catheter after 4 days; if resident has no output on his own, only In/Out cath. Outputs and re-anchor Foley catheter in 2 days and document as a failed attempt to remove indwelling catheter. All residents with an indwelling catheter removed have had an audit completed for care plans related to removal of the indwelling catheter. All residents with an indwelling catheter removed have had an assessment for bladder discomfort, distention of the bladder and accurate urinary output implemented for 3 days post indwelling catheter removal. The DDCO in-serviced all licensed nurses on the plan of care for removing an indwelling catheter and assessment and documentation of the bladder post indwelling catheter removal for distention, discomfort and accurate output. In-servicing was completed on 02/16/2012 and the SDC/Designee will continue to in-service new licensed nurses. The DNS/Designee will monitor all residents with an indwelling catheter removal and report any findings in the monthly PI meeting. The PI committee</p>				

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	<p>residual]." A physician's order, dated 1/19/12 at 2:00 p.m., included, but was not limited to, "If unable to void straight cath [catheterize] Q [every] 4 - 6 hr [hours] prn [as needed] if bladder 'full' &amp; causing discomfort, Q 6 [symbol for hours] if [symbol for no] bladder distension [symbol for without] voiding."</p> <p>The resident's Interim Plan of Care, dated 1/19/12, indicated problems/needs of at risk for skin impairment, pain, and falls. Documentation failed to indicate the resident's problem/need related to voiding and bladder fullness/distension.</p> <p>The physician's order for "If unable to void straight cath [catheterize] Q [every] 4 - 6 hr [hours] prn [as needed] if bladder 'full' &amp; causing discomfort, Q 6 [symbol for hours] if [symbol for no] bladder distension [symbol for without] voiding" was transcribed onto the Medication Record for 1/19/12, and next to the order was written, "FYI [for your information]."</p> <p>Documentation in Resident Progress Notes and on the Medication Record failed to indicate the resident was assessed for bladder fullness, bladder discomfort, and bladder distention from 1/19/12 at noon through 1/20/12 at 1:00 p.m.</p>		will determine if compliance is achieved after 90 days and the need for any further monitoring. (attachment C)				

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NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-SELLERSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 7823 OLD HWY # 60 SELLERSBURG, IN 47172
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	<p>Resident Progress Notes for Nursing indicated the resident was found on the floor next to the bed on 1/19/12 at 8:30 p.m. and 11:30 p.m. On 1/20/12 at 12:45 p.m., Resident Progress Notes for Social Services indicated the resident was transferred to a room closer to the Nurse's Station. Resident Progress Notes for Nursing on 1/20/12 at 1:00 p.m., indicated the resident's family was concerned about the resident's increased lethargy and requested the resident be transferred to the hospital.</p> <p>The local hospital Emergency Room Record for the resident, dated 1/20/12, indicated "Impression: Acute delirium, dementia, UTI [urinary tract infection]." A physician's "Progress Note," dated 1/21/12, indicated, "...had urinary retention while here last time..."</p> <p>During interview completed with the Director of Nursing Services (DNS) and District Director of Clinical Operations (DDCO) on 2/15/12 at 12:55 p.m., a Bladder Voiding Pattern Record for 1/19/12 and 1/20/12 for Resident B was provided. The DDCO indicated she was uncertain why the document was not in the resident's record but perhaps had been in the CNA documentation binder. She indicated the document showed that the resident had voided on 1/19/12 and</p>			
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	<p>1/20/12, but did not indicate assessment of the resident related to bladder fullness, bladder discomfort, and bladder distention.</p> <p>2. The clinical record for Resident D was reviewed on 2/14/12 at 2:45 p.m. The record indicated the resident was admitted from the hospital on 1/16/12. The Patient Nursing Evaluation indicated the resident had an indwelling Foley urinary catheter upon admission. Diagnoses included, but were not limited to, benign prostatic hypertrophy.</p> <p>Physician's Admission Orders Record included, but were not limited to, "On 1/18/12 remove 16 Fr [French] 5 cc F/C [Foley catheter]. If [symbol for no] output in 6 [symbol for hours], notify [name of Nurse Practitioner]."</p> <p>The resident's Interim Plan of Care, dated 1/16/12, indicated problems/needs of at risk for dysphagia/new gastrostomy tube, skin breakdown, potential for falls, and Do Not Resuscitate. Documentation on the care plan failed to indicate the resident's problem/need related to the Foley catheter.</p> <p>The clinical record indicated the following related to the resident's urine output, catheter and voiding:</p>			

