

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155334	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/22/2012
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-WILDWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 7301 E 16TH ST INDIANAPOLIS, IN 46219
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F0000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00106972. This visit resulted in an extended survey-substandard quality of care.</p> <p>This visit was in conjunction with the Investigation of Complaints IN00108540, IN00108423, IN00108356, and IN00108294.</p> <p>Complaint IN00106972-Substantiated. No deficiencies related to the allegations are cited</p> <p>Survey dates: May 14, 15, 16, 17, 18, 2012 Extended survey dates: May 20, 21, and 22, 2012</p> <p>Facility number: 000227 Provider number: 155334 AIM number: 100267520</p> <p>Survey team: Karina Gates, BHS- TC Courtney Mujic, RN Beth Walsh, RN (May 14, 15, 16, 17, 18, 21, and 22, 2012 only) Barb Hughes, RN (May 14, 15, 16, 17, 18, 21, and 22, 2012 only)</p>	F0000		

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>Census bed type: SNF/NF: 142 Total: 142</p> <p>Census payor type: Medicare: 44 Medicaid: 70 Other: 28 Total: 142</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on June 4, 2012 by Bev Faulkner, RN.</p>				

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F0224 SS=F	<p>483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRI ATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interview and record review, the facility failed to identify allegations of abuse/mistreatment, to ensure they were reported timely, thoroughly investigated and protection for residents from further abuse was provided for 12 of 77 residents interviewed by the facility for potential abuse (Resident #71, 100, 5, 325, 106, 182, 145, 178, 326, 238, 407, and 150); 4 of 6 residents who met the criteria for abuse (Resident #182, 213, 181, and 106). This had the potential to affect 142 residents in the facility.</p> <p>Findings include:</p> <p>1. During an interview with Resident #213 on 5/16/12 at 10:31 a.m., she indicated a night nurse was rude to her regarding administration of Tylenol the previous weekend. She indicated she did not know who the</p>	F0224	<p>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required A. Residents 71,100,182,145,238,150,213,181, 106,201,213, concerns were investigated and follow through completed. Each of these residents have been re-visited and their visits were reviewed by Admin and/or DNS to assure that there were no further concerns or allegations of abuse. Residents have stated that there have been no further incidents or concerns. If there are any concerns voiced by residents their concerns are addressed per regulations and Kindred P/P immerdiately. Residents 100,145,150,181 and 106 are no longer at facility.B. Residents who are cognatively intact were interviewed using the QIS and/or Angel Care forms to determine if any allegations of abuse were made and had not been reported to facility staff</p>	06/20/2012			

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	<p>nurse was.</p> <p>The investigation report to this alleged abuse incident dated 5/21/12 was provided by the Social Services Director on 5/21/12 at 3:00 p.m. The report indicated "She explained that a week ago Saturday at approximately 12am-2am that she had approached her med (medication) nurse at the nurse's desk to ask for Tylenol. She states that the nurse responded to her, "Why do you need Tylenol when you just had a huge dose of morpphine [sic]." She explained to the nurse that she does not have morphine as she has discussed her meds (medications) with her doctor in detail. She reports also explaining that she had discussed her discomfort with her therapist who had reported to her that she should ask for Tylenol when in discomfort...</p> <p>I discussed the details of this situation with the resident. She reported that she thinks staff should not discount what the resident says and they may very well be aware of their meds and conditions. She explained that the approach was poor and that the nurse</p>		<p>management. Any concerns are immediatly, given to ED, and thoroughly investigated.C. The facility Management and all staff were re-educated on the facility standards and guidelines for identifying abuse, exploitation, and reporting of abuse. Abuse education is conducted during orientation and periodically through the year. All staff have been re-educated to assure that they understand that any allegations or abuse are addressed immediately and that employee who is alleged of any type of abuse is immediatly removed from patient areas and suspended. Adminitrator is immediatly notified and an investigation is started. Notification is made to the ISDOH, family or responsible party,and physician. Angel rounds are made Monday through Friday and random residents are interviewed using the QIS Process and/or Angel Care form to determine if any concerns of abuse are identified and immediately reported to ED. The facility Management Team review all event reports, grievances and concerns daily during the Monday thru Friday morning meeting in order to review , resolve, and follow-up with any concerns that residents may have. Administrator will attend resident council meetings monthly for next three months and then</p>		

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	<p>did increase her tone when talking with her."</p> <p>During interview with the Social Services Director on 5/22/12 at 10:38 a.m., she indicated it was unknown who the nurse Resident #213 was referring to in the above incident. During another interview with the Social Services Director on 5/22/12 at 11:38 a.m., she indicated the nurse in question was LPN #17 and that she was not suspended prior to the 5/21/12 investigation of the above incident . She indicated it was figured out who the nurse was within the past hour, since 10:38 a.m. on 5/22/12, after being questioned about who the actual nurse was that Resident #213 was referencing in her allegation. She indicated LPN #17 was scheduled to come in that day at 2:00 p.m. and would be "talked to" prior to beginning her shift. She indicated it was her understanding that the approach being implemented was to investigate potential abuse first, then suspend.</p> <p>The abuse policy subsection entitled</p>		<p>quarterly to see if residents have any concerns that need addressed if the council agrees to allow Administrator to attend a portion of their meeting.D. Monday thru Fri Angel Care rounds are completed by department heads and their residents are asked the QIS and/or Angel Care Form questions to determine if any allegations of abuse, neglect or exploitation have occurred and if they were immediately reported. These reports will be reviewed at the PI meeting monthly and then quarterly thereafter to assure that all concerns or allegations have been followed up on and review to see that Kindred P/P and regulations are being followed.</p>		

