

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155188	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/29/2013
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-GREENFIELD			STREET ADDRESS, CITY, STATE, ZIP CODE 200 GREEN MEADOWS DR GREENFIELD, IN 46140		
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: January 23, 24, 25, 28, 29, 2013</p> <p>Facility number: 000099 Provider number: 155188 AIM number: 100291140</p> <p>Survey team: Angel Tomlinson RN TC Barbara Gray RN Sharon Lasher RN Leslie Parrett RN</p> <p>Census bed type: SNF/NF: 160 Total: 160</p> <p>Census payor type: Medicare: 26 Medicaid: 94 Other: 40 Total: 160</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 2/05/13 by Suzanne Williams, RN</p>	F0000	<p>February 15, 2013 Indiana State Department of Health2 N. MeridianIndianapolis, IN 46204 RE: Kindred Transitional Care and Rehabilitation-Greenfield Plan of Correction Credible Allegation of Compliance, and Request for Desk Review/ IDR request below</p> <p>Dear Kim Rhoades, On January 23rd, 2013 surveyors from the Indiana State Department of Health completed an inspection at Kindred Transitional Care and Rehabilitation- Greenfield. As a result of the inspection, the surveyors alleged that the Center was not in substantial compliance with certain Medicare and Medicaid certification requirements. Enclosed you will find the HCFA-2567L with the Center's Plan of Correction for the alleged deficiencies. Preparation of the Plan of Correction does not constitute an admission by the Center of the validity of the cited deficiencies or of the facts alleged to support the citation of the deficiencies. Please also consider this letter and the Plan of Correction to be the Center's credible allegation of compliance. The center will achieve substantial compliance with the applicable certification requirements on February 28th, 2012. Please notify me immediately if you do not find the</p>		

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

TITLE

(X6) DATE

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

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			<p>Plan of Correction to be written credible evidence of the Center's substantial compliance with the applicable requirements as of this date. In that event, I will be happy to provide you with additional evidence of compliance so you may certify that the center is in substantial compliance with the applicable requirements. This letter is also our request for a desk review to verify that the Center achieved substantial compliance with the applicable requirements as of the dates set forth in the Plan of Correction and credible allegation of compliance. This letter is also to request a FACE to FACE Informal dispute Resolution for re F-309, F323, F353, F214. Thank you for your assistance with this matter. Please call me if you have any questions. Sincerely, Monica Jill Pearson, HFAdminstrator(317) 462-3311</p>	

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F0241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, record review and interview, the facility failed to appropriately dress a resident for daily activities as a gait belt was kept on the resident, positioned under her breasts, while she was up for daily activities, for 1 of 1 resident reviewed for dignity (Resident #133).</p> <p>Findings include:</p> <p>On 1/23/13 at 11:15 a.m., Resident #133 was observed in a wheelchair in the dining room for the lunch meal. Resident #133 was observed wearing a gait belt, with the belt positioned up above the waist area, under the resident's breast area.</p> <p>During observation of Resident #133 on 1/23/13 at 1:05 p.m., the resident was sitting in straight back chair by the nurses' station, wearing the gait belt that was positioned under her breast area.</p> <p>On 1/24/13 at 10:50 a.m., Resident #133 was observed sitting in her</p>	F0241	<p>F241 The facility must provide care for the residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This tag has been respectfully submitted for informal dispute resolution. 1. The gait belt was removed from Resident #133 at the time of survey, although the family was aware and had approved use of the gait belt daily as a fall prevention intervention, effective 10-4-2012. In fact, when the unit manager contacted the family to inform them of the removal of the gait belt, they indicated that they were "not happy with this decision" because they felt that by Resident #133 wearing the gait belt daily many falls had been prevented. The family at no time felt that it was undignified for the resident to wear the gait belt, rather, that it was an effective tool for the resident's protection. The facility IDT (Interdisciplinary Team) met and determined that this intervention remained the best intervention for this resident, however, in the future; the facility would provide a wide fashionable</p>	02/28/2013			

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	<p>wheelchair by the nurses' station with the gait belt positioned snugly, under resident's breast area.</p> <p>On 1/25/13 at 10:20 a.m., Resident #133 was observed in the hallway, sitting in her wheelchair, with the gait belt positioned under the resident's breast area.</p> <p>Interview on 1/25/13 at 10:36 a.m. with LPN #2 indicated Resident #133 wears the gait belt when she is in the wheelchair due to the resident being, "unpredictable and gets up frequently at times." LPN #2 indicated staff could grab the gait belt quickly when the resident stands up, to prevent her from falling.</p> <p>Review on 1/23/13 at 10:55 a.m., of a Minimum Data Set Assessment (MDS), dated 12/19/12, for Resident #133 indicated a Brief Interview for Mental Status (BIMS): BIMS score - "Resident unable to complete interview." The resident's "Cognitive Skills for Daily Decision Making" indicated decisions are poor and moderately impaired, with cues/supervision required.</p> <p>A care plan, dated 12/11, for falls indicated:</p>		<p>belt to worn at waist-level. 2. No other residents have the potential to be affected by this practice due to the fact that this fall prevention intervention was specific to Resident #133. "Gait belt to be worn at all times" will not be implemented as a fall prevention intervention for any resident in the future. 3. The IDT has been re-educated relative to dignity and respect of individuality, including but not limited to ensuring that any fall prevention intervention implemented maintains resident dignity. Each implemented intervention will remain resident specific in an effort to prevent any reoccurrence of particular event (i.e., fall, etc.) in the future. Nursing center staff receive education upon hire in regards to dignity and respect of individuality for all residents and annually thereafter. Nursing center staff will be re-educated relative to dignity and respect of individuality. 4. A PI tool has been developed and compliance rounds will be conducted three times per week for one month by a member of the nursing management team to monitor for any interventions that could be perceived as potential impairment of a resident's dignity. If any concerns are noted, immediate action will be taken to remove said concern. Thereafter, random compliance rounds will be conducted, on at least two days, during the week prior to</p>				