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	<p>Resident Progress Notes, dated 1/18/12 at 12:30 p.m., indicated the Foley catheter was removed, and a new order was received to straight catheterize the resident if the resident did not void within 8 hours.</p> <p>The Comprehensive Intake-Output Record for 1/18/12 indicated Urine Output of 850 cc on the evening shift on 1/18/12. No Urine Output was recorded for the Night Shift or Day Shift on 1/18/12, and no 24 Hour Total was indicated for Urine Output on 1/18/12.</p> <p>The Comprehensive Intake-Output Record for 1/19/12 on Night Shift indicated "Void X 2" with "Straight cath - 850 cc written above" on Night Shift. No Urine Output for Day Shift and Evening Shift, and no 24 Hour Total Urine Output was recorded for 1/19/12.</p> <p>Resident Progress Notes for 1/19/12 at 3:00 a.m., indicated, "...Pt [patient] void X 2...."</p> <p>Resident Progress Notes for 1/19/12 at 6:00 a.m., indicated, "This nurse called to Res room Res on hands and knees on mat beside bed....brief dry....Res unable to tell what was doing states, 'I don't know.' Res denies need to void...."</p>			
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	<p>Resident Progress Notes for 1/19/12 at 5:30 p.m., indicated, "Nurse called to pt room by CNA. Pt found sitting on floor next to bed on mat....pt said I was trying to go to the bathroom....Assisted off floor...put in W/C @ nurses station...." Documentation failed to indicate the resident was assisted to toilet or the bladder assessed.</p> <p>Resident Progress Notes for 1/20/12 at 12:30 a.m., indicated, "Res c/o not being able to urinate. Pt. has distended bladder. Pt was straight cathed. Nurse obtained 850 cc of dark tea colored urine w/ [with] foul odor....NP [Nurse Practitioner] was notified."</p> <p>A Physician's Telephone Order for 1/20/12 at 2:00 a.m., indicated an order for urinalysis with culture and sensitivity in the morning and, "May straight cath Q [every] 8 if [symbol for no] void."</p> <p>Resident Progress Notes for 1/20/12 at 2:30 a.m., indicated, "...bladder soft non distended...."</p> <p>A Condition Change Form for 1/20/12 (untimed) indicated, "Res cont [continued] [symbol for without] [sic] difficulty voiding," and the resident was straight catheterized at 8:10 a.m., with</p>			
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	<p>650 cc of tea colored urine obtained. The Nurse Practitioner was notified, and an anchored Foley catheter was ordered.</p> <p>During interview completed with the Director of Nursing Services (DNS) and District Director of Clinical Operations (DDCO) on 2/15/12 at 12:55 p.m., a Bladder Voiding Pattern Record for 1/18/12, 1/19, and 1/20/12 for Resident D was provided. The DDCO indicated she was uncertain why the document was not in the resident's record but perhaps had been in the CNA documentation binder. She indicated the document showed that the resident had voided on 1/18/12, 1/19/12 and 1/20/12, but did not indicate assessment of the resident related to the amount the resident was voiding or bladder distension.</p> <p>3.1-41(a)(2)</p>						

