STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155444	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORWOOD HEALTH AND REHABILITATION CENTER	3720 N NORWOOD RD HUNTINGTON, IN 46750

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F000000	This visit was for a Recertification and State Licensure Survey. Dates of Survey: October 28, 29, 30, 31, November 1, 4, 2013. Facility number: 000463 Provider number: 155444 AIM number: 100290910 Survey team: Karen K. Koeberlein, RN-TC Angela Selleck, RN Toni Maley, BSW (October 29, 30, 31, November 1, 2013) Census bed type: SNF/NF: 63 Total: 63 Census payor type: Medicaid: 44 Medicare: 3 Other: 16 Total: 63 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality Review completed by Debora Barth, RN.	F000000	Preparation and/or execution of this plan does not constitute admission or agreement by the provider to the facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed soley because it is required by the provisons of the federal and state law.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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F000156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes:			

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	A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits,			

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	and how to receive refunds for previous payments covered by such benefits. Based on interview and record review, the facility failed to ensure residents who were discontinued from Medicare services and had not exhausted their 100 days of Medicare services were given timely notice regarding the end date of their Medicare services for 2 of 3 residents reviewed for proper notification of benefits change (Resident #80 and #11). Findings include: 1.) During an 10/31/13, 1:25 p.m. interview, the Administrator indicated the facility had no documentation regarding Resident #80 and notification of Medicare non-coverage. The Administrator additionally indicated Resident #11 had a letter, dated 5/29/13, which lacked documentation of the resident or his family having been notified, orally or in writing, that his Medicare coverage would end that day. The Administrator indicated the facility followed the practice of providing notice of Medicare non-coverage in three days and he did not know why Resident #11 and #80 were lacking this documentation.	F000156	The facility shall follow, Attachment A, CMS Form Instructions for the Notice of Medicare Non-Coverage[NOMNC] which will ensure residents exhausting or discontinuing skilled services are notified of their appeal rights not less than 2 days prior unless the resident decides to discharge without 2 day notice. Corrective Action for resident's affected:No residents were adversly affected. The Administrator or designee shall be responsible to review the NOMNC with each resident being discharged from skilled services at least 2 days prior. Their signature shall be obtained verifying notice anddate of notice. Other residents having the potential to be affected.No resident were adversly affected. The Administrator or designee shall be responsible to review the NOMNC with each resident discharging from skilled services at least 2 days prior. Their signature shall be obtained verifying notice and date of notice.Measures to ensure practice does not reoccur:Each working day, the Social Worker shall review all the skilled residents for discharge from skilled services. These reviews shall include the DON and Therapy Manager. All planned discharges will identify a d/c date and the Administrator or designee	12/04/2013

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	2.) Resident #80's closed record was reviewed on 11/1/13 at 10:00 a.m. Resident #80 diagnoses included, but were not limited to, closed fracture of the ribs, depression and a intra-cranial injury. Resident #80 was admitted to the facility on 6/5/13 and discharged from the facility on 7/3/13. The record indicated the resident had physical therapy and occupational services during his stay in the facility. The record lacked any documentation of notification for Medicare non-coverage. 3.) Resident #11's record was reviewed on 11/1/13 at 10:30 a.m. Resident #11 current diagnoses included, diabetes mellitus, Alzheimer's disease and depression. Resident #11 returned to the facility from a hospital stay on 5/10/13. Resident #11 received Medicare therapy services following the hospital stay. Resident #11 had an undated, unsigned "Notice of Medicare Non-coverage" which indicated services would end 5/29/13. 4.) During an 11/1/13, 8:25 a.m. interview, the Director of Nursing indicated both Resident #11 and Resident #80 ended their qualified Medicare covered stays because they had reached their therapy goals and		shall ensure a copy of the NOMNC, Attachment B, shall be reviewed and signed by the resident or responsible party at least 2 days prior to their discharge or the exhaustion of their skilled benefit coverage. This corrective action will be monitored by:The Business Office Manager shall shall monitor compliance Compliance shall be further monitored by the QA Committee until compliance is obtained or for 3 months.	

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	no longer required a Medicare covered service. 3.1-4(a)			

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F000244 SS=D	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. Based on interview and record review, the facility failed to ensure Resident Council concerns regarding lengthy call light waits were resolved. This deficient practice impacted 6 of 23 residents interviewed regarding waiting for care and services (Residents #37, #56, #61, #67 #13 and #22). Findings Include: During a 10/31/13, 2:30 p.m., interview the Resident Council President indicated residents frequently complained about lengthy call light waits during Resident Council Meetings. She additionally indicated, she was unsure if the facility gave a response to the council regarding how the facility would address this concern. Review of Resident Council minutes for the year 2013 (January through October) indicated the resident's had concerns regarding lengthy call light	F000244	The facility will address all Resident Council grievances and recommendations including answering call lights in a timely manner.Corrective action for residents affected:All residents have the potential of being affected. The facility has a comprehensive plan of correction, see below, to ensure residents are satisfied with the response time to answering call lightsOther residents having the potential to be affected:All residents have the potential to be affected. The facility has a comprehensive plan of correction, see below, to ensure residents are satisfied with the response time to answering call lights.Measures to ensure practice does not reoccur:1] An all staff in-service was conducted on 11/12/13 by the Administrator identifying the importance and responsibility of all staff to ensure call lights are answered timely.2] Beginning the week of 11/18/13, and weekly thereafter for a minimum of 8 consecutive weeks, the Administrator/designee shall participate in weekly Resident Council Meetings. Each meeting	12/04/2013