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	<p>Focus: Resident is at risk for falls R/T (related to) dementia with behaviors and osteoarthritis.</p> <p>Goals: Minimize falls by using nursing interventions daily through next review.</p> <p>Interventions: Gait belt on while out of bed.</p> <p>On 1/25/13 at 1:20 p.m., interview with the Administrator indicated she was not aware of a policy or procedure for the use of the gait belts, but would check for both documents. No policy or procedure related to gait belts were presented prior to exit.</p> <p>3.1-3(t)</p>		<p>monthly Performance Improvement Committee (PIC) meeting. Thus, these compliance rounds will be conducted for a minimum total of six months. The Director of Nursing Services will report the findings of these rounds to the Performance Improvement Committee monthly. The PIC will determine when substantial compliance has been met. 5. Date of Compliance: February 28, 2013</p>		

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F0282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to follow physician's orders for a fluid restriction, for 1 of 25 residents reviewed for physician's orders. (Resident #52)</p> <p>Findings Include:</p> <p>The record of Resident #52 was reviewed on 1/25/13 at 1:15 p.m. Resident #52's diagnoses included, but were not limited to, shortness of breath, diabetic, heart disease and renal failure.</p> <p>Resident #52's physician orders, dated 7/27/12, indicated "Dialysis Monday, Wednesday and Friday" and physician orders, dated 8/12/12, indicated "1500 ml (milliliters) fluid restriction, 750 ml-nursing and 750-dietary."</p> <p>Resident #52's "Comprehensive Intake-Output Record," dated 12/1/12 to 12/30/12, indicated 15 entries for intakes on night shift during December 2012 with no other entries</p>	F0282	<p>F282 The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. 1. The fluid restriction for Resident #52 was reviewed with dialysis and remains at a 1500 cc fluid restriction daily. Resident #52 is aware of the fluid restriction and complies with it daily. The nursing staff has been re-educated on the requirement of documenting on the Comprehensive Intake and Output Record daily Resident's #52 intakes in order to monitor compliance with the physician order. 2. Any other resident with a physician's order for a fluid restriction has the potential to be affected. Audits have been conducted for these residents to ensure that the physician order for fluid restriction is being followed. 3. Licensed nursing staff has been re-educated relative to provision of services by qualified persons/per care plan, including but not limited to following physician orders for fluid restriction and the documentation requirements. Licensed nurses will review the Comprehensive Intake and Output record daily to</p>	02/28/2013

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	<p>documented on any shift. The "Comprehensive Intake-Output Record" lacked entries of intake for lunch or dinner for the entire month of December 2012.</p> <p>An interview with Unit Manager #8 on 1/29/13 at 2:50 p.m., indicated the intake for December 2012 had not been filled out and that was the only area in Resident #52's record where her intake would be recorded to determine how much fluid Resident #52 was receiving.</p> <p>3.1-35(g)(2)</p>		<p>ensure that the resident's intake is documented. The amount for the fluid restriction will be monitored daily and any non-compliance will be reported to the physician. 4. A PI tool has been developed and the Unit Managers, or designee, will audit the Comprehensive Intake and Output record three times weekly for one month for compliance. Any identified concerns will promptly be addressed with the responsible individual(s). Thereafter, the Unit Managers, or designee, will conduct random audits of the Comprehensive Intake and Output records, on at least two days, during the week prior to monthly Performance Improvement Committee (PIC) meeting. Thus, these audits will be conducted for a minimum total of six months. The Director of Nursing Services will report the findings of these rounds monthly to the Performance Improvement Committee monthly. The PIC will determine when substantial compliance has been met. 5. Date of Compliance: February 28, 2013</p>		

