

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15A011	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/15/2015
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NAME OF PROVIDER OR SUPPLIER ESPECIALLY KIDZ HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 2325 S MILLER ST SHELBYVILLE, IN 46176
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint's IN00184588, IN00185968 & IN00188449.</p> <p>Complaint # IN00184588-Substantiated. Federal/state deficiencies related to allegations are cited at F-282, F-318, F-514</p> <p>Complaint # IN00185968-Substantiated. Federal/state deficiencies related to allegations are cited at F-318, F-514</p> <p>Complaint # IN00188449-Substantiated. No deficiencies related to allegations are cited.</p> <p>Unrelated deficiency is cited.</p> <p>Survey dates: December 13, 14 & 15, 2015</p> <p>Facility number: 000273 Provider number: 15A011 AIM number: 100267870</p> <p>Census bed type: NF: 122 Total: 122</p> <p>Census payor type:</p>	F 0000	<p>Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under and state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey. Due to the low scope and severity of the survey finding, please find the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance, feel free to contact me.</p>	

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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F 0246 SS=D Bldg. 00	<p>Medicaid: 121 Other: 1 Total: 122</p> <p>Sample: 7</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 30576 on December 17, 2015.</p> <p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>Based on observation, interview and record review the facility failed to provide a resident with a speciality wheelchair, resulting in the resident inability to get out of bed except for baths for several months for 1 of 4 residents reviewed for range of motion in a total sample of 7 (Resident #G).</p> <p>Finding include:</p> <p>1.) Review of the record of Resident #G</p>	F 0246	F246 Requires the facility to provide a residents with speciality chair . 1. Resident G had a chair adapted to meet his needs until his new chair arrives. 2. All residents have the potential to be affected. Administrative staff assessed all residents wheelchairs and noted the resident's that were in need of new adaptive chairs. No further concerns were noted. See below for corrective measures. 3. The staff was inserviced on the proper way	12/29/2015

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	<p>on 12/15/15 at 11:50 a.m., indicated the resident's diagnoses included, but were not limited to, profound intellectual disabilities, epilepsy, cerebral palsy, ventilator dependent secondary to respiratory failure, bilateral clubbed feet and congenital quadraparesis.</p> <p>The November 2015, physician recapitulation (recap) for Resident #G indicated the resident was to be up ad lib in an adaptive wheelchair with a pommel cushion, bilateral footrest and rear anti-tippers for safety, chest harness, lap belt, and trunk laterals. The resident was ordered bilateral ankle, foot orthosis (ankle/foot brace) when up in the wheelchair.</p> <p>The wheelchair assessment for Resident #G indicated "according to the Interdisciplinary Team" the wheelchair order is specifically for safety, positioning; and mobility related to the diagnosis of cerebral palsy. The "2nd Quarter changes" dated, 6/17/15, indicated "awaiting new chair at this time". The "3rd Quarter changes" dated, 9/30/15, indicated "continue" waiting.</p> <p>The daily device skin assessment (no date or time) for Resident #G indicated the resident was suppose to wear a splint device daily and his skin should be</p>		<p>to inform administrator that a resident's chair is in need of repair. The staff is to submit a work order to acknowledge a chair is needing repair. (See attachment A) 4.</p> <p>The administrator or his designee will utilize the monitoring tool weekly times four weeks, then every two weeks times two months, then quarterly thereafter to ensure wheelchairs are being repaired timely and that no other chairs are needing repair until 100% of compliance is obtained and maintained. (See attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly if warranted.</p> <p>5. The above corrective measures will be completed on or before December 29, 2015.</p>		