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	waits for 5 of the 10 months as follows: 9/5/13, 8/1/13, 5/2/13, 3/14/13 and 2/7/13. The facility's response to each concern was to re-educate staff regarding the importance of answering call lights promptly. The facility did not indicate they had developed a plan to address lengthy call light waits. During individual resident interviews 6 of 23 residents indicated they had difficulties with lengthy call light waits (30 minutes regularly, longer periods periodically) on a regular ongoing basis as follows: Resident #37 on 10/30/13 at 1:33 p.m. Resident #56 on 10/30/13 at 10:05 a.m. Resident #61 on 10/30/13 at 11:17 a.m. Resident #13 on 10/30/13 at 1:29 p.m. Resident #67 on 10/30/13 at 8:38 a.m. Resident #22 on 10/30/13 at 11:30 a.m. During an 11/1/13, 2:00 p.m. interview, the Administrator indicated the facility had educated the staff in response to the Resident Council concerns of lengthy call light waits. He indicated the facility had told 3rd		will focus on call light concerns and resolution.3] Also beginning the week of 11/18/13, each department manager will be responsible for doing call light audits, see Attachment C. At least one audit will be completed each day covering all 3 shifts at least weekly for a minimum of 8 consecutive weeks. Call light audits will be reviewed by the DON/designee 5 X weekly for trends with interventions implemented as appropriate.4] Each resident will be interviewed, see Attachment D, at least monthly for their satisfaction to call light responses. Any "unsatisfactory" response will require follow-up by the Administrator.This corrective action will be monitored by:The Administrator and DON will review the results of the above plans with the QA Committee at least monthly for the next 3 months and at least quarterly thereafter. Any negative trends will require additional plans of action untill "satisfaction" results.	

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	shift staff to only work in pairs if the resident is a 2 person assist. He indicated the facility had not developed a plan to address the waits believing they were isolated concerns. When informed residents continued to express concern during their individual interviews, he indicated he had not been aware it was an ongoing problem. 3.1-3(l)			

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F000309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on interview, and record review, the facility failed to ensure a resident received intermittent catheterization at the ordered times with follow up urinary output documented as ordered for 1 of 1 resident reviewed for catheterization services (Resident #52). Findings include: 1. During an interview on 10/30/13 at 10:37 a.m., Resident #52 indicated that he was scheduled to be straight catheterized every six hours. Resident #52 indicated the scheduled times were 9:30 a.m., 3:30 p.m., 9:30 a.m., and 3:30 a.m. Resident #52 stated "I have had some late catheterizations and that really influences my sleeping when they miss the catheterization times. It adversely affects my sleep, because I get up multiple times throughout the	F000309	It is the practice of this facility to provide necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Corrective Action for residents affected:Resident #52 had no indications of harm due to late intermittent catheterizations. Urinary output was changed to be documented at the time of catheterization documentation instead of as follow-up documentation. Other residents having the potential to be affected:All other residents with scheduled intermittent catheterizations have the potential to be affected.There are currently no other residents receiving scheduled intermittent catheterizations. Measures to ensure this practice does not reoccur:Licensed nursing staff will be re-educated on Medication Administration Operating Standard Guidelines and Catheter and Removal Procedure.This corrective action will be monitored by:An audit	12/04/2013

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	night to try to urinate due to the discomfort." Resident #52's record was reviewed on 10/31/13 at 3:20 p.m. Resident #52's current diagnoses included, but were not limited to, chronic kidney disease, hypothyroidism, hyperpotassemia, hypertension, generalized pain, retention of urine, urinary incontinence, urinary frequency, history of fall, end stage renal disease, chronic kidney disease stage V, edema, urinary tract infection and disorders of the urinary system. Resident #52 had a current physician order to be straight catheterized every six hours. The schedule was every day at 3:00 a.m.; 9:00 a.m.; 3:00 p.m. and 9:00 p.m. The original order date was 6/26/13. Resident #52 currently had an order to monitor output follow-up (5 minutes) with an order date of 6/26/13. Resident #52 had a current 9/2013 (no day) care plan regarding urinary health and an approach to this problem was straight catheterization four times daily as ordered. Resident #52's record indicated the scheduled times for straight		tool, Attachment E, will be used to monitor timely scheduled intermittent catheterizations and documentation of urinary output. This tool will be completed daily, during normal days of business, x2 weeks, then 3x weekly x 2 weeks, then weekly x 2 weeks, then monthly in QA process x6 months or until compliance is achieved. Any findings will be addressed immediatley.	