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F0456 SS=D	<p>The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a shower bench in the residents' shower room was maintained safely to prevent a fall. The deficient practice affected 1 of 3 residents reviewed related to falls in a sample of 6. (Resident C)</p> <p>Findings include:</p> <p>During Initial Tour on 2/14/12 at 11:20 a.m., Unit Manager #9 indicated Resident C was very independent and would be going home soon. Unit Manager #9 indicated Resident C had fallen recently.</p> <p>The clinical record for Resident C was reviewed on 2/14/12 at 1:35 p.m.</p> <p>Nurse's Notes, dated 2/4/12 at 3:30 p.m., indicated, "Pt [patient] was taking a shower [symbol for with] the help from a family member. The bench that she was sitting on broke causing her to fall to her buttocks. She didn't strike her head &amp; the only apparent injury are [sic] 2 bruises to her buttocks. [Names of Nurse Practitioner and Director of Nursing Services] was notified. An order for an x-ray of her coccyx &amp; hip was obtained &amp; carried out. There was no evidence of a</p>	F0456	<p>It is the policy of this facility to maintain all essential mechanical, electrical, and patient care equipment in safe operation condition. The shower stall in question was taken out of service on 2/3/12 using the facilities lock-out, tag-out procedure. All wall mounted shower benches we removed from the shower rooms on 2/5/12. The facility maintains a preventive maintenance program, which schedules essential mechanical, electrical and patient care equipment for weekly, monthly and quarterly inspections. The maintenance department as been educated on the preventive maintenance program and the lock-out, tag-out process. If at any time an item needs to be taken out of service the Executive Director will review for proper lock-out, tag-out process. The maintenance department will complete routine inspections of mechanical, electrical and patient care equipment. The Executive Director audits the preventive maintenance program weekly and report findings at the monthly PI meeting until compliance has been met. The Maintenance Director will be responsible to ensure compliance with this standard</p>	03/05/2012			

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	<p>fx [fracture]. her pain was relieved [symbol for with] her prn [as needed] medication. All of her VS [vital signs] &amp; neuro [check mark] have been wnl [within normal limits]."</p> <p>On 2/14/12 at 2:05 p.m., Resident C was not observed in her room. Two visitors were in the room. Interview with one of the visitors at this time indicated the resident was in therapy and would return to the room shortly. The visitor indicated the resident had a fall in the shower room. He indicated the resident's sister, was assisting the resident with a shower, and when the resident sat on the shower bench, it fell off the wall. He indicated the resident weighs about 80 pounds. He pointed to his back and indicated the resident had a bruise on her back after the fall, which hurt for quite a while.</p> <p>During interview in regard to the broken shower bench on 2/14/12 at 2:50 p.m., the employee responsible for Central Supply and Maintenance Assistant (CS/MA) indicated there were four shower stalls in the large shower room between the 200 and 300 halls. He indicated that apparently a heavy resident had sat on and loosened one of the shower benches attached to the wall. He indicated he had placed a STOP sign on the stall so it would not be used. He indicated a family</p>			
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	<p>member of the Resident C took the resident into the shower room, ignored the STOP sign, sat the resident on the shower bench, which broke off the wall.</p> <p>Review of the list of interviewable residents provided by the facility on 2/14/12 at 11:55 a.m., indicated Resident C was interviewable.</p> <p>During interview completed in the resident's room on 2/14/12 at 4:10 p.m., Resident C indicated there was no sign in the shower room indicating she should not use the shower bench. She indicated her sister was assisting her with her shower, and as soon as she sat on the shower bench, the bench broke, and she immediately fell onto the floor. The resident indicated she was in pain after the fall, and "had an imprint of the floor drain on her butt [buttocks]" after the fall. The resident indicated she had been ill and hospitalized recently and thought she now weighed less than 80 pounds.</p> <p>Upon exit from Resident C's room at the end of the interview, the Administrator was in the hallway outside the resident's room. The Administrator indicated the report of the incident had been entered into the facility's event reporting system as part of the quality assurance program. The Administrator indicated no report had</p>						