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	<p>assessed daily. There were 61 days that indicated the resident did not have his splint device in place due to he had no wheelchair.</p> <p>The Annual Minimum Data Set (MDS) for Resident #G, dated 6/16/15, indicated he was severely cognitively impaired for daily decision making. The resident's daily and activity preferences included, but were not limited to, doing things with groups of people, spending time outdoors and participating in religious activities. The resident was totally dependent of two people to transfer and totally dependent of one person for locomotion on and off the unit. The resident had impairment on both sides of his lower and upper extremities.</p> <p>During observation on 12/15/15 at 10:20 a.m., Resident #G was laying in a crib bed on his left side. The resident had his eyes open.</p> <p>Interview with LPN #2 on 12/15/15 at 12:00 p.m., when queried when Resident #G was going to get up out of bed and wear his bilateral foot/ankle splints, LPN #2 indicated Resident #G did not get out of bed except 3 times a week for his baths and was transported to his baths on a gurney. LPN #2 indicated she was unsure of the exact date the resident's</p>						

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	<p>wheelchair was broken but it had been 7 to 8 months ago.</p> <p>Interview with LPN #2 on 12/15/15 at 1:05 p.m., indicated it was reported to her that Resident #G's wheelchair needed repaired and it got put in the trash. LPN #2 indicated she was unsure who had disposed of his wheelchair. LPN #2 indicated he did not wear his bilateral foot/ankle splints because they were not applied while he was in bed. LPN #2 indicated the resident was always in bed except his baths. LPN #2 indicated the aide takes him to his baths on a gurney and tries to let him stay on the gurney as long as possible, as he was in good spirits when he got to get up out of the bed. LPN #2 indicated he received his activities and schooling at the bedside.</p> <p>Interview with the Activity Director on 12/15/15 at 1:20 p.m., indicated she did not know the exact date Resident #G no longer had a wheelchair. The Activity Director indicated she knew the resident had his wheelchair on May 17, 2015, as he had attended church and this was the last activity he attended. The Activity Director indicated the resident now received activities at the bedside.</p> <p>Interview with CNA #3 on 12/15/15 at 1:25 p.m., indicated Resident #G had</p>			

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	<p>been without a wheelchair for a long time. CNA #3 indicated he could not use a geri chair to get up because he was spastic and she was afraid he would fall out of it. CNA #3 indicated "he just stays in bed all the time". CNA #3 indicated the resident did wear foot splints when he had a wheelchair, but he did not wear them while he was in bed. During observation at this time, Resident #G was provided incontinence care and range of motion while laying in bed. The resident had bilateral contractures of the foot and ankle.</p> <p>Interview with the Director Of Nursing (DON) on 12/15/15 at 4:50 p.m., indicated he was unable to determine the exact date Resident #G did not have a wheelchair. The DON indicated he did know the resident's wheelchair had been too small. The DON indicated he searched the building for the resident's wheelchair and was unable to find it. The DON indicated he contacted the physician and the physician felt it would be safe for the resident to attend activities and school on a gurney with a nurse or respiratory therapist present.</p> <p>3.1-3(v)(1)</p>			

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F 0282 SS=D Bldg. 00	<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 observation, interview and record review the facility failed to apply splint devices and speciality wheelchair as ordered by the physician and care planned for 2 of 4 residents reviewed for range of motion/splint devices in a total sample of 7 (Resident #G and Resident #F).</p> <p>Findings include:</p> <p>1.) Review of the record of Resident #G on 12/15/15 at 11:50 a.m., indicated the resident's diagnoses included, but were not limited to, profound intellectual disabilities, epilepsy, cerebral palsy, ventilator dependent secondary to respiratory failure, bilateral clubbed feet and congenital quadraparesis.</p> <p>The November 2015, physician recapitulation (recap) for Resident #G indicated the resident was to be up ad lib in an adaptive wheelchair with a pommel cushion, bilateral footrest and rear anti-tippers for safety, chest harness, lap belt, and trunk laterals. The resident was ordered bilateral ankle, foot orthosis</p>	F 0282	<p>F282 Requires the facility to apply splint devices and speciality wheelchairs as ordered by the physician. 1. Resident G had a chair adapted to meet his needs until his new chair arrives and his splints will be applied per physician's orders. 2. All residents have the potential to be affected. Administrative staff assessed all residents wheelchairs and noted the resident's that were in need of new adaptive chairs. No further concerns were noted. The administrative staff also reviewed all resident's programs for splinting to ensure the splints are applied correctly. See below for corrective measures. 3. The staff was inserviced on the proper way to inform administrator that a resident's chair is in need of repair. The staff is to submit a work order. (See attachment A) The staff was also educated on applying splints per the splinting program. 4. The administrator or his designee will utilize the monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter to</p>	12/29/2015