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F0309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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.</p> <p>Based on observation, interview and record review, the facility failed to ensure residents on dialysis received ordered dietary and fluid restrictions, related to the failure to educate the family of a resident's dietary needs and monitor intake for a resident on a fluid restriction, for 2 of 2 residents reviewed for dialysis care. (Resident #48 and #52)</p> <p>Findings include:</p> <p>1. The record of Resident #48 was reviewed on 1/28/13 at 8:30 a.m. Resident #48's diagnoses included, but were not limited to, end stage, renal failure, anemia and diabetes.</p> <p>Resident #48's MDS (Minimum Data Set) assessment, dated 1/14/13, indicated the following:</p> <ul style="list-style-type: none"> - BIMS (Brief Interview for Mental Status) 14,;a score of 13-15 indicating cognition intact - eating, supervision, oversight, encouragement or cueing, with set up 	F0309	<p>F309 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. This tag has been respectfully submitted for informal dispute resolution.</p> <p>1. The fluid restriction for Resident #52 was reviewed with dialysis and remains at a 1500 cc fluid restriction daily. Resident #52 is aware of the fluid restriction and complies with it daily. The nursing staff has been re-educated on the requirement of documenting on the Comprehensive Intake and Output Record daily Resident's #52 intakes in order to monitor compliance with the physician order. 2. Resident #48 and her family had previously received education in regards to the diet order, regular diet with low concentrated sweets and no added salt. However, the dietitian re-educated both the resident and the family about the restrictions</p>	02/28/2013			

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	<p>help only - weight loss, yes.</p> <p>Resident #48's care plan, dated 11/29/12, indicated "Focus, Resident is at risk for nutritional decline related to: diagnosis of renal insufficiency, hypertension, and diabetes. Hemodialysis 3 times per week. Requires LCS (Low Concentrated Sweet), NAS (Low Sodium), limited foods high in potassium and phosphorus with 1500 ml (milliliter) fluid restriction. Significant weight loss attributed to recent start of hemodialysis. Recent return from hospital with decreased appetite which may have promoted weight loss in addition to dialysis. Goal, Resident will consume an average of 75% food/beverages at meals. Interventions, date initiated, 1/14/13, Nepro (Dialysis) supplement between meals. Date initiated, 10/25/12, notify family and physician of significant weight changes, spouse, resident and physician are aware of weight loss, determine resident's food/beverage preferences and eating patterns, administer vitamin/mineral supplement per physician order, monitor/evaluate energy intake and/or food/beverage intake via meal intake records and observations.</p>		<p>with the diet. 2. Any other resident with a physician's order for a fluid restriction or for a restricted diet has the potential to be affected. Audits have been conducted for all of these residents to ensure that the physician order for fluid restriction is being followed. For those residents that have physician ordered restricted diets, the dietician has made certain that education has been provided to the resident and/or family about its limitations, and that the same has been documented. 3. Licensed nursing staff has been re-educated relative to provision of care and services, including but not limited to following physician orders for fluid restriction and the documentation requirements. The licensed nurses will review the Comprehensive Intake and Output record daily to ensure that the resident's intake is documented. The amount for the fluid restriction will be monitored daily and any non-compliance will be reported to the physician. The dietitian has been re-educated relative to provision of care and services, including but not limited to ensuring that necessary education is provided to the resident and/or family about their dietary restrictions with the same documented in the medical record. The Assistant Director of Nursing, or designee, will audit the medical records of any newly</p>		

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	<p>Resident #48's physician orders indicated the following:</p> <ul style="list-style-type: none"> - 10/23/12, Dialysis Tuesday, Thursday and Saturday - 11/22/12, Nephro-cap, 1 mg, by mouth every day - 11/26/12, diet: LCS, NAS: texture: regular and liquids: regular - 1/3/13, Nepro shake, 1 can between meals and Prostate (protein), 30 cc (cubic centimeters), by mouth, three times a day, dietary supplement <p>On 1/29/13 at 11:15 a.m., Resident #48 was observed eating some mashed potatoes and gravy.</p> <p>During an interview on 1/29/13 at 11:00 a.m., the Dietary Manager indicated Resident #48 has had a significant weight loss. "She does not like the food here, but in October I went over her likes and dislikes. I have to add so many foods to her dislikes because of her restricted diet. For her weight loss we have started Nephro-caps, Nepro supplements and Prostate." The Dietary Manager indicated she did not have any documentation of Resident #48's husband being educated on what foods she should or shouldn't have, but she was aware Resident #48's husband brought most of her meals into the facility and she didn't eat</p>		<p>admitted resident and those residents that have a diet order change that indicates a diet restriction to ensure that any necessary education has been provided and documented. 4. A PI tool has been developed and the Unit Managers, or designee, will audit the Comprehensive Intake and Output record three times weekly for one month for compliance. Any identified concerns will promptly be addressed with the responsible individual(s). Thereafter, the Unit Managers, or designee, will conduct random audits of the Comprehensive Intake and Output records, on at least two days, during the week prior to monthly Performance Improvement Committee (PIC) meeting. Thus, these audits will be conducted for a minimum total of six months. A PI tool has been developed and Director of Nursing, or designee, will audit those medical records with new diet restrictions weekly for one month for compliance. Any identified concerns will promptly be addressed with the responsible individual(s). Thereafter, Director of Nursing, or designee, will conduct random audits of at least five medical records of residents with newly ordered diet restrictions, during the week prior to monthly PIC meeting,. Thus, these audits will be conducted for a minimum total of six months. 5. The Director of</p>		