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	<p>"Protection of Resident During An Investigation" provided by the Executive Director on 5/14/12 at 2:00 p.m., indicated the procedure was that a staff member implicated in an abuse/neglect situation would be suspended pending investigation results.</p> <p>2. On 5/17/12 at 1:30 p.m., the DON (Director of Nursing) provided 77 abuse interviews conducted on 5/15/12 with 77 residents by the Social Services department. Of the 77 interviews reviewed, 6 of them indicated the resident did not feel staff treated them with respect and dignity (Resident #182, 145, 178, 326, 71, and 100); 5 of them indicated the resident had been treated roughly by staff (Resident #71, 100, 5, 325, and 106); and 9 of them indicated that staff had yelled at or been rude to the resident (Resident #145, 178, 326, 71, 100, 5, 106, 238, and 150).</p> <p>During interview with the ED (Executive Director), DON (Director of Nursing), ADON (Assistant Director of</p>				

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	<p>Nursing), and SSA (Social Services Assistant) on 5/18/12 at 10:35 a.m., the ED indicated the DON and ADON were responsible for reviewing the 77 above mentioned abuse interviews. The ED, DON, and ADON all indicated there were no concerns with any of the interviews.</p> <p>At this time, the abuse interview conducted with Resident #407 was reviewed in which the resident indicated staff had yelled at or been rude to her, commenting "Couple are rude. Days/Evening. Doesn't do any good to report it. Nothing changes. Have talked to (name of staff member), (name of ADON), (name of Social Services Director) many times."</p> <p>In response to this interview, the DON stated, "We haven't had a chance to get through all of these."</p> <p>The abuse interview conducted with Resident #325 was also reviewed at this time in which the resident indicated, "1 girl jerked on bad arm..."</p>				

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	<p>In response to review of this interview, the DON stated, "(Name of SSA) read this one and should have given this to either myself or (Name of ADON). This is a possible abuse allegation. The word jerked means to investigate. This is not acceptable. I don't know if it's the culture or that staff don't consider what they're doing as rude. We need to get staff to understand what rude really is."</p> <p>At this time, the SSA joined the interview and indicated her instructions were to go around and do these interviews and bring them to the DON. She indicated she finished the interviews at 8:00 p.m. on 5/15/12 and handed the stack of interviews to the DON the morning of 5/16/12.</p> <p>The ADON indicated the procedure they use to investigate abuse is to talk to the resident first, then the staff members in contact with the resident, and then determine whether or not it's abuse. She indicated most of this is done before we report it to the administrator and if there are no words being used by the staff that</p>			

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	<p>indicate abuse, she doesn't consider it an allegation of abuse, but rather a customer service issue. She indicated she knew the system looked broken.</p> <p>The ED indicated she expected any interview with anything negative to come back to either herself, the DON, or the ADON. She indicated they needed to work on interviews and inservicing on abuse and what it is. She indicated they needed to get staff to understand what abuse really is. She stated, "We knew we needed to focus on this."</p> <p>During interview with the ED at 2:20 p.m. on 5/18/12, she indicated social services should have stopped interviewing when the first allegation of abuse came in and reported it to me. She indicated the DON should have looked at the abuse interviews.</p> <p>During another interview with the ED on 5/21/12 at 10:40 a.m., she indicated they had 2 major breakdowns. The first was the Social Services staff member should have</p>			

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	<p>came to her right away when she got negative responses. The second was the DON should have informed me when she got them, but she didn't even look through the stack of interviews on 5/16/12 when she got them.</p> <p>During an interview with the ED on 5/21 at 2:05 p.m., she indicated she didn't have any more information to give on abuse. She stated, "I don't know what else we can do at this point."</p> <p>The subsection of the abuse policy entitled "Responding to and Investigating an Abuse Allegation" indicated all abuse allegations are to be reported to the Executive Director immediately.</p> <p>3. Resident #181 was included in the resident interviews completed by the facility on 5/15/2012. The resident's response to the question, 'do you feel staff treat you with respect and dignity?' was, "on the most part, early a. m. hours rush when helping, this morning she was not abusive but rough, see below." Her response to</p>				

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	<p>the question, 'have you ever been treated roughly by staff?' was "yes, not abusive." An additional resident interview completed by the facility and dated 5/15/2012 indicated, 'have you ever been treated roughly by staff?' was, "once, patient states doesn't recall exactly but imagines it is a week or two. Doesn't recall the exact date. She says she was white lady with long pony tail with German accent. States never saw again, again patient states recall recent (2 to 3 weeks ago.) States she doesn't know if it was a nurse or CNA. Patient states that person took her to the bathroom and brought patient back to bed. Patient sat on bed and person held her legs to position her back in bed; however, she states that this person threw her legs almost past the opposite edge of the bed. Patient states that this person came back later and patted her calling her I love you baby. Patient cannot recall who she told or reported too and also said I just kept my mouth shut because I was mad..."</p> <p>An Interview with the Executive Director and Assistant Director of Nursing on 5/17/2012 at 3:12 p.m., indicated they were unaware of any incidences or reports of abuse relating to the resident within the last</p>			

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	<p>8 months since the Assistant Director of Nursing has been at this facility.</p> <p>Review of the investigation provided by the Executive Director on 5/21/2012 at 12:00 p.m., indicated the resident was re-interviewed on 5/18/2012 concerning the alleged mistreatment reported to the Social Services Assistant on 5/15/2012. The facility also interviewed the alleged CNA involved in this occurrence. The investigation was still in process.</p> <p>Interview with the Executive Director on 5/22/2012 at 11:28 a.m., indicated that on Friday night (the 18th of May) around 7 p. m., the CNA, whose physical description matched the description given by the resident in her report, was interviewed. The Executive Director says she believes that the CNA addressed the resident's concern right away. She would not consider it an abuse situation, but an improper way of putting a resident to bed and definitely warrants a counseling/training session for this specific CNA. She doesn't think that the resident was hurt or anything, she thinks it was just that the CNA probably put the resident to bed too quickly, moved her legs too quickly or something. Since she took the time to show the resident that there was</p>				