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	<p>(ankle/foot brace) when up in the wheelchair.</p> <p>The wheelchair assessment for Resident #G indicated "according to the Interdisciplinary Team" the wheelchair order is specifically for safety, positioning; and mobility related to the diagnosis of cerebral palsy. The "2nd Quarter changes" dated, 6/17/15, indicated "awaiting new chair at this time". The "3rd Quarter changes" dated, 9/30/15, indicated "continue" waiting.</p> <p>The daily device skin assessment (no date or time) for Resident #G indicated the resident was suppose to wear a splint device daily and his skin should be assessed daily. There were 61 days that indicated the resident did not have his splint device in place due to he had no wheelchair.</p> <p>The Quarterly Minimum Data Set (MDS) for Resident #G, dated 9/23/15, indicated he had impairment on both sides of his lower and upper extremities and was totally dependent of two people for transfers.</p> <p>The careplan for Resident #G, dated 10/6/15, indicated the resident required a splint /brace to ensure proper positioning of limbs. The schedule was bilateral</p>		<p>ensure wheelchairs are being repaired timely and that no other chairs are needing repair until 100% of compliance is obtained and maintained. (See attachment B) The DON or his designee will also conduct daily rounds and observe three residents splints to ensure they are applied per splinting program daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment C) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly if warranted. 5. The above corrective measures will be completed on or before December 29, 2015.</p>	

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	<p>knee/foot orthosis while up in the wheelchair. "Apply the splint/device as ordered.</p> <p>The careplan for Resident #G, dated 10/6/15, indicated the resident required an adaptive wheelchair with lap tray belts, chest harness and pommel cushion due to inability to maintain proper body positioning.</p> <p>During observation on 12/15/15 at 10:20 a.m., Resident #G was laying in a crib bed on his left side. The resident had his eyes open.</p> <p>Interview with LPN #2 on 12/15/15 at 12:00 p.m., when queried when Resident #G was going to get up out of bed and wear his bilateral foot/ankle splints, LPN #2 indicated Resident #G did not get out of bed except 3 times a week for his baths and was transported to his baths on a gurney. LPN #2 indicated she was unsure of the exact date the resident's wheelchair was broken but it had been 7 to 8 months ago.</p> <p>Interview with LPN #2 on 12/15/15 at 1:05 p.m., indicated it was reported to her that Resident #G's wheelchair needed repaired and it got put in the trash. LPN #2 indicated she was unsure who had disposed of his wheelchair. LPN #2</p>			

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	<p>indicated he did not wear his bilateral foot/ankle splints because they were not applied while he was in bed.</p> <p>Interview with CNA #3 on 12/15/15 at 1:25 p.m., indicated Resident #G had been without a wheelchair for a long time. CNA #3 indicated he could not use a geri chair to get up because he was spastic and she was afraid he would fall out of it. CNA #3 indicated "he just stays in bed all the time". CNA #3 indicated the resident did wear foot splints when he had a wheelchair, but he did not wear them while he was in bed. During observation at this time, Resident #G was provided incontinence care and range of motion while laying in bed. The resident had bilateral contractors of the foot and ankle and no splint device in place. 2. Resident #F's record was reviewed on 12/14/15 at 2:56 p.m. Her diagnoses documented on her December 2015 physician recapitulation orders included but were not limited to, cerebral palsy, left short heel cord, and contractures of all extremities.</p> <p>Resident #F's quarterly MDS dated 9/7/15, indicated she was rarely/never understood and rarely/never understood others. She was severely impaired in her daily decision making skills. She required total dependence of two plus</p>			