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	<p>much of the food the facility provided.</p> <p>During an interview on 1/28/13 at 12:00 p.m., Resident #48 indicated she did not like the food at the facility, and her husband brings her lunch and dinner almost everyday. "My husband will bring my lunch in after while."</p> <p>During an interview on 1/29/13 at 11:25 a.m., Resident #48's husband indicated he brings Resident #48's lunch and dinner in almost every day. "She doesn't eat much breakfast and she never has. I bring in potato soup, cheese and broccoli soup, meatloaf, mashed potatoes and gravy and different kinds of vegetables. She does not eat much here, some things like beef broth, jello and ice cream. They do not see what she eats, like today I brought in the other half of what I brought her yesterday - meatloaf, mashed potatoes, gravy and green beans. Resident #48's husband indicated, "No, they have not told me much about her diet or what she should or shouldn't have."</p> <p>During an interview on 1/29/13 at 1:44 p.m., CNA #5 stated "we take her tray into her room but most of the time she will refuse because her husband brings her meals every day.</p>		Nursing Services will report the findings of these audits monthly to the PIC monthly. The PIC will determine when substantial compliance has been met. 6. Date of Compliance: February 28, 2013		

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	<p>I don't see what or how much she eats, so I just ask her how much she ate."</p> <p>During an interview on 1/29/13 at 2:10 p.m., CNA #4 stated "no, she does not eat what we serve, maybe some broth or a snack because her husband brings in her food, and that is almost all she eats. I just ask her how much she eats of the food he brings in."</p> <p>Resident #48's "Weight Record" indicated the following:</p> <ul style="list-style-type: none"> - 10/25/12, 215 - 11/22/12, 201 - 12/4/12, 213 - 1/4/13, 190 <p>2. The record of Resident #52 was reviewed on 1/25/13 at 1:15 p.m. Resident #52's diagnoses included, but were not limited to, shortness of breath, diabetic, heart disease and renal failure.</p> <p>Resident #52's physician orders, dated 7/27/12, indicated "Dialysis Monday, Wednesday and Friday" and physician orders, dated 8/12/12, indicated "1500 ml (milliliters) fluid restriction, 750 ml-nursing and 750-dietary."</p>						

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	<p>Resident #52's "Comprehensive Intake-Output Record," dated 12/1/12 to 12/30/12, indicated 15 entries for intakes on night shift during December 2012 with no other entries documented on any shift. The "Comprehensive Intake-Output Record" lacked entries of intake for lunch or dinner for the entire month of December 2012.</p> <p>An interview with Unit Manager #8 on 1/29/13 at 2:50 p.m., indicated the intake for December 2012 had not been filled out and that was the only area in Resident #52's record where her intake would be recorded to determine how much fluid Resident #52 was receiving.</p> <p>3.1-37(a)</p>				

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F0323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to implement fall interventions for 2 of 4 residents reviewed for accidents, for 9 who met the criteria for accidents. (#190 and #263)</p> <p>Findings include:</p> <p>1.) Resident #263's record was reviewed on 1/29/13 at 1:45 P.M. She was admitted to the facility on 1/7/13. Her diagnoses included but were not limited to hypertension, chronic obstructive pulmonary disease, chronic respiratory failure, and open fracture end of the radius with ulna.</p> <p>An Admission Nursing Evaluation for Resident #263, dated 1/7/13 at 1:40 P.M., indicated she had no history of falling.</p> <p>An Admission Assessment for Resident #263, dated 1/7/13 at 1:40 P.M., indicated she was oriented to time, place, and person. She was</p>	F0323	<p>F323 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This tag has been respectfully submitted for informal dispute resolution. 1. Resident #263's interventions for fall prevention were re-implemented by the staff after the family left the bedside. The family had been at bedside with four chairs pulled up to the bed so that they could visit and had removed the mat from the side of bed. As they were leaving the staff was entering the room to assist Resident #263 to the bathroom. The staff did place gripper socks on the resident prior to transferring her. The gripper socks were not on while the resident was in bed due the fact that the resident's condition had declined to the point that she was unable to physically get out of bed on her own. Upon returning the resident to bed, the staff placed the mat next to the bed and placed the bed in a comfortable position. Resident #190's interventions remain</p>	02/28/2013			