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	<p>still a foot of space on each side of the bed after she was done moving her, she thinks this means its just a customer service issue. When she, the Executive Director, gets all these investigations back she will determine every employee who needs an inservice about proper transferring.</p> <p>4. In an interview with Resident #106, on 5/14/12 at 2:15 p.m., he indicated a staff member rough-handled him, cussed at him, and threaten to kick his feet. The resident was unable to remember a name, but was able to describe the staff member.</p> <p>This interview/incident was reported to the Executive Director on 5/14/12 at 2:35 p.m.</p> <p>On an interview form, from an interview conducted by Social Services #20, with Resident #106, dated 5/15/12, with no time indicated, the question, "Has staff ever yelled at or been rude to you" was marked "yes." There was a comment made in the same section as the above question with a name mentioned on who yelled and/or was rude, with a description of the staff member.</p> <p>Employee files were reviewed on 5/21/12 at 9:30 a.m. There was an</p>				

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	<p>employee with a similar name as the name listed on the interview form, from the interview conducted with Social Services and Resident #106.</p> <p>In an interview with the Executive Director on 5/21/12 at 3:15 p.m., she indicated that she was unaware of a name mentioned in a Social Services interview with Resident #106, on 5/15/12. The Executive Director also indicated that she is aware of the employee with a similar name.</p> <p>On 5/22/12 at 11:30 a.m., the Executive Director indicated that the employee with the similar name from the Social Services interview was not called until 5/21/12, when the name were brought to the Executive Director's attention the previous day.</p> <p>3.1-28(a)</p>						

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F0226 SS=F	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interview and record review, the facility failed to follow their policies to report to the Administrator immediately and to protect residents from possible further abuse during abuse investigations in that employees were not removed from all resident contact during the abuse investigations for 12 of 77 residents interviewed by the facility for potential abuse (Resident #71, 100, 5, 325, 106, 182, 145, 178, 326, 238, 407 and 150); 4 of 6 residents who met the criteria for abuse (Resident #182, 213, 181, and 106); and 1 of 1 resident randomly interviewed regarding abuse (Resident #201). This had the potential to affect 142 residents in the facility.</p> <p>Findings include:</p> <p>1. During an interview with Resident #213 on 5/16/12 at 10:31 a.m., she</p>	F0226	<p>A. Residents 182,213,181,106 concerns were investigated and follow through completed Each of these residents have been re-visited and their visits were reviewed by Admin and/or DNS to assure that there were no further concerns or allegations of abuse. Residents have stated that there have been no further incidents or concerns. If there are any concerns voiced by residents their concerns are addressed per regulations and Kindred P/P. Staff members who were reported as being rude or rough were counicled and inserviced on resident abuse and what is considered to be abuse by regulations and Kindred P/P. Residents 181 and 106 are no longer in the facility.B. Residents who are cognatively intact were interviewed using the QIS Process for abuse to determine if any allegations of abuse (verbal/and or physical) had not been reported to facility staff management or that facility staff had not acted upon. Any issues identified were immediately addressed, investigated and reported according to facility, regulations.C. The facility</p>	06/20/2012	

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	<p>indicated a night nurse was rude to her regarding administration of Tylenol the previous weekend. She indicated she did not know who the nurse was.</p> <p>The investigation report to this alleged abuse incident, dated 5/21/12, was provided by the Social Services Director on 5/21/12 at 3:00 p.m. The report indicated "She explained that a week ago Saturday at approximately 12am-2am that she had approached her med (medication) nurse at the nurse's desk to ask for Tylenol. She states that the nurse responded to her, "Why do you need Tylenol when you just had a huge dose of morpphine [sic]." She explained to the nurse that she does not have morphine as she has discussed her meds (medications) with her doctor in detail. She reports also explaining that she had discussed her discomfort with her therapist who had reported to her that she should ask for Tylenol when in discomfort...</p> <p>I discussed the details of this situation with the resident. She reported that</p>		<p>Management and all staff were re-educated on the facility standards and guide lines for identifying abuse, exploitation, and reporting of abuse. Abuse education is conducted during orientation and periodically through the year. Staff have been re-educated to assure that they understand that any allegations of abuse are addressed immediately and that employee who is alleged of any type of abuse is immediately removed from patient areas and suspended. Adminitrator is immediatly notified and an investigation is started. Notification is made to the ISDOH, family or responsible party, and physician. Angel rounds are made Monday through Friday and random residents are interviewed using the QIS and/or the Angel Care form to determine if any concerns of abuse are identified and immediately reported to ED. The facility Management Team will review all event reports, audit tools, grievances, and concerns daily during the Monday thru Friday morning meeting in order to investigate , resolve, and follow-up with any allegations of abuse, neglect or exploitation. D. Monday thru Fri Angel Care rounds are completed by department heads and their residents are asked the Angel Care Form and/or QIS questions to determine if any</p>		