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	<p>persons for bed mobility and transfer. She did not walk. She required total dependence of 1 person for her dressing and personal hygiene. She had functional limitation in both of her upper and lower extremities. She utilized a wheelchair for mobility.</p> <p>A physician's order for Resident #F documented on her December 2015 physician recapitulation orders dated 5/5/15, indicated she would wear leg braces on both legs a minimum of 4 hours daily as tolerated on days only.</p> <p>A Splint/Brace care plan for Resident #F updated 9/23/15, indicated she required the use of a splint/brace to ensure proper positioning of her limbs. She would wear the leg braces to both legs when she was in her wheelchair. Her interventions for the use of the leg braces indicated she would wear the leg braces as ordered.</p> <p>An interview with CNA #12 on 12/14/15 at 2:30 p.m., indicated Resident #F attended school Monday through Friday.</p> <p>On 12/15/15 at 10:45 a.m., Resident #F was observed seated in her wheelchair. Resident #F was not wearing any leg braces. At that time, an interview with Para Educator #7 at the facility's school classroom indicated she had never seen</p>			

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	<p>Resident #F wearing any type of leg braces.</p> <p>An interview on 12/15/15 at 10:55 a.m., with Teacher #8 at the facility's school classroom indicated she had never seen Resident #F wearing any type of leg braces.</p> <p>On 12/15/15 at 3:25 p.m., Resident #F was observed seated in her wheelchair in her bedroom. She was not wearing any leg braces.</p> <p>An interview with QMA #9 on 12/15/15 at 3:35 p.m., indicated she had not seen Resident #F's leg braces. QMA #9 indicated she did not work in that area very often.</p> <p>An interview with CNA #10 on 12/15/15 at 3:45 p.m., indicated she had never seen any leg braces for Resident #F. CNA #10 had not been informed Resident #F wore leg braces. CNA #10 was unable to locate Resident #F's leg braces.</p> <p>On 12/15/15 at 3:50 p.m., Unit Manager #1 located 2 pairs of leg braces in Resident #F's bedroom on top of a dresser across the room.</p> <p>An interview with CNA #11 on 12/15/15 at 4:10 p.m., indicated she had been</p>			

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	<p>Resident #F's CNA that day from 7:00 a.m., until 3:10 p.m. CNA #10 had been in a hurry to get Resident #F ready for school that morning and had not put the leg braces on that day. CNA #11 usually placed the leg braces on Resident #F while she was in bed.</p> <p>The Physician Orders procedure provided by the Director of Nursing (DON) on 12/15/15 at 6:00 p.m., indicated the following: "Purpose: Physician's orders are administered upon the clear, complete and signed order of an individual lawfully authorized to prescribe...."</p> <p>The Care Plan Development and Review procedure provided by the DON on 12/15/15 at 6:10 p.m., indicated the following: "Purpose: To ensure an interdisciplinary approach to plan for and meet resident's needs. Policy: Facility personnel will ensure development of a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs. Procedure: Physician orders for immediate care are those written orders facility personnel need to provide essential care to the resident, consistent with the resident's mental and physical status, upon admission. These orders should, at a</p>			

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	<p>minimum, include dietary, medications and routine care to maintain or improve the resident's functional abilities until personnel can conduct a comprehensive assessment and develop an interdisciplinary care plan. 2. A preliminary care plan is developed upon admission. All disciplines must initiate a care plan addressing pertinent issues related to the care of the resident. 3. An interdisciplinary team, in conjunction with resident, family member(s) legal representative should develop quantifiable objectives for the highest level of function the resident may be expected to attain. 4. The comprehensive care plan is designed to: Address the needs, strengths and preferences identified in the comprehensive resident assessment. Be oriented toward preventing avoidable declines in functioning or functional levels Reflect standards of current professional practice. Incorporate risk factors associated with identified problems and ways to manage said risk factors. Reflect treatment goals and objectives in measurable outcomes. Identify treatment goals and objectives in measurable outcomes. Identify the professional services that are responsible for each element of care. Enhance the optimal functioning of the resident by focusing on a rehab program...."</p>			