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	<p>been made previously before the resident's fall related to any problem with the shower bench. The Administrator was requested to provide any information he had related to the shower bench.</p> <p>On 2/14/12 at 4:00 p.m., the shower room between the 200 and 300 halls was observed. In the "Women's Shower" section of the room, were four shower stalls with white plastic shower benches in them. The DNS (Director of Nursing Services) entered the shower room and indicated she was uncertain which shower stall had the faulty bench, since all the shower benches had now been removed as a precaution. She showed the places on the shower stall walls where the shower benches had been removed. The DNS indicated she had been notified of the fall, and she indicated she was "surprised little Mrs. [name of Resident C]" fell. CS/MA entered the shower room and indicated the faulty bench was in the third stall from the left, facing the stalls. The tile around the screw holes where the bench had been attached were observed to have broken areas. The CS/MA motioned with his arms in front of the shower stall and indicated the STOP sign was in front of the shower stall.</p> <p>The shower room was observed again on</p>			
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	<p>2/15/12 at 9:45 a.m., and during the observation, the Director of Nursing Services entered the room. During interview at this time, she indicated she did not understand why Resident C's family would select to use a shower marked with the STOP sign when other shower stalls were available.</p> <p>During interview on 2/15/12 at 11:00 a.m., the Administrator provided documentation related to the broken shower bench.</p> <p>Review of the documentation at this time indicated a "Maintenance Request" form, dated 2/3/12 at 10:15 a.m. The form indicated the request was from CNA #10 with problem: "Shower bench is coming off wall in second stall." The portion of the form completed by Maintenance indicated, "Problem: Corrected; Date: 2/4/12." A handwritten notation indicated, "2-3 posted lock out tag &amp; inspected benches [sic]." In the "Comments" section indicated, "2-5-12 Removed benches [sic] as safety hazard; ordered shower benches [sic] 2-8-12." The document was signed with the Administrator's signature and dated 2/8/12.</p> <p>Documentation also indicated a "Lock Out - Tag Out Usage Log" indicating the</p>						