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	<p>she thinks staff should not discount what the resident says and they may very well be aware of their meds and conditions. She explained that the approach was poor and that the nurse did increase her tone when talking with her."</p> <p>During interview with the Social Services Director on 5/22/12 at 10:38 a.m., she indicated it was unknown who the nurse Resident #213 was referring to in the above incident. During another interview with the Social Services Director on 5/22/12 at 11:38 a.m., she indicated the nurse in question was LPN #17 and that she was not suspended prior to the 5/21/12 investigation of the above incident. She indicated it was figured out who the nurse was within the past hour, since 10:38 a.m., on 5/22/12, after being questioned about who the actual nurse was that Resident #213 was referencing in her allegation. She indicated LPN #17 was scheduled to come in that day at 2:00 p.m., and would be "talked to" prior to beginning her shift. She indicated it was her understanding that the</p>		<p>allegations of abuse, neglect or exploitation have occurred and if they were immediately reported. These reports will be reviewed at the PI meeting monthly and then quarterly thereafter to assure that all concerns or allegations have been followed up on and review to see that Kindred P/P and regulations are being followed.</p>		

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	<p>approach being implemented was to investigate potential abuse first, then suspend.</p> <p>The abuse policy subsection entitled "Protection of Resident During An Investigation" provided by the Executive Director on 5/14/12 at 2:00 p.m., indicated the procedure was that a staff member implicated in an abuse/neglect situation would be suspended pending investigation results.</p> <p>2. On 5/17/12 at 1:30 p.m., the DON (Director of Nursing) provided 77 abuse interviews conducted on 5/15/12 with 77 residents by the social services department. Of the 77 interviews reviewed, 6 of them indicated the resident did not feel staff treated them with respect and dignity (Resident #182, 145, 178, 326, 71, and 100); 5 of them indicated the resident had been treated roughly by staff (Resident #71, 100, 5, 325, and 106); and 9 of them indicated that staff had yelled at or been rude to the resident (Resident #145, 178, 326, 71, 100, 5, 106, 238,</p>			

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	<p>and 150).</p> <p>During interview with the ED (Executive Director), DON (Director of Nursing), ADON (Assistant Director of Nursing), and SSA (Social Services Assistant) on 5/18/12 at 10:35 a.m., the ED indicated the DON and ADON were responsible for reviewing the 77 above mentioned abuse interviews. The ED, DON, and ADON all indicated there were no concerns with any of the interviews.</p> <p>At this time, the abuse interview conducted with Resident #407 was reviewed in which the resident indicated staff had yelled at or been rude to her, commenting "Couple are rude. Days/Evening. Doesn't do any good to report it. Nothing changes. Have talked to (name of staff member), (name of ADON), (name of Social Services Director) many times."</p> <p>In response to this interview, the DON stated, "We haven't had a chance to get through all of these."</p>				

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	<p>The abuse interview conducted with Resident #325 was also reviewed at this time in which the resident indicated, "1 girl jerked on bad arm..."</p> <p>In response to review of this interview, the DON stated, "(Name of SSA read this one and should have given this to either myself or (Name of ADON). This is a possible abuse allegation. The word jerked means to investigate. This is not acceptable. I don't know if it's the culture or what that staff don't consider what they're doing as rude. We need to get staff to understand what rude really is."</p> <p>At this time, the SSA joined the interview and indicated her instructions were to go around and do these interviews and bring them to the DON. She indicated she finished the interviews at 8:00 p.m., on 5/15/12 and handed the stack of interviews to the DON the morning of 5/16/12.</p> <p>The ADON indicated the procedure they use to investigate abuse is to talk to the resident first, then the staff</p>						

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	<p>members in contact with the resident, and then determine whether or not it's abuse. She indicated most of this is done before we report it to the administrator and if there are no words being used by the staff that indicate abuse, she doesn't consider it an allegation of abuse, but rather a customer service issue. She indicated she knew the system looked broken.</p> <p>The ED indicated she expected any interview with anything negative to come back to either herself, the DON, or the ADON. She indicated they needed to work on interviews and inservicing on abuse and what it is. She indicated they needed to get staff to understand what abuse really is. She stated, "We knew we needed to focus on this."</p> <p>During interview with the ED at 2:20 p.m. on 5/18/12, she indicated social services should have stopped interviewing when the first allegation of abuse came in and reported it to me. She indicated the DON should have looked at the abuse interviews.</p>						

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	<p>During another interview with the ED on 5/21/12 at 10:40 a.m., she indicated they had 2 major breakdowns. The first was the Social Services staff member should have come to her right away when she got negative responses. The second was the DON should have informed me when she got them, but she didn't even look through the stack of interviews on 5/16/12 when she got them.</p> <p>During an interview with the ED on 5/21 at 2:05 p.m., she indicated she didn't have any more information to give on abuse. She stated, "I don't know what else we can do at this point."</p> <p>The subsection of the abuse policy entitled "Responding to and Investigating an Abuse Allegation" indicated all abuse allegations are to be reported to the Executive Director immediately.</p>			

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	<p>3. On 5/15/12 at 11:00 a.m., Res. #201 was interviewed in the presence of CNA #18 and stated "they were mean to her" causing pain to her shoulders.</p> <p>The facility E.D. was interviewed on 5/16/12 at 11:50 a.m., about the alleged abuse of Resident #201 witnessed by CNA #18. She indicated she had not received any report of an incident involving Resident # 201, but that a potential abuse incident should have been reported to her immediately; and she would now start an investigation.</p> <p>During an interview with LPN #8 on 5/16/12 at 1:30 p.m., he indicated that CNA #18 had reported the incident involving Resident #201 to him on 5/15/12. He indicated he wrote a statement of the incident and gave it to the DON on following morning of 5/16/12.</p> <p>On 5/17/12 at 2:p.m. a copy of an undated statement, reported by LPN #8, of the incident on 5/15/12 involving Resident #201 was received.</p> <p>During an interview with the E.D. and RN #20 on 5/21/12 at 10:30 a.m., the E.D. stated "I know we have a</p>			