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F 0318 SS=E Bldg. 00	<p>This Federal tag relates to Complaint IN00184588.</p> <p>3.1-35(g)(2)</p> <p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Based on observation, interview and record review the facility failed to provide range of motion services and splint devices for residents who required these treatments and services to prevent further contractures (Resident #G, Resident #D, Resident #F and Resident #B).</p> <p>Findings include:</p> <p>1.) Review of the record of Resident #G on 12/15/15 at 11:50 a.m., indicated the resident's diagnoses included, but were not limited to, profound intellectual disabilities, epilepsy, cerebral palsy, ventilator dependent secondary to respiratory failure, bilateral clubbed feet and congenital quadraparesis.</p>	F 0318	F318 Requires the facility to provide range of motion services and splint devices for residents who require these treatments and services to prevent further contractures. 1. Resident G had a chair adapted to meet his needs until his new chair arrives and his splints will be applied per splinting program. Resident D, F and B had their range of motion program and their splinting programs reviewed with no changes made. 2. All residents have the potential to be affected. All resident's splinting and range of motion programs were reviewed to ensure appropriateness. no concerns noted. See below for corrective measures. 3. The staff was inserviced on the range of motion policy and procedure. (See	12/29/2015

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	<p>The November 2015, physician recapitulation (recap) for Resident #G indicated the resident was to be up ad lib in an adaptive wheelchair with a pommel cushion, bilateral footrest and rear anti-tippers for safety, chest harness, lap belt, and trunk laterals. The resident was ordered bilateral ankle, foot orthosis (ankle/foot brace) when up in the wheelchair.</p> <p>The daily device skin assessment (no date or time) for Resident #G indicated the resident was suppose to wear a splint device daily and his skin should be assessed daily. There were 61 days that indicated the resident did not have his splint device in place due to he had no wheelchair.</p> <p>The Quarterly Minimum Data Set (MDS) assessment for Resident #G, dated 9/23/15, indicated his functional limitation in range of motion was impaired on both sides of his upper and lower extremities</p> <p>The careplan for Resident #G, dated 10/6/15, indicated the resident required a splint /brace to ensure proper positioning of limbs. The schedule was bilateral knee/foot orthosis while up in the wheelchair. "Apply the splint/device as</p>		<p>attachment D) The staff was also educated on applying splints per the resident's splinting program. 4. The DON or his designee will conduct daily rounds and observe three residents splints to ensure they are applied per splinting program daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment C) The DON or his designee will also observe three resident's receiving ROM to ensure their programs are being completed to meet the needs of the residents daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment C) . The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly if warranted. 5. The above corrective measures will be completed on or before December 29, 2015.</p>	

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	<p>ordered.</p> <p>The careplan for Resident #G, dated 10/6/15, indicated the resident had decreased mobility and was unable to actively range his joints due to spastic quadriplegia. The resident was to have 5-10 reps of passive range of motion exercises daily to his upper and lower extremities.</p> <p>The October 2015 Restorative nursing documentation for Resident #G, indicated his passive range of motion was to be provided with a.m. and p.m. care. There were 12 times the resident was documented as receiving these services.</p> <p>The December 2015 Restorative nursing documentation for Resident #G, indicated his passive range of motion services were not completed 5 times.</p> <p>An interview with LPN #2 on 12/15/15 at 1:05 p.m., indicated it was reported to her that Resident #G's wheelchair needed repaired and it got put in the trash. LPN #2 indicated she was unsure who had disposed of his wheelchair. LPN #2 indicated he did not wear his bilateral foot/ankle splints because they were not applied while he was in bed.</p> <p>An interview with CNA #3 on 12/15/15</p>			