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	<p>shower bench was "Locked Out" by Maintenance on 2-3-12 at 3:30 p.m., with a STOP sign.</p> <p>During interview on 2/15/12 at 1:30 p.m., CNA #10 indicated she had reported the faulty shower bench to (Name of Maintenance Supervisor) after she was in the shower room with a resident on 2/3/12. CNA #10 indicated she did not usually use the shower stall where the bench broke, because the residents prefer a larger stall. CNA #10 indicated she planned to use the smaller stall on the day she identified the faulty bench, because another resident was using the larger stall. CNA #10 indicated she flipped the shower bench down, so the resident could sit on it. CNA #10 indicated she pressed on the bench, as always, because they "scare me," and the corner of the bench titled down on one side. CNA #10 motioned with finger and thumb to indicate about 1 and 1/2 to 2 inches that the screws on one side of the bench were coming out of the wall.</p> <p>During this same interview, the Administrator indicated he was at work in the facility on Sunday, 2/5/12, and asked the Maintenance Supervisor to remove all shower benches from the shower room as a safety precaution.</p>			
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	<p>During interview on 2/16/12 at 3:35 p.m., RN #13 indicated she was on duty when the shower bench broke during Resident C's shower. RN #13 indicated after the resident returned to her room, she, RN #13, returned to the shower room. She indicated she observed where the shower bench had pulled from the wall. She indicated she saw no indication the shower stall or broken shower bench had a sign that it should not be used. She indicated the Maintenance Supervisor was called, and he came in and removed the broken bench that day.</p> <p>During interview at the Exit Conference on 2/16/12 at 4:00 p.m., the Administrator indicated when he came into the facility on 2/5/12, he went into the shower room to observe the broken bench. He indicated at the time of his observation, he saw a STOP sign on the shower curtain pushed to the side of the stall. He indicated maybe the STOP sign was pushed to the side of the stall and that was why the sign had not been seen.</p> <p>This federal tag is related to Complaint IN00103698.</p> <p>3.1-19(bb)</p>			
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F0514 SS=D	<p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to ensure the clinical record was consistent and accurate related to documentation of pain and bruising at the time of a fall (Resident C) and complete and accurate for urinary output (Resident D). The deficient practice affected 2 of 6 residents reviewed related to documentation in the clinical record in a sample of 6. (Residents C and D)</p> <p>Findings include:</p> <p>1. The clinical record for Resident C was reviewed on 2/14/12 at 1:35 p.m.</p> <p>Nurse's Notes, dated 2/4/12 at 3:30 p.m., indicated, "Pt [patient] was taking a shower [symbol for with] the help from a family member. The bench that she was sitting on broke causing her to fall to her buttocks. She didn't strike her head &amp; the only apparent injury are [sic] 2 bruises to her buttocks. [Names of Nurse</p>	F0514	<p>It is the policy of this facility to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. Resident C has discharged home. Resident D's output is being documented on the comprehensive Intake-Output Record Q shift. All residents with pain or bruises after an accident have had their documentation reviewed for accuracy. All residents requiring accurate output after indwelling catheter removal have had the Comprehensive Intake-Output Records reviewed for accurate completion. Licensed Nurses will be in serviced on the proper documentation of pain, bruises and accurate intake and output. The DNS/Designee will perform audits 5 times a week of the Intake-Output Record, assessment of bruises, and documentation of residents with pain for accuracy x 30 days, then</p>	03/05/2012
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	<p>Practitioner and Director of Nursing Services] was notified. An order for an x-ray of her coccyx &amp; hip was obtained &amp; carried out. There was no evidence of a fx [fracture]. Her pain was relieved [symbol for with] her prn [as needed] medication. All of her VS [vital signs] &amp; neuro [check mark] have been wnl [within normal limits]." The note was signed by LPN #19.</p> <p>A Post Fall Evaluation, dated 2/4/12 at 4:00 p.m. indicated, "Description of Fall: Res [resident] in shower room Bench fell from wall. Res. fell to floor bruising her R [right] hip &amp; bottom. Res. sister in shower room - Res c/o [complained of] pain 7/10 [on a pain scale rating]." The note was signed by RN #13.</p> <p>A Weekly Non-Pressure Skin Condition Report indicated, "Date of First Observation: 2/4/12 [no time indicated] Site/Location: Bruise to Buttocks Condition is: Bruise." An anatomical picture of a body indicated a circle on the right lower buttock. An entry dated 2/4 indicated: Size: 1 X 1 in a column for "Size in CM [centimeters]. Documentation was lacking related to the bruising on the resident's right hip or a second bruise as indicated in the Nurse's Note. On the reverse of the form, an entry dated 2/4/12, "Pain associated w/</p>		3 times a week for 30 days, then weekly x 30 days. The findings will be discussed at the monthly PI meeting until compliance is met as determined by the PI committee. (attachment D)				

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	<p>[with] Non-Pressure Skin Condition: No." The report was signed by LPN #11.</p> <p>During interview on 2/16/12 at 10:15 a.m., the Director of Nursing Services indicated the documentation in the record did not give a clear picture of the assessment, including bruising, after the resident's fall.</p> <p>During interview on 2/16/12 at 3:05 p.m., LPN #19 indicated he assessed the resident for bruising after the fall, and she had an imprint of the floor drain on her bottom at that time.</p> <p>During interview on 2/16/12 at 3:35 p.m., RN # 13 indicated she assessed the resident for bruising after the fall, and she had a small bruise on the right side of her bottom and three red marks where she had hit the vent. She indicated the resident's pain was "pretty bad" to her hip and sacrum, and an order for extra pain medication was obtained to help manage the pain.</p> <p>2. The clinical record for Resident D was reviewed on 2/14/12 at 2:45 p.m. The record indicated the resident was admitted from the hospital on 1/16/12. The Patient Nursing Evaluation indicated the resident had an indwelling Foley urinary catheter upon admission. Diagnoses included, but</p>			