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	<p>understood and had the ability to understand others. She moved about the bed without assistance, aware of position in bed in proximity to the edge of the bed. She had no history of falling and was oriented to her own ability. She was independent for ambulation and did not use an assistive device. She required limited assistance for transfer. She walked frequently and had no mobility limitations.</p> <p>A Health Status note for Resident #263 dated 1/7/13 at 2:00 P.M., indicated she was alert and oriented times 3. She had bilateral edema in her legs and feet. She ambulated well by herself.</p> <p>Progress notes for Resident #263 indicated the following: 1/8/13 at 1:13 A.M.- She was found sitting on the floor. She had indicated she was trying to go the bathroom and did not know what happened. She had a skin tear on her right index finger and complained her wrist hurt. Her right wrist was bruised and swollen. A local company was notified to obtain a stat x-ray. 1/8/13 at 6:55 A.M.-The local company had not arrived to obtain an x-ray and her condition had worsened. She had a large amount of swelling and bruising to her right</p>		<p>effective per the plan of care. Resident #190 had not had a fall since 10-18-12 until the staff assisted fall on 1-24-13, thus the intervention implemented on 10-18-2012 had proven to be effective. The staff member that transferred Resident #190 without assist of two was re-educated on Resident #190's transferring needs. Per the Kindred Policy, Accidents and Supervision to Prevent Accidents, this is an acceptable intervention, and resident has not had a fall since, thus this intervention has also proven to be effective. Resident #190 was referred back to therapy for strengthening. 2. Other residents requiring fall prevention interventions have the potential to be affected. These interventions have been reviewed for appropriateness and if necessary, changes have been made. Staff has been re-educated ensuring that the correct amount of assistance is provided with transfers. 3. Education has been provided to the nursing staff relative to residents being free of accident hazards/supervision/devices, including but not limited to the Accidents and Supervision to Prevent Accidents Policy. A PI tool has been developed and Unit Managers, or designee, will observe five transfers a week, across all shifts, for one month, to ensure that the correct amount of assistance has been provided.</p>		

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	<p>arm. She complained of severe pain. An order was obtained to send her to a local Emergency Room for evaluation and treatment.</p> <p>A local Emergency Room note for Resident #263 dated 1/8/13 at 10:14 A.M., indicated she had a right wrist fracture.</p> <p>An Interdisciplinary Team Fall Data Information Review for Resident #263, dated 1/11/13 at 3:00 P.M., indicated interventions in place at the time of her fall on 1/8/13, included a call bell in place and her bed low. Interventions in place after her fall on 1/8/13, included a call light in reach, her bed low, and a bed alarm.</p> <p>Progress notes for Resident #263 indicated the following: 1/11/13 at 3:41 A.M.-She was trying to get up and fell. She was confused and obtained a 16 centimeter (cm) skin tear. During her assessments she began experiencing a drop in blood pressure. She was sent to a local Emergency Room for evaluation and treatment. 1/11/13 at 7:54 A.M. -When she had been asked what happened when she fell, she indicated she was trying to sit up in bed and fell. Her 16 cm skin tear was on her left hand.</p>		<p>Thereafter, Unit Managers, or designee, will conduct random observations, of at least three transfers, during the week prior to monthly PIC meeting. Thus, these observations will be conducted for a minimum total of six months. A PI tool has been developed and compliance rounds will be conducted three times per week for one month by a member of the nursing management team to ensure fall prevention interventions are implemented according to the plan of care. If any concerns are noted, immediate action will be taken to remove said concern. Thereafter, random compliance rounds will be conducted, on at least two days, during the week prior to monthly Performance Improvement Committee (PIC) meeting. Thus, these compliance rounds will be conducted for a minimum total of six months. The Director of Nursing Services will report the findings of these rounds to the Performance Improvement Committee monthly. The PIC will determine when substantial compliance has been met. 4. The Director of Nursing Services will report the findings of these rounds and observations monthly to the Performance Improvement Committee (PIC) monthly. The PIC will determine when substantial compliance has been met. 5. Date of Compliance: February 28, 2013</p>				

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	<p>An Interdisciplinary Team Fall Data Information Review for Resident #263 dated 1/11/13 at 3:10 P.M., indicated interventions in place at the time of her fall on 1/11/13, included call bell in place, her bed low, and an alarm. Interventions in place after her fall on 1/11/13, included a call light, her bed low, a bed alarm, and a floor mat.</p> <p>A Fall Care Plan for Resident #263, initiated 1/8/13, indicated the following: Focus-She was at high risk for falls related to a history of falls. Goal-She would comply with safety measures. She would have a reduced number of falls. Interventions included but were not limited to-The facility fall protocol would be followed. She would be provided non-skid footwear. Added 1/11/13-She would use a bedside impact absorbing floor mat next to her bed when she was in bed.</p> <p>Resident #263's Admission Minimum Data Set assessment dated 1/19/13, indicated the following: She scored 15 on her Brief Interview for Mental Status, which indicated she was cognitively intact. She required extensive assistance of one person for bed mobility, transfer, to walk in her room, dressing, and toilet use.</p>			

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	<p>She was not steady, only able to stabilize with staff assistance for moving from a seated to standing position, walking, turning around, moving on and off the toilet, and surface-to-surface transfer. She had impairment on one upper extremity. She had 1 fall since admission.</p> <p>On 1/29/13 at 2:03 P.M., Resident #263 was observed lying in bed on her back with the head of her bed raised 30 degree. She had bilateral half upper bed rails. Her bed was in high position. She had a blue cast on her right arm from her wrist to her elbow. She had a skin tear on her left forearm near her wrist area that was scabbed over and in the shape of a horseshoe. No impact absorbing mat was on the floor but a blue mat was folded up against the wall.</p> <p>On 1/29/13 at 2:06 P.M., CNA #6 and CNA #7 came into Resident #263's bedroom to provide care. CNA #6 indicated she was informed in shift report that morning, Resident #263's family had been in to visit and moved the mat. CNA #6 indicated she had been informed the family had moved the mat because Resident #263 had not been actively trying to get out of bed and they lined their chairs alongside her bed. CNA #7 indicated</p>						