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	<p>problem in reporting abuse."</p> <p>4. On 5/16/12 at 3:55 p.m., an interview was conducted with CNA #3 who indicated she assisted CNA #19 in attempting to toilet Resident #201. She indicated that CNA #19 was having difficulty transferring this resident on 5/15/12 "after the concert" (at about 4:30 p.m.), and she used a curse word while in resident's room, indicating she would not hurt her back in the transfer process.</p> <p>During an interview with the facility E.D. on 5/16/12 at 4:55 p.m., she indicated this incident had not been reported to her, but that it should have been reported immediately to her according to facility policy.</p> <p>During an interview with the facility DON on 5/16/12 at 5:20 p.m., she indicated the incident had been reported to her on the morning of 5/16/12 and she had talked with the resident.</p> <p>During an interview with the E.D., DON, and RN #20 on 5/16/12 at 5:30 p.m., it was indicated that they were all now aware of the allegation of abuse made by CNA #3 alleged to have occurred by CNA #19. The E.D. indicated that CNA #19 would not be</p>						

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	<p>working again until 5/18/12 giving them time to do an investigation before she returns to work.</p> <p>According to facility policy titled "Protection of Resident During an Investigation" it indicated CNA#19 should have been immediately suspended pending investigation of the abuse allegation.</p> <p>5. Resident #181 was included in the resident interviews completed by the facility on 5/15/2012. The resident's response to the question, 'do you feel staff treat you with respect and dignity?' was, "on the most part, early a. m. hours rush when helping, this morning she was not abusive but rough, see below." Her response to the question, 'have you ever been treated roughly by staff?' was "yes, not abusive." An additional resident interview completed by the facility and dated 5/15/2012, indicated, 'have you ever been treated roughly by staff?' was, "once, patient states doesn't recall exactly but imagines it is a week or two. Doesn't recall the exact date. She says she was white lady with long pony tail with German accent. States never saw again, again patient states recall recent (2 to 3</p>				

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	<p>weeks ago.) States she doesn't know if it was a nurse or CNA. Patient states that person took her to the bathroom and brought patient back to bed. Patient sat on bed and person held her legs to position her back in bed; however, she states that this person threw her legs almost past the opposite edge of the bed. Patient states that this person came back later and patted her calling her I love you baby. Patient cannot recall who she told or reported too and also said I just kept my mouth shut because I was mad..."</p> <p>An Interview with the Executive Director and Assistant Director of Nursing on 5/17/2012 at 3:12 p.m., indicated they were unaware of any incidents or reports of abuse relating to the resident within the last 8 months since the Assistant Director of Nursing has been at this facility.</p> <p>Review of the investigation provided by the Executive Director on 5/21/2012 at 12:00 p.m., indicated the resident was re-interviewed on 5/18/2012 concerning the alleged mistreatment reported to the social services assistant on 5/15/2012. The facility also interviewed the alleged CNA involved in this occurrence. The investigation was still in process.</p>				

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	<p>Interview with the Executive Director on 5/22/2012 at 11:28 a.m. indicated, on Friday night (the 18th of May) around 7 p.m., the CNA, whose physical description matched the description given by the resident in her report, was interviewed, and not removed from resident contact. The Executive Director says she believes that the CNA addressed the resident's concern right away. She would not consider it an abuse situation, but an improper way of putting a resident to bed and definitely warrants a counseling/training session for this specific CNA. She doesn't think that the resident was hurt or anything, she thinks it was just that the CNA probably put the resident to bed too quickly, moved her legs too quickly or something. Since she took the time to show the resident that there was still a foot of space on each side of the bed after she was done moving her, she thinks this means it's just a customer service issue. When she, the Executive Director, gets all these investigations back she will determine every employee who needs an inservice about proper transferring.</p> <p>A policy titled, 'Protection of resident during an investigation,' indicated, "Procedure, 1. A staff member(s)</p>			

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	<p>implicated in an abuse/neglect situation, regardless of discipline, will be: a. immediately removed from any resident contact. c. suspended pending investigation results."</p> <p>6. In an interview with Resident #106, on 5/14/12 at 2:15 p.m., he indicated a staff member rough-handled him, cussed at him, and threaten to kick his feet. The resident was unable to remember a name, but was able to describe the staff member.</p> <p>This interview/incident was reported to the Executive Director on 5/14/12 at 2:35 p.m.</p> <p>On an interview form, from an interview conducted by Social Services #20, with Resident #106, dated 5/15/12, with no time indicated, the question, "Has staff ever yelled at or been rude to you" was marked "yes." There was a comment made in the same section as the above question with a name mentioned on who yelled and/or was rude, with a description of the staff member.</p> <p>Employee files were reviewed on 5/21/12 at 9:30 a.m. There was an employee with a similar name as the name listed on the interview form, from the interview conducted with</p>				

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	<p>Social Services and Resident #106.</p> <p>In an interview with the Executive Director on 5/21/12 at 3:15 p.m., she indicated that she was unaware of a name mentioned in a Social Services interview with Resident #106, on 5/15/12. The Executive Director also indicated that she is aware of the employee with a similar name.</p> <p>On 5/22/12 at 11:30 a.m., the Executive Director indicated that the employee with the similar name from the Social Services interview was not called/interviewed until 5/21/12, when the name were brought to the Executive Director's attention the previous day.</p> <p>A policy titled, Identification of an Event That May Constitute Abuse, dated 7/22/12, received from the Administrator on 5/14/12 at 2:00 p.m., indicated that the Executive Director, Director of Nursing Services, and Social Services should be immediately notified. The policy also indicated the root cause(s) of the event should be determined, including performance failures on the part of a person or entity.</p> <p>On 5/14/12 at 2:00 p.m., a policy titled, Responding to and</p>				