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	<p>were not limited to, benign prostatic hypertrophy.</p> <p>Physician's Admission Orders Record included, but were not limited to, "On 1/18/12 remove 16 Fr [French] 5 cc F/C [Foley catheter]. If [symbol for no] output in 6 [symbol for hours], notify [name of Nurse Practitioner]."</p> <p>The clinical record indicated the following related to the resident's urine output, catheter and voiding:</p> <p>Resident Progress Notes, dated 1/18/12 at 12:30 p.m., indicated the Foley catheter was removed, and a new order was received to straight catheterize the resident if the resident did not void within 8 hours.</p> <p>The Comprehensive Intake-Output Record for 1/18/12 indicated Urine Output of 850 cc on the evening shift on 1/18/12. No Urine Output was recorded for the Night Shift or Day Shift on 1/18/12, and no 24 Hour Total was indicated for Urine Output on 1/18/12.</p> <p>The Comprehensive Intake-Output Record for 1/19/12 on Night Shift indicated "Void X 2" with "Straight cath - 850 cc" written above on Night Shift. No Urine Output for Day Shift and Evening</p>			
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	<p>Shift, and no 24 Hour Total Urine Output was recorded for 1/19/12.</p> <p>Resident Progress Notes for 1/19/12 at 3:00 a.m., indicated, "...Pt [patient] void X 2..." Documentation lacked indication of the amount voided.</p> <p>Resident Progress Notes for 1/20/12 at 12:30 a.m., indicated, "Res c/o not being able to urinate. Pt. has distended bladder. Pt was straight cathed. Nurse obtained 850 cc of dark tea colored urine w/ [with] foul odor....NP [Nurse Practitioner] was notified."</p> <p>During interview completed with the Director of Nursing Services (DNS) and District Director of Clinical Operations (DDCO) on 2/15/12 at 12:55 p.m., a Bladder Voiding Pattern Record for 1/18/12, 1/19, and 1/20/12 for Resident D was provided. The DDCO indicated she was uncertain why the document was not in the resident's record but perhaps had been in the CNA documentation binder. She indicated the document showed that the resident had voided on 1/18/12, 1/19/12 and 1/20/12 but did not indicate assessment of the resident related to the amount the resident was voiding.</p> <p>This federal tag is related to Complaint IN00103698.</p>				

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	3.1-50(a)(1) 3.1-50(a)(2)			
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F9999	<p>STATE FINDINGS</p> <p>3.1-12 TRANSFER AND DISCHARGE RIGHTS</p> <p>The transfer and discharge rights of residents of a facility are as follows: (9) For health facilities, the written notice specified in subdivision (7) must include the following: (G) The name, address, and telephone number of the division and local long term care ombudsman.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure the Notice of Transfer and Discharge included the name and contact information for the local long term care ombudsman for 3 of 3 residents reviewed related to discharge paperwork in a sample of 6 residents. (Residents E, F, and G)</p> <p>Findings include:</p> <p>1. The closed clinical record for Resident E was reviewed on 2/15/12 at 2:35 p.m. The record indicated the resident was</p>	F9999	<p>It is the policy of this facility to include the name, address, and telephone number of the division and local long term care ombudsman on the written notice of transfer and discharge. All transfer and discharge notices will be replaced with a master copy, that is already completed with the name, address, and telephone number of the division and local long term care ombudsman. All residents who are transfer or discharged from the facility will receive a transfer/discharge notice. Medical Records and nursing staff have been educated in the use of the transfer/discharge notice. All transfers and discharges will be audited for a proper completion of the transfer/discharge notice by medical records. Results of this audit will be reviewed at the monthly PI meeting until compliance has been met. (attachment A) The Director of Nursing will be responsible to ensure compliance with this standard.</p>	03/05/2012	