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	<p>she would place the mat down on the floor beside the bed after finishing care. CNA #7 stated "technically it is still part of her care."</p> <p>On 1/29/13 at 2:12 P.M., CNA #6 and CNA #7 assisted Resident #263 to her bedside commode. Prior to the transfer, gripper socks were placed on her feet and her bed was lowered to a comfortable position. When Resident #263 sat up on the edge of the bed, she was observed to have two large purple discoloration areas on her back and one large purple discoloration area on her left outer mid back. Bruising was visible on her right thumb near her cast.</p> <p>An interview with the Director of Nursing on 1/29/13 at 2:23 P.M., indicated Resident #263 was admitted to the facility on 1/2/13 at 1:00 P.M., and she fell on 1/8/13 at 1:00 A.M. Resident #263 had gotten up to go to the bathroom and fell. Resident #263 fractured her wrist during the fall. Resident #263 fell again on 1/11/13. Resident #263 had tried to sit up on the side of the bed and slid out. Resident #263 had received no injury from that fall. She indicated the facility Fall Protocol included but was not limited to the following interventions: Residents</p>			

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	<p>were oriented to their call light. Residents were oriented to the bathroom. Bed wheels were locked. Beds were kept in the lowest position that was comfortable for the resident i.e., if the resident sat on the bedside, their feet would comfortably reach the ground.</p> <p>2.) Review of the record of Resident #190 on 1-28-13 at 9:00 a.m. indicated the resident's diagnoses included, but were not limited to, diabetes mellitus, hyperlipidemia, dementia, asthma and depression.</p> <p>The Minimum Data Set (MDS) assessment for Resident #190, dated 11-29-12 indicated the following: makes self understood-understood, ability to understand others-understands, transfer-extensive assistance of two people, walk in room- did not occur, walk in corridor- did not occur, toilet use- extensive assistance of two people, balance during transitions and walking- not steady, only able to stabilize with staff assistance, mobility device- wheelchair, urinary and bowel continence toileting program- no, falls since admission- yes.</p> <p>The post fall evaluation for Resident #190, dated 9-28-12 indicated the resident was found on the floor with</p>				

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	<p>the chair alarm sounding. The resident indicated he was trying to go to bed and was transferring self to the bed. The intervention implemented was the resident was unsteady and needed assistance with transfers, will encourage the resident to use the call light.</p> <p>The post fall evaluation for Resident #190, dated 10-18-12 indicated the resident was talking with an CNA in his room and scooted off the edge of the bed onto the floor. The resident indicated he was trying to get up to go to the bathroom. The intervention implemented was the resident was assisted back to the bed and reminded to ask for assistance with all transfers. Educate staff on checking alarms throughout the shift for placement and functioning.</p> <p>The post fall evaluation for Resident #190, dated 1-24-13 indicated the resident was lowered to the floor by the CNA in the shower room. The intervention was educate the staff on proper transfer.</p> <p>Interview on 1-24-13 at 11:00 a.m. with Unit Manager #3 indicated Resident #190 had a fall within the last 30 days. Unit Manager #3 indicated the resident was lowered to</p>			

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	<p>the floor in the shower room.</p> <p>Interview with Unit Manager #3 on 1-28-13 at 2:30 p.m. indicated when Resident #190 fell on 9-28-12 the facility implemented an intervention of encouraging him to use the call light. Unit Manager #3 indicated there were no other interventions implemented. Unit Manager #3 indicated the fall that occurred on 10-18-12 was an isolated event and the CNA was in the resident's room and he scooted off of the bed. When queried why the intervention was to check alarms for the fall on 10-18-13, Unit Manager #3 indicated the resident was trying to go to the bathroom. When queried if the facility had attempted to place Resident #190 on a toileting program and have staff check with him frequently for his toileting needs, Unit Manager #3 indicated the facility asks every resident every two hours if they need to go to the bathroom and there were no implementation specific for Resident #190's toileting needs. Unit Manager #3 indicated on 1-24-13 the resident was in the shower room in his wheelchair and the CNA attempted to transfer him into the shower chair without assistance. Unit Manager #3 indicated the resident required two staff for his transfers. Unit Manager #3 indicated the CNA</p>			

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	<p>thought she could do it by herself and should have asked for assistance.</p> <p>Interview with Resident #190 on 1-29-13 at 11:06 a.m. indicated the facility did want him to use his call light for assistance to go to the bathroom. Resident #190 indicated he did not call for assistance to go to the bathroom unless he felt like he needed help. Resident #190 indicated he knew when he needed to go to the bathroom. Resident #190 indicated he had a call light if he needed help. Resident #190 indicated the facility thought he needed two people to assist with his transfers. Resident #190 indicated the facility usually only used one person to transfer him. Resident #190 indicated no staff came around and asked him if he needed to go to the bathroom.</p> <p>The accidents and supervision to prevent accidents policy provided by the Director Of Nursing (DON) on 1-29-13 at 2:15 p.m. indicated the following: "The center provides an environment that is free from accident hazards over which the center has control and provides supervision and assistive devices to each patient to prevent avoidable accidents." "Staff are involved in observing and identifying potential hazards in the</p>						