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	<p>at 1:25 p.m., indicated the resident did wear foot splints when he had a wheelchair, but he did not wear them while he was in bed. During observation at this time, Resident #G was provided incontinence care and range of motion while laying in bed. The resident had bilateral contractures of the foot and ankle and no splint device in place.</p> <p>An interview with Unit Manager #1 on 12/15/15 at 5:30 p.m., indicated she was unable to find documentation that Resident #G had received passive range of motion services in November 2015.</p> <p>2.) Review of the record of Resident #D on 12/15/15 at 10:30 a.m., indicated the resident's diagnoses included, but were not limited to, contractures of the upper and lower extremities, cerebral palsy, severe osteopenia and profound intellectual disability.</p> <p>The Quarterly MDS assessment for Resident #D, dated 10/16/15, indicated the residents functional limitation in range of motion was impaired on both sides of his upper and lower extremities.</p> <p>The careplan for Resident #D, dated 10/16/15, indicated the resident was to be provided with passive range of motion daily with activities of daily living.</p>			

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	<p>The October 2015 restorative nursing program documentation log for Resident #D indicated the resident was to have 5-10 reps (not specific to what extremities) with a.m., and p.m., care. The log documentation indicated the resident did not receive these services 12 times.</p> <p>The December 2015 restorative nursing program documentation log for Resident #D indicated the resident did not receive passive range of motion services 5 times.</p> <p>During observation on 12/15/15 at 1:15 p.m., Resident #D was lying in bed, he had contractures of the bilateral hands, wrist, fingers and feet.</p> <p>Interview with CNA #4 on 12/14/15 at 2:00 p.m., indicated she was not always able to provide range of motion to the residents. CNA #4 indicated when she was unable to complete a resident's range of motion services she left the documentation blank for that resident.</p> <p>Interview with CNA #5 on 12/15/15 at 11:15 a.m., indicated staff were unable to complete all residents range of motion programs. CNA #5 indicated when she was unable to complete a resident's program she left the documentation</p>			
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	<p>blank.</p> <p>Interview with Unit Manager #1 on 12/15/15 at 5:30 p.m., indicated she was unable to find documentation that Resident #D had received passive range of motion services in November 2015.</p> <p>3. Resident #F's record was reviewed on 12/14/15 at 2:56 p.m. Her diagnoses documented on her December 2015 physician recapitulation orders included but were not limited to, cerebral palsy, left short heel cord, and contractures of all extremities.</p> <p>Resident #F's quarterly MDS dated 9/7/15, indicated she was rarely/never understood and rarely/never understood others. She was severely impaired in her daily decision making skills. She required total dependence of two plus persons for bed mobility and transfer. She did not walk. She required total dependence of 1 person for her dressing and personal hygiene. She had functional limitation in both of her upper and lower extremities. She utilized a wheelchair for mobility.</p> <p>A physician's order for Resident #F documented on her December 2015 physician recapitulation orders dated 5/5/15, indicated she would wear leg braces on both legs a minimum of 4</p>			

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	<p>hours daily as tolerated on days only.</p> <p>A Splint/Brace care plan for Resident #F updated 9/23/15, indicated she required the use of a splint/brace to ensure proper positioning of her limbs. She would wear the leg braces to both legs when she was in her wheelchair. Her interventions for the use of the leg braces indicated she would wear the leg braces as ordered.</p> <p>An interview with CNA #12 on 12/14/15 at 2:30 p.m., indicated Resident #F attended school Monday through Friday.</p> <p>On 12/15/15 at 10:45 a.m., Resident #F was observed seated in her wheelchair. Resident #F was not wearing any leg braces. At that time, an interview with Para Educator #7 at the facility's school classroom indicated she had never seen Resident #F wearing any type of leg braces.</p> <p>An interview on 12/15/15 at 10:55 a.m., with Teacher #8 at the facility's school classroom indicated she had never seen Resident #F wearing any type of leg braces.</p> <p>On 12/15/15 at 3:25 p.m., Resident #F was observed seated in her wheelchair in her bedroom. She was not wearing any leg braces.</p>			