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	<p>discharged to the hospital on 2/2/12. At this time, the record included no copy of the Notice of Transfer or Discharge.</p> <p>2. The closed clinical record for Resident F was reviewed on 2/15/12 at 2:50 p.m. The record indicated the resident was discharged home on 1/24/12. The copy of the Notice of Transfer or Discharge, dated 1/24/12, indicated the section for State Ombudsman was completed, but the name, telephone number, and address of the local long term care ombudsman was left blank.</p> <p>3. The closed clinical record for Resident G was reviewed on 2/15/12 at 2:15 p.m. The record indicated the resident was discharged to the hospital on 1/11/12. The record included no copy of the Notice of Transfer and Discharge.</p> <p>During interview on 2/15/12 at 4:45 p.m., the Medical Records Supervisor was shown the Notice of Transfer and Discharge for Resident F, and the copy of the notices for Residents E and G were requested. The Medical Records Supervisor indicated the residents would not have a Notice of Transfer and Discharge, since they were discharged to the hospital for medical care.</p> <p>During interview on 2/15/12 at the Daily</p>			

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	<p>Conference completed at 5:20 p.m., the District Director for Clinical Operations indicated Residents E and G should have Notice of Transfer and Discharge, and the records would be located.</p> <p>On 2/16/12 at 9:25 a.m., the District Director for Clinical Operations was requested and provided the Notices of Transfer and Discharge for Resident E and G. Each of the notices included State Ombudsman information, but both forms were blank in the section for the name, address, and phone number of the local long term care ombudsman.</p> <p>This state finding is related to Complaint IN00103952.</p> <p>3.1-12(a)(9)(G)</p> <p>3.1-13 ADMINISTRATION AND MANAGEMENT</p> <p>The administrator is responsible for the overall management of the facility but shall not function as a departmental supervisor, for example, director of nursing or food service supervisor, during the same hours. The responsibilities of the administrator shall include, but are not limited to, the following:</p>						

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	<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>(D) major accidents.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure an accident in which a shower bench in use by a resident fell from the wall was reported to the Indiana State Department of Health. The deficient practice affected 1 of 3 residents reviewed related to falls in a sample of 3. (Resident C)</p> <p>Findings include:</p> <p>During Initial Tour on 2/14/12 at 11:20 a.m., Unit Manager #9 indicated Resident C was very independent and would be going home soon. Unit Manager #9 indicated Resident C had fallen recently.</p> <p>The clinical record for Resident C was reviewed on 2/14/12 at 1:35 p.m.</p> <p>Nurse's Notes, dated 2/4/12 at 1:35 p.m., indicated, "Pt [patient] was taking a</p>			
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	<p>shower [symbol for with] the help from a family member. The bench that she was sitting on broke causing her to fall to her buttocks...." The Notes also indicated the resident did not strike her head and had two bruises to her buttocks; the Nurse Practitioner and Director of Nursing Services were notified; x-rays were obtained and indicated no fractures; and the resident's pain was managed with as needed narcotic medications.</p> <p>During interview completed in the resident's room on 2/14/12 at 4:10 p.m., Resident C indicated there was no indication in the shower room that she should not use the shower bench. She indicated her sister was assisting her with her shower, and as soon as she sat on the shower bench, she immediately fell onto the floor. The resident indicated she was in pain after the fall, and "had an imprint of the floor drain on her butt [buttocks]" after the fall.</p> <p>Upon exit from Resident C's room at the end of the interview, the Administrator was in the hallway outside the resident's room. During interview at this time, the Administrator indicated the resident's fall from the broken shower bench was not reported to the Indiana State Department of Health, because the resident is "alert, oriented, and her own person."</p>						

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	<p>During interview on 2/15/12 at 12:55 p.m., the Administrator indicated the facility follows the Indiana State Department of Health policy related to reporting significant injuries. He indicated the facility did not have a policy that specified size of lacerations or contusions to be reported as significant injuries. He indicated the state rule did not define "major accident," and since Resident C did not have a significant injury, the fall caused by the broken shower bench was not reported.</p> <p>This state finding is related to Complaint IN00103698.</p> <p>3.1-13(g)(1)(D)</p>			
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