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	<p>environment, while taking into consideration the unique characteristics and abilities of each patient. "Center communicates the interventions to relevant staff, assigning responsibility to appropriately trained individuals, implementing and documenting interventions." "Center implements interventions correctly and consistently, including adequate supervision."</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p>			

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F0325 SS=D	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on observation, interview and record review, the facility failed to assess and provide for the food preferences of a resident who had significant weight loss and had cultural preferences regarding food, for 1 of 3 residents reviewed for significant weight loss of 4 residents who met the criteria for significant weight loss (Resident #73).</p> <p>Finding includes:</p> <p>1.) Review of the record of Resident #73 on 1-25-13 at 9:20 a.m. indicated the resident's diagnoses included, but were not limited to, depression, dementia with behavioral disturbances, hypertension, diabetes and depression.</p> <p>The medical nutritional therapy assessment for Resident #73, dated 7-17-12, indicated under</p>	F0325	<p>F325 The facility must maintain nutrition status unless unavoidable. This tag has been respectfully submitted for informal dispute resolution.</p> <p>1. Resident # 73 has resided in the facility for approximately 7 years. The facility has provided, and continues to provide, a diet that spans many cultures and includes Resident #73's. The dietician attempted to re-interview Resident #73 for current preferences, however, the resident's advanced dementia prevented any sufficient data gathering. The dietitian spoke with the resident's son who stated, "yes, my mom liked that type of food prior to admitting, but who's to say that it is still her preference since being there for almost 7 years." 2. Other residents with cultural/ethnic/religious food preferences have the potential to be affected. The dietary manager will meet with these residents and discuss preferences. The facility</p>	02/28/2013	

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	<p>food/nutrition related history, list any religious/cultural/ethnic food preferences - none was listed.</p> <p>Resident #73's weight record indicated the following: 8-2-12 - 118 pounds, 9-2-12 - 124 pounds, 10-1-12 - 125 pounds, 11-2-12 - 122 pounds, 12-1-12 - 117 pounds, 1-2-13 - 111 pounds and on 1-28-13 - 112 pounds.</p> <p>The progress note for Resident #73, dated 1-8-13, indicated a "weight warning" for the resident, with a -7.5% change over 90 days. Resident was started on a nutritional supplement. The MD and family were aware.</p> <p>The progress note for Resident #73, dated 1-11-13 indicated the resident's weight was down a significant amount with January weight of 111 pounds reflecting a loss of 10% in 30 days. The resident was started on Remeron (appetite stimulant) on 1-7-13. The resident was on a low concentrated sweet diet and had house fortified supplements offered between meals. The resident had been refusing meals, substitutes and snacks.</p> <p>The progress note for Resident #73, dated 1-24-13, indicated the resident did not like the house fortified pudding</p>		<p>will attempt to honor these wishes if able to do so or will ask for assistance from the family. 3. Education has been provided to the dietary manager and dietician relative to maintaining nutritional status unless unavoidable, including but not limited to ensuring that residents and/or family are interviewed specifically about any cultural/ethnic/religious food preference. These preferences will be documented on the resident's plan of care. The facility will attempt to honor these wishes or ask the family for assistance. A PI tool has been developed and Director of Nursing and/or Assistant Director of Nursing, or designee, will interview three newly admitted residents and three residing residents about their food preference and correlate preferences to the plan of care for consistency per week for one month. If any concerns are noted, immediate action will be taken to remove said concern. Thereafter, random interviews will be conducted, with at least five residents, about their food preferences during the week prior to monthly Performance Improvement Committee (PIC) meeting. Thus, these compliance rounds will be conducted for a minimum total of six months. 4. The Director of Nursing Services will report the findings of these audits monthly to the Performance Improvement</p>		

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	<p>and will recommend discontinuing it.</p> <p>The progress note for Resident #73, dated 1-28-13, indicated the resident was now accepting the house fortified pudding at items. The house fortified pudding would be provided. The resident's food preferences were on file.</p> <p>The care plan for Resident #73, with an original date of 8-18-11 and a revision date of 1-11-13, indicated the resident had a significant weight loss in 30 days. The resident had been refusing meals, snacks and substitutes at times. The interventions included but were not limited to, appetite stimulant in place and house fortified supplement, labs as ordered, MD and family were notified of weight loss and monitor oral intake and weight.</p> <p>The food intake record for Resident #73 dated January 2013 indicated the following: 1-1-13 the resident ate between 26% -50% of breakfast and lunch and 51% -75% of supper 1-2-13 the resident ate 0-25% of breakfast and 26%-50% of lunch and supper 1-3-13 the resident ate 26%-50% of breakfast, 0-25% of lunch and 26%</p>		Committee (PIC) monthly. The PIC will determine when substantial compliance has been met. 5. Date of Compliance: February 28, 2013		