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	<p>An interview with QMA #9 on 12/15/15 at 3:35 p.m., indicated she had not seen Resident #F's leg braces. QMA #9 indicated she did not work in that area very often.</p> <p>An interview with CNA #10 on 12/15/15 at 3:45 p.m., indicated she had never seen any leg braces for Resident #F. CNA #10 had not been informed Resident #F wore leg braces. CNA #10 was unable to locate Resident #F's leg braces.</p> <p>An interview with CNA #11 on 12/15/15 at 4:10 p.m., indicated she had been Resident #F's CNA that day from 7:00 a.m., until 3:10 p.m. CNA #10 had been in a hurry to get Resident #F ready for school that morning and had not put the leg braces on that day.</p> <p>4. Review of Resident #B's record on 12/14/15 at 2:10 p.m., indicated his diagnoses included but were not limited to, bilateral hip dislocation, spastic quadriparesis, blindness, contractures of all extremities, scoliosis, spastic quadriplegia, severe spasticity, hypertonicity and excessive secretions secondary to neurological impairment.</p> <p>A review of the annual Minimum Data Set (MDS) dated 9/3/15 indicated Resident B's range of motion (ROM) for</p>			

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	<p>his upper and lower extremities were impaired on both sides.</p> <p>12/14/15 at 12:54 p.m., Resident #B was observed receiving care by CNA #15. His bilateral hands, wrists and feet were contracted. His legs were stiff, and he was positioned for comfort after the care. There were no signs or symptoms of pain.</p> <p>Physician's recapulation orders dated 12/1/15 through 12/31/15 indicated ROM to be completed one hour after giving phenobarbital: Phenobarbital 20mg/5ml give 15ml (60mg) daily at 8:00 a.m., Phenobarbital 20mg/5ml give 22.5mg (90mg) daily at 5:00 p.m.</p> <p>A review of Restorative nursing for passive range of motion (PROM) documentation for October 2015 indicated Passive ROM - 5-10 repetitions as per resident tolerance. A.M. care for the 5th, 6th, 16th and 20th were not initialed as having been completed. P.M. care for the 4th, 6th, 9th, 14th, 17th, 20th, 24th, 25th and 31st were not initialed as having been completed.</p> <p>An interview with the Director of Nursing on 12/15/15 at 5:40 p.m., indicated the November range of motion documentation could not be located.</p>			

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	<p>A care plan in place for range of motion indicated "Problem: Resident has decreased mobility and is unable to actively range joints related to:contractures Diagnosis: spastic quadriplegia, osteoporosis and scoliosis Goal: The resident will tolerate 5-10 repetitons of passive range of motion exercises to upper and lower extremities as evidenced by no signs/symptoms of pain or discomfort thru next review. Interventions: Give the resident PROM exercises as recommended. See restorative tracking log for details..."</p> <p>Review of a document titled Range of Motion, Passive provided by the Director of Nursing on 12/15/15 at 6:00 p.m., indicated "Purpose: Range of motion (ROM) exercises are indicated for residents with temporary or permanent loss of mobility, sensation or consciousness and as a restorative measure to prevent loss of function, muscle contractures and/or deformity. Policy: Range of motion exercises are provided to assist residents to reach and maintain highest level of ROM possible and to prevent avoidable decline..."</p> <p>The Splinting Application procedure provided by Unit Manager #1 on 12/15/15 at 6:10 p.m., indicated the</p>			

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F 0514 SS=D Bldg. 00	<p>following: "Purpose: Extremities of residents are maintained in a functional position that places the muscles at length for maximum function. Policy: A physician order for splinting, indicating which extremity and frequency, is obtained before a program may be initiated. The splinting program is initiated by Occupational Therapy (OT) or Physical Therapy (PT). The splinting program is noted in the resident's care plan. Splint application designated to be completed by nursing personnel shall be documented by the licensed nurse on the treatment record. Procedure: ...3. Apply splint according to therapy recommendations and physician's order. 4. Remove splint after designated period of time...."</p> <p>This Federal tag relates to Complaint IN00184588 and IN00185968</p> <p>3.1-42(a)(2)</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE 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</p>			

