

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 01/29/2015
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NAME OF PROVIDER OR SUPPLIER NORWOOD HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3720 N NORWOOD RD HUNTINGTON, IN 46750
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F000000	<p>This visit was for the Investigation of Complaint #IN00163548.</p> <p>Complaint IN00163548 - Substantiated. Federal/State deficiency related to the allegations were cited at F312.</p> <p>Survey date: January 29, 2015</p> <p>Facility number: 000463 Provider number: 155444 AIM number: 100290910</p> <p>Survey team: Angela Selleck, RN-TC Shelley Reed, RN</p> <p>Census bed type: SNF/NF: 50 Total: 50</p> <p>Census payor type: Medicare: 5 Medicaid: 37 Other: 8 Total: 50</p> <p>Sample: 5</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F000000	<p>This plan of correction is Norwood Health and Rehabilitation Center's credible allegation of compliance. Preparation and execution of this plan of correction does not constitute admission or agreement of Norwood Health and Rehabilitation Center to the facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared and executed solely because it is required by the provisions of federal and state law.</p> <p>Norwood Health and Rehabilitation Center respectfully requests that this Plan of Correction be accepted and considered for paper compliance.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F000312 SS=D	<p>Quality review completed by Debora Barth, RN.</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on record review and interview, the facility failed to ensure residents who were dependent on staff for grooming and personal hygiene received those services in regards to a shower/complete bed bath for 2 of 5 residents reviewed for assistance with activities of daily living in a sample of 5. (Residents E and F)</p> <p>Findings include:</p> <p>1. The clinical record for Resident (E) was reviewed on 1/29/15 at 11:20 a.m. Diagnoses for the resident included, but were not limited to, persistent mental disorder, hypertension, macular degeneration, senile dementia and end stage renal disease.</p> <p>The most recent Admission Minimum Data Set (MDS) assessment, dated 12/8/14, indicated Resident (E) was severely cognitively impaired.</p>	F000312	<p>Corrective action for the resident(s)affected: The residents listed no longer reside in the facility. Corrective action for other residents having the potential to be affected: The shower schedule for all residents residing in the facility was changed on 2/2/15 in an effort to provide all residents with atleast two showers or baths per week, to accommodate their desire to be showered in the morning or evening and on specific days. A shower binder was created on each nursing unit containing the shower schedule and dividers, 1-31, to file completed shower sheets. Systemic change to ensure that the practice does not recur: Nursing staff was provided with education about the use of the new shower binders. Education was also provided about the appropriate process to be taken if a shower is not given for any reason. Monitoring plan for the corrective action:</p>	02/12/2015

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	<p>Review of a current health care plan problem/need assessment, dated 12/1/14, indicated the resident had a self-care deficit related to impaired decision making and history of a fracture. Interventions for this problem included, but were not limited to, "personal hygiene with one person physical assist and bathing with one person physical assist." Another problem indicated Resident (E) had skin complications from dermatitis. Interventions for this problem included, but were not limited to, "keep skin clean and dry and keep fingernails clean and short."</p> <p>Review of the shower schedule indicated Resident (E) was to receive showers on Wednesday and Saturday. During the month of December, Resident (E) did not have any documented shower days.</p> <p>During the month of January, Resident (E) received a shower on 1/22/15.</p> <p>During an interview on 1/29/15 at 2:30 p.m., the Director of Nursing indicated no showers sheets were found for the month of December. She indicated the facility had recently changed the shower schedule to more easily track because they had a difficult time monitoring the schedule. Resident (E) had been in the</p>		<p>Shower sheets will be audited five times weekly by the Director of Nursing and Nurse Managers during the Clinical Meeting for 30 days, then monitoring will be done three times weekly for 60 days, then weekly for 90 days. Results of audits will be forwarded to QA&A for tracking and trending monthly for 3 months, then quarterly thereafter for a minimum of 6 months. Date of compliance: 2/12/15</p>				

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	<p>facility for more than 50 days before a documented shower had been given.</p> <p>2. The clinical record for Resident (F) was reviewed on 1/29/15 at 11:40 a.m. Diagnoses for the resident included, but were not limited to; knee joint replacement, atrial fibrillation, depressive disorder, generalized pain and edema.</p> <p>The most recent Discharge Minimum Data Set (MDS) assessment, dated 1/19/15, indicated Resident (F) was cognitively intact.</p> <p>The shower schedule was provided by the Director of Nursing on 1/29/15 at 11:15 a.m. It indicated Resident (F) was to receive showers on Wednesday and Saturday. During the month of January Resident (F) had no documented shower days. A shower sheet, dated 1/19/15, provided by the Director of Nursing on 1/29/15 at 4:55 p.m., indicated Resident (F) refused a shower due to family gave the resident a shower on 1/18/15.</p> <p>During an interview on 1/29/15 at 5:04 p.m., the Director of Nursing indicated Resident (F) did not receive a shower or bath on scheduled shower day of 1/17/15. The Director of Nursing indicated the only refusal documented was on 1/19/15.</p> <p>No further information was provided at</p>			

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	exit. 3.1-38(b)(2)				