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	<p>-50% of supper</p> <p>1-4-13 the resident ate 0-25% of breakfast, lunch and supper, on</p> <p>1-5-13 the resident ate 26%-50% of breakfast and 0-25% of lunch and supper, on</p> <p>1-6-13 the resident ate 76%-100% of breakfast and 0-25% of lunch and supper, 1-7-13 the resident ate 76%-100% of breakfast and 0-25% of lunch and 26%-50% of supper</p> <p>1-8-13 the resident ate 0-25% of breakfast, lunch and supper</p> <p>1-9-13 the resident ate 0-25% of breakfast, lunch and supper</p> <p>1-10-13 the resident ate 0-25% of breakfast, lunch and supper</p> <p>1-11-13 the resident refused breakfast and lunch and ate 0-25% of supper</p> <p>1-12-13 the resident ate 26%-50% of breakfast, 76%-100% of lunch and 26%-50% of supper</p> <p>1-13-13 the resident ate 76%-100% of breakfast and 0-25% of lunch and supper</p> <p>1-14-13 the resident ate 0-25% of breakfast, lunch and supper</p> <p>1-15-13 the resident ate 26%-50% of breakfast and 0-25% of lunch and supper</p> <p>1-16-13 the resident ate 0-25% of breakfast, lunch and supper</p> <p>1-17-13 the resident ate 0-25% of breakfast, lunch and supper</p>			

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	<p>1-18-13 the resident refused breakfast and lunch and ate 26% -50% of supper</p> <p>1-19-13 the resident ate 0-25% of breakfast, lunch and supper</p> <p>1-20-13 the resident ate 0-25% of breakfast, lunch and supper</p> <p>1-21-13 the resident ate 51%-75% of breakfast, 76%-100% of lunch and 0-25% of supper</p> <p>1-22-13 the resident at 0-25% of breakfast, lunch and supper</p> <p>1-23-13 the resident ate 0-25% of breakfast and lunch and ate 26% -50% of supper</p> <p>1-24-13 the resident ate 0-25% of breakfast, lunch and supper</p> <p>Interview with LPN #2 on 1-25-13 at 11:00 a.m. indicated Resident #73's family had brought the resident in some ethnic soup earlier. LPN #2 indicated the family sometimes brings the resident in the cultural foods she likes. LPN #2 indicated the resident really liked it when the family brought her food.</p> <p>During observation on 1-25-13 at 11:45 a.m., Resident #73 was sitting at the dining room table. The resident had a rib sandwich, french fries, fruit, ice cream and a cookie. The resident took her cookie and crumbled it up in her milkshake and ate 1/4 of it with a</p>			

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	<p>butter knife. The staff attempted to give the resident a spoon to eat with, but the resident sat the spoon down and continued to eat with her butter knife. The resident did not eat anything else. Interview with CNA #1 at this time indicated Resident #73 did not like regular food.</p> <p>Interview with CNA #1 on 1-25-13 at 12:00 p.m. indicated Resident #73 did not have a favorite meal and did not like to eat regular food.</p> <p>Interview with Resident #73's family member on 1-28-13 at 2:10 p.m. indicated Resident #73's favorite food was from her own culture, and this was the food she had eaten her whole life. The family member indicated the resident liked soup, rice and vegetables. The family member indicated the resident was a big eater and loved cooking her cultural food. The family member indicated the resident used to stay up all night and snack. The family member indicated the facility was aware the resident liked cultural food. The family member indicated the facility had never given the resident the food she liked, because Resident #73 had to eat what the other residents ate. The family member indicated the family sometimes brought the resident in the</p>						

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	<p>cultural food, and she would eat that.</p> <p>Interview with the Dietary Manager on 1-29-13 at 11:00 a.m. indicated the facility put resident likes and dislikes on the food card that came out with the trays. The Dietary Manager provided Resident #73's food card and it indicated the resident did not like eggs, bananas or fish. The food card did not have any food preferences listed.</p> <p>Interview with the Registered Dietician (RD) on 1-29-13 at 11:30 a.m. indicated Resident #73 did like cultural food and the resident's family did bring it in for her sometimes. The RD indicated the facility did serve a variety of different cultural food at times. The RD indicated the facility had sweet and sour chicken, rice, soup and vegetables available. The RD indicated the residents' food preferences were kept in a binder. The RD went through the "diet history/ food preference" documentation and indicated there was no documentation for Resident #73.</p> <p>Review of the "diet history/food preferences" indicated one of the questions asked if there were any special food requests related to</p>			

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	<p>cultural/ethnic/religious food.</p> <p>The "Nutrition" policy, provided by the Director Of Nursing (DON) on 1-29-13 at 2:15 p.m., indicated the "Patients should not lose weight or have nutrition deficits unless the patient's clinical condition demonstrates that this is not possible." "The nutritional assessment is used to define meaningful interventions to address any nutrition-related problems." The care plan should reflect the resident's goals and choices.</p> <p>3.1-46(a)(1)</p>				