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	<p>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 observation, interview, and record review, the facility failed to accurately document the application of a resident's leg brace for 1 of 7 residents reviewed for documentation. (Resident #F)</p> <p>Findings include:</p> <p>Resident #F's record was reviewed on 12/14/15 at 2:56 p.m. Her diagnoses documented on her December 2015 physician recapitulation orders included but were not limited to, cerebral palsy, left short heel cord, and contractures of all extremities.</p> <p>Resident #F's quarterly MDS dated 9/7/15, indicated she was rarely/never understood and rarely/never understood others. She was severely impaired in her daily decision making skills. She required total dependence of two plus persons for bed mobility and transfer. She did not walk. She required total dependence of 1 person for her dressing and personal hygiene. She had functional</p>	F 0514	<p>F514 Requires the facility to accurately document the application of a resident's leg brace. 1. Resident F had the braces applied per splinting program. 2. All residents have the potential to be affected. All resident's splinting programs were reviewed to ensure the programs meet the needs of the resident. Documentation for the programs were reviewed for accuracy. No concerns were noted. See below for corrective measures. 3. The splinting policy and procedure was reviewed with no changes made. (See attachment E) The staff was inserviced on the above procedure focusing on documentation once the splint is applied per program4. The DON or her designee will utilize the nursing monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter to ensure accurate documentation when splinting is completed until 100% compliance is obtained and maintained. The DON or his designee will monitor 3 observation of splinting</p>	12/29/2015

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	<p>limitation in both of her upper and lower extremities. She utilized a wheelchair for mobility.</p> <p>A physician's order for Resident #F documented on her December 2015 physician recapitulation orders dated 5/5/15, indicated she would wear leg braces on both legs a minimum of 4 hours daily as tolerated on days only.</p> <p>A Splint/Brace care plan for Resident #F updated 9/23/15, indicated she required the use of a splint/brace to ensure proper positioning of her limbs. She would wear the leg braces to both legs when she was in her wheelchair. Her interventions for the use of the leg braces indicated she would wear the leg braces as ordered.</p> <p>A Treatment Record for Resident #F indicated she had worn her leg braces on December 15, 2015</p> <p>On 12/15/15 at 10:45 a.m., Resident #F was observed seated in her wheelchair. Resident #F was not wearing any leg braces. At that time, an interview with Para Educator #7 at the facility's school classroom indicated she had never seen Resident #F wearing any type of leg braces.</p> <p>An interview on 12/15/15 at 10:55 a.m.,</p>		<p>occurring and then ensure that documentation is accurate daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment C) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly. 5. The above corrective measures will be completed on or before December 29, 2015.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15A011	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/15/2015
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NAME OF PROVIDER OR SUPPLIER ESPECIALLY KIDZ HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 2325 S MILLER ST SHELBYVILLE, IN 46176
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	<p>with Teacher #8 at the facility's school classroom indicated she had never seen Resident #F wearing any type of leg braces.</p> <p>On 12/15/15 at 3:25 p.m., Resident #F was observed seated in her wheelchair in her bedroom. She was not wearing any leg braces.</p> <p>An interview with QMA #9 on 12/15/15 at 3:35 p.m., indicated she had not seen Resident #F's leg braces. QMA #9 indicated she did not work in that area very often.</p> <p>An interview with CNA #10 on 12/15/15 at 3:45 p.m., indicated she had never seen any leg braces for Resident #F.</p> <p>An interview with CNA #11 on 12/15/15 at 4:10 p.m., indicated she had been Resident #F's CNA that day from 7:00 a.m., until 3:10 p.m. CNA #10 had been in a hurry to get Resident #F ready for school that morning and had not put the leg braces on that day.</p> <p>This Federal tag relates to Complaint IN00184588 and IN00185968.</p> <p>3.1-50(a)(2)</p>			