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	<p>Investigating an Abuse Allegation, dated 7/22/10, was received from the Administrator. The policy indicated that all abuse allegations should be reported to the Executive Director and the Director of Nursing immediately.</p> <p>A policy titled, Protection of Resident During an Investigation, dated 4/28/09, received from the Administrator on 5/14/12 at 2:00 p.m., indicated a staff member(s) implicated in an abuse/neglect situation, regardless of discipline, will be interviewed and their version of the event documented. Also in the policy, it indicated, the staff member will be suspended pending investigation results.</p> <p>3.1-28(a)</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 and record review, the facility failed to ensure staff treated a resident who was yelling out incoherently with respect and dignity for 1 of 1 randomly observed residents.</p> <p>Findings include:</p> <p>During a random observation on 5/16/2012 at 12:45 p.m., Resident #99 was standing up at the main entrance receptionist desk. The resident was intermittently yelling out incoherent speech. CNA #7 responded to the resident by loudly shushing her three separate times when the resident made verbal noise. The shushing was loud enough to be heard from behind a closed door across the hall from the receptionist's desk.</p> <p>Resident #99's clinical record was reviewed on 5/16/2012 at 3:00 p.m. The resident was admitted to the facility on 2/8/2008. Diagnoses included but were not limited to;</p>	F0241	<p>A. Residents careplans were reviewed and updated as well as residents c.n.a. assignment sheet. C.N.A. was counceled and inserviced related to behaviors.B. Residents requiring special neeeds were reassessed by the Social Services Director to ensure the psychosocial and quality of life needs are being met and care plans were updated as needed.C. Staff are educated during orientation and periodically related to treating residents with dignity and respect. Random observations will be conducted by the ED and DNS to ensure that residents are treated with dignity and respect. Any staff that are observed treating residents inappropriatly will be immediately counceled and reinserviced on behaviors.D. The audits will be reviewed during PI monthly for 3 months and then quarterly to assure that all residents are treated with dignity and respect. Once substantial compliance is assured by the audits the audits will be discontinued and any further instances will be reported on Angel Care and/or QIS form and handled as a complaint or concern and appropriate action</p>	06/20/2012

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	<p>chronic paranoid schizophrenia, dementia with behavior disturbance, history of seizure disorder, cerebrovascular accident(stroke,) and anxiety.</p> <p>A care plan, dated 4/23/2012, indicated, "Problem description: I have a diagnosis of anxiety and exhibit this by pacing, repetitive behaviors and verbalizations. Approaches; If I seem anxious, staff will attempt to rule out source or trigger for the anxiety. Approach me in calm manner."</p> <p>A care plan, dated 4/23/2012, indicated, "Problem description: I have short term memory impairment. Approaches; Because I may become frustrated due to my forgetfulness, staff will provide me comfort and reassurance as needed. Staff will approach me in a kind manner and provide me comfort as I can feel lonely possibly and unsure of my life roles due to my memory impairment."</p> <p>A care plan, dated 4/23/2012, indicated, "Problem description: I have long term memory impairment. Approaches; Staff to approach me in a calm manner that is comforting and supportive. If I seem upset, staff will attempt to determine the source for</p>		taken to ensure that Kindred P/P and regulations are followed.		

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	<p>this, such as environmental factors....temperature, lighting as well as hunger or fear. Staff will allow me a time to calm down and then attempt to re-approach me."</p> <p>3.1-3(t)</p>			

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F0253 SS=D	<p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>Based on observation, interview, and record review, the facility failed to keep 1 of 38 resident's bathrooms clean and sanitary, in a total sample of 38.</p> <p>Findings include:</p> <p>On 5/16/12 at 3:00 p.m., a two fingers width (1-1 1/2 inches) reddish- brown stain, arm's length long (approximately 24 inches), was observed on the bathroom floor of Room #202, close to the toilet.</p> <p>During an interview with CNA #3 on 5/16/12 at 3:15 p.m., she indicated a resident scrapped her leg on the side of wheelchair in Room #202, around 9:00 p.m., on 5/15/12, causing her to bleed moderately.</p> <p>On 5/17/12 at 9:15 a.m., 10:30 a.m., 10:55 a.m., and 12:30 p.m., the same stain, described above, was observed on the bathroom floor in Room #202.</p> <p>In an interview with the ADON (Assistant Director of Nursing), on 5/17/12 at 10:55 a.m., the ADON</p>	F0253	<p>A. On 5/16/12 residents bathroom was cleaned and brown stain on floor was removed. B. All bathrooms were checked for cleanliness and any that were not clean were cleaned. A schedule was prepared by housekeeping director to check off that all bathrooms are cleaned each day. C. All housekeeping staff have been inserviced on the cleaning policy and procedure which includes the cleaning of bathrooms. Housekeeping Supervisor will conduct random bathroom checks on each wing on a minimum of six bathrooms for cleanliness daily on his scheduled days of work. These checks will be recorded by the Housekeeping Supervisor on housekeeping check list. Any issues found will be immediately addressed to assure that bathrooms are clean daily. D. ED or designee will make weekly walking rounds to assure that all bathrooms are clean and will report any findings to housekeeping supervisor. House keeping Supervisor is to check all bathrooms Monday through Friday to assure that all are clean and that floors are cleaned. Results will be reported by the Housekeeping supervisor</p>	06/20/2012			

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	<p>indicated it is an expectation of housekeeping to clean each resident room and bathroom daily.</p> <p>A review of the policy, received from the Administrator on 5/21/12 at 10:20 a.m., titled Healthcare Services Group, Inc., Job to be Done: Bathroom Cleaning, dated 1/1/2000, indicated that the last step when cleaning a resident's bathroom was to with a "...damp mop-start in far corner. Get behind commode, move trash can, mop out the door." The Administrator also indicated that bathrooms are to be cleaned daily and this was the policy for daily cleaning of a bathroom.</p> <p>3.1-19(f)</p>		to the PI meeting until substantial compliance is achieved as evidenced by housekeeping check lists of bathrooms.		