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	catheterization were not completed as ordered and/or the record lacked urine output documentation on the following dates and times: a.) 10/1/13 scheduled for 3:00 p.m. was completed at 6:10 p.m. three hours and ten minutes after the scheduled time and the urine output was not documented. b.) 10/2/13 scheduled for 9:00 p.m. was completed at 11:00 p.m., two hours after the scheduled time. c.) 10/4/13 scheduled for 3:00 a.m. was completed at 4:55 a.m., one hour and 55 minutes after the time scheduled. d.) 10/5/13 scheduled for 9:00 p.m. urine output was not documented. e.) 10/7/13 scheduled for 3:00 p.m. was completed at 5:32 p.m., two hours and 32 minutes after the scheduled time. f.) 10/8/13 scheduled for 9:00 p.m. was completed at 11:56 p.m., two hours and 56 minutes after the scheduled time. g.) 10/11/13 scheduled for 3:00 a.m. was completed at 5:15 a.m., two			

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	hours and 15 minutes after the scheduled time. h.) 10/12/13 scheduled for 3:00 a.m., urine output was not documented. i.) 10/13/13 scheduled for 3:00 a.m. was completed at 5:27 a.m., two hours and 27 minutes after the scheduled time and the urine output was not documented. j.) 10/14/13 scheduled for 9:00 p.m. was completed on 10/15/13 at 3:16 a.m., six hours and 16 minutes after the scheduled time. k.) 10/17/13 scheduled for 3:00 p.m. was completed at 10:13 p.m., seven hours and 13 minutes after the scheduled time. l.) 10/20/13 scheduled for 9:00 p.m. was completed at 11:37 p.m., two hours and 37 minutes after the scheduled time. m.) 10/22/13 scheduled for 9:00 p.m. was completed at 11:00 p.m., two hours after the scheduled time. n.) 10/23/13 scheduled for 3:00 a.m. was completed on 10/22/13 at 11:00 p.m., eight hours prior to scheduled time and the urine output was not			

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	documented. o.) 10/24/13 scheduled for 3:00 p.m. was completed at 10:31 p.m., seven hours and 31 minutes after the scheduled time and the urine output was not documented. p.) 10/26/13 scheduled for 3:00 a.m. was completed at 6:11 a.m., three hours and 11 minutes after the scheduled time and urine output was not documented. q.) 10/26/13 scheduled for 9:00 p.m. was completed on 10/27/13 at 4:47 a.m., seven hours and 47 minutes after the scheduled time and the urine output was not documented. r.) 10/27/13 scheduled for 3:00 a.m. was completed on 10/27/13 at 4:47 a.m., one hour and 47 minutes after the scheduled time and the urine output was not documented. s.) 10/27/13 scheduled for 9:00 p.m. was completed on 10/28/13 at 7:43 a.m., ten hours and 43 minutes after the scheduled time and the urine output was not documented. t.) 10/28/13 scheduled for 3:00 a.m. was completed at 7:43 a.m., four hours and 43 minutes after the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155444	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/04/2013
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	scheduled time and the urine output was not documented. u.) 10/28/13 scheduled for 9:00 p.m. was completed on 10/29/13 at 12:18 a.m., three hours and 18 minutes after the scheduled time. v.) 10/30/13 scheduled for 3:00 p.m. was completed at 6:54 p.m., three hours and 54 minutes after the scheduled time. w.) 10/31/13 scheduled for 3:00 a.m. was completed at 10:29 a.m., seven hours and 29 minutes after the scheduled time and the urine output was not documented. x.) 10/31/13 scheduled for 9:00 a.m. was completed at 10:29 a.m., one hour and 29 minutes after the scheduled time and the urine output was not documented. y.) 10/31/13 scheduled for 9:00 p.m. was completed on 11/1/13 at 6:13 a.m., nine hours and 13 minutes after the scheduled times and the urine output was not documented. During an interview on 11/1/13 at 9:53 a.m., the Assistant Director of Nursing indicated that the order to monitor output follow-up meant to			

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	document the urine output after the straight catheterization was completed. During an interview on 11/1/13 at 10:00 a.m., the Director of Nursing and Nurse Consultant indicated that the order to monitor output follow-up order meant to monitor and document urine output. The output should have been documented after each straight catheterization. Both were aware that the straight catheterization was not always completed at the scheduled times and the urine output was not always documented. Review, on 11/1/13 at 9:00 a.m., of the "Catheter Insertion and Removal, Male, " dated 2006, indicated "...Purpose: To relieve bladder distention and to determine amount of residual urine in bladder after resident urinates..." 3.1-37(a)			