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F0279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to ensure care plans were developed and updated for urinary catheter usage and pressure ulcer treatment, for 3 of 47 residents reviewed for care plans. Resident's #300, #76 and #19.</p> <p>Findings include:</p> <p>1. Resident #300's record was reviewed on 5/18/2012 at 11:30 a.m. Resident #300 was admitted to the facility on 3/20/2012. Diagnoses included but were not limited to;</p>	F0279	<p>A. Resident #300 is no longer in facility. Resident #19 care plan has been reviewed and updated for turning and transferring, Resident #76 care plan has been reviewed and updated.B. All residents have the poterntial to be affected by not reviewing or revising the plan of care with changes in the resident's condition All residents' care plans with catheters, pressure areas and transferred with a medical devise have been reviewed and revised as necessary. Care plans of new admissions and residents have been audited and by MDS as assessments are</p>	06/20/2012	

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	<p>tracheostomy, muscle spasms, vitamin D deficiency, anxiety, aspiration pneumonia, gastroesophageal reflux disease, hypertension, acute respiratory failure, hemiplegia, cerebrovascular accident (stroke,) depression, encephalopathy, decreased mental status, gastrostomy tube.</p> <p>A 'patient nursing evaluation,' dated 3/20/2012, indicated, "dehydration screening: check marked for, dependent on others for fluids. Bladder status screening: check marked for, frequently incontinent and indwelling catheter justification listed, skin breakdown prevention."</p> <p>An admission MDS assessment, dated 3/27/2012, indicated, "CAA's (care area assessments) triggered and addressed in care plan included urinary incontinence and indwelling catheter and dehydration/fluid maintenance."</p> <p>No care plans relating to urinary elimination or urinary catheter usage were found in the record.</p> <p>Interview with the Assistant Director of Nursing on 5/18/2012 at 3:30 p.m., indicated she was unsure why there weren't any catheter or dehydration</p>		<p>completed.C. Staff Development Coordinator will re-inservice the licensed nurses on how to develop and/or revise, review care plans of new admissions and residents with PV, catheters, transfers The M-F clinical meeting will audit and reassess as appropriate. In addition, MDS will develop, review and use careplan on admission ,quarterly, annually. Care Plans will be audited by DON or designee during the clinical meeting weekly for four weeks, monthly for three months and then quarterly. D. The unit manager or designee will audit all residents with a catheter,wounds and mechanical transferring devices and update the care plans. New orders will be reviewed in clinical meetings and care plans to be revised. MDS will review the care plan upon changes of condition and required assessments. The results of the audits will be reviewed during PI for three months and then quarterly .</p>		

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	<p>care plans. There were care plan updates relating to dehydration that she considered to be part of the care plan. The catheter was removed on 4/17/2012.</p> <p>2. Resident #76's clinical record was reviewed on 5/17/2012 at 11:00 a.m. The resident was admitted on 1/9/2012. Diagnoses included but were not limited to; metabolic encephalopathy, urinary tract infection, osteoporosis, renal (kidney) failure, glaucoma, constipation, gastroesophageal reflux disease.</p> <p>A 'Resident Weekly Skin Check Sheet' for March 2012 indicated, "Week 1, dated 3/1/12, no new areas reported. Week 2, dated 3/8/12, no new areas reported or observed. Week 3, dated 3/15/12, no new areas noted or reported. Week 4, dated 3/22/12, no new areas noted skin clean and dry, preexisting coccyx present will continue to monitor." [sic]</p> <p>Interview with the Assistant Director of Nurses on 5/17/2012 at 11:20 a.m., indicated the resident does not have any current skin areas, she looked at the resident herself just now.</p> <p>A MD telephone order, dated</p>						

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	<p>3/19/2012 at 3:30 p.m., indicated, "Calmoseptine to coccyx q shift until NP evals Stage 2 ulcer."</p> <p>A 'Weekly pressure ulcer BWAT report' week 1, dated 4/18/2012, indicated, "stage 2 pressure ulcer," and week 2, dated 4/23/2012, indicated, "resolved."</p> <p>A 'Risk for pressure ulcer' care plan indicated only one date listed, 1/12/2012, next to the Braden scale score. Additionally, check marks next to the following approaches; "complete weekly skin assessment, report changes in skin status to physician, complete Braden scale risk assessment quarterly and prn with skin risk analysis, discuss non-compliance issues with resident/responsible party and educate about primary risk factors and prevention, notify nurse immediately of any new areas on skin breakdown, redness, blisters, bruises, discoloration noted during bathing or daily care, monitor lab results as ordered and report abnormal results to physician, provide pressure relieving or reduction device: specialty mattress (Stat II,) chair cushion (Broda.) Approaches not check-marked included; provide diet as ordered and monitor nutritional</p>			

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	<p>status and dietary needs, consult dietitian prn (as needed). Assist prn to reposition/shift weight to relieve pressure. Position with pillows to maintain proper body alignment prn. Float heels when in bed as indicated. Provide incontinence care after incontinence episodes; apply barrier cream prn. Avoid prolonged periods of skin on skin contact. Minimize pressure over boney [sic] prominences. May use lifting device, draw sheet to reduce friction."</p> <p>A 'Risk for Pressure Ulcer' care plan with no dates listed, indicated, "approach: maintain the head of bed at lowest position of elevation, and for shortest period of time that is consistence with medical conditions and other restrictions."</p> <p>Interview with LPN #8 on 5/21/2012 at 3:00 p.m., indicated Resident #76 did have two different stage 2 pressure ulcers. They were healed really quickly, the first one probably lasted about 5 days and the second one lasted probably 7 days. By the time the wound care nurse came to look at it, it was gone. The first one was treated with calmoseptine lotion and the second with Santyl both ordered by the MD. He was unsure as to why the care plan wasn't</p>						

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	<p>updated, but indicated the interventions put in place between the first pressure ulcer and developing the second one included; treatment for the condition, she was turned every two hours or more, she has a Stat II pressure reducing bed, keeping her clean and dry, barrier cream used all the time because she is always incontinent. When finding a skin area, his expectation is that the 1st step is to call the MD and then they will usually order something in the meantime and then they will write that the wound team will come and look at it. The wound team comes every Monday. LPN #8 also expects the weekly skin sheets should be documented on the shower days. The MD ordered the Stat II bed. When LPN #8 started his position at the facility in March he remembers the resident was already on the Stat II bed so it was originally ordered before he started. The CNA's mostly ensure residents are turned and repositioned minimally every 2 hours. The nurses are expected to monitor their halls, and LPN #8, in his role as Unit Manager, also does rounds to ensure residents are being turned.</p> <p>3. Review of clinical record for Resident #19 on 5/17/12 at 12:00 p.m., indicated that resident has a</p>			

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	<p>stage 4 pressure ulcer. Care plans for risk of skin breakdown and altered skin integrity failed to list the frequency that the resident should be turned.</p> <p>Review of Care Plans on 5/17/12 at 12:30 p.m., for skin breakdown and altered skin integrity indicated that Resident #19 would be assisted with bed mobility/turning prn. Care plans were not updated to include turning resident every 2 hours or using a Hoyer lift for transfer.</p> <p>During an interview on 5/17/12 at 12:10 p.m., LPN #8 indicated that the Resident #19 is to be turned every 2 hours and staff normally do this in the morning, around meal times and in the evening. It was noted during the interview that neither turning of this resident every 2 hours nor transporting by a Hoyer (mechanical lift) was documented.</p> <p>3.1-35(a)</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 interview and record review, the facility failed to follow physician's orders for obtaining blood pressures for 1 of 10 residents reviewed for following physician's orders, in a sample of 34 (Resident #247).</p> <p>Findings include:</p> <p>The clinical record for Resident #247 was reviewed on 5/17/12 at 2:00 p.m.</p> <p>The diagnoses for Resident #247 included, but were not limited to: hypertension, diabetes, and morbid obesity.</p> <p>The March and April 2012 Physician Orders indicated that blood pressures are to be taken every day at 8:00 a.m. and 8:00 p.m.</p> <p>On the March and April Medication Record 2012, there were blank spaces on the medication record, which would indicate that blood pressures were not obtained as ordered, on the following dates and</p>	F0282	<p>A. Resident #247 has blood pressure monitoring BID and facility is at 100% compliance.B. Audit was completed on all residents charts to assure that all residents having orders for blood pressure checks were audited and placed on audit tool.All residents have who have orders for blood pressure checks has the potential to be affected by not following the physicians order of obtaining blood pressures as ordered.C. Daily audit has been initiated to ensure ther implementation of care plan follow through that blood pressures are being preformed as indicated in the resident's physicians orders. Nursing will be re-inserviced regarding the following the physician's orders by obtaining blood pressures by the Staff Development Co-ordinator or designee. The residents MARS will be audited weekly for four weeks and then monthly to ensure tha the MD orders are recorded to monitoring blood pressures D. The Unit Managers or designee will audit the MAR's daily for four weeks then two times weekly for 4 weeks and then monthly for 3 months to ensure compliance. The results</p>	06/20/2012	

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	<p>shifts: 3/3/12-8 p.m., 3/4/12-8 p.m., 3/7/12-8 a.m., 3/8/12-8 a.m. and 8 p.m., 3/11/12-8 a.m., 3/17/12-8 p.m., 4/14/12-8 p.m., and 4/22-8 p.m.</p> <p>Information was requested, on 5/17/12 at 2:25 p.m., for the missing blood pressure documentation to determine if the blood pressures were obtained as ordered.</p> <p>On 5/18/12 at 10:00 a.m., the ADON (Assistant Director of Nursing) indicated that she was unable to provide any information or documentation that the missing blood pressures were completed as ordered on the dates listed above.</p> <p>3.1-35(g)(2)</p>		of the audits will be discussed iat the PI Meeting (QA)on a monthly basis until full compliance has been achieved.				

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F0309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, record review and interview, the facility failed to ensure an indication for use of PRN (as needed) pain medication, failed to ensure a pre-assessment and post assessment of the resident's pain was completed before and after administration of PRN pain medication for 1 of 9 residents reviewed for receiving pain medication for pain control, in a total sample of 10 and failed to recognize a skin condition for 1 of 3 residents reviewed who met the criteria for skin conditions. (Resident #247 and #C)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #247 was reviewed on 5/17/12 at 2:00 p.m.</p> <p>The diagnoses for Resident #247 included, but are not limited to: cellulitis of leg, diabetes, and morbid</p>	F0309	<p>A. Resident #247 pain management care has been reviewed and updated to reflect resident # 247current medical plans by the Unit Manager. Licensed staff assigned to resident #247 have been re-inserviced on the facility's Pain Management Program by the Unit Manager. Pain management procedures have been implemented for the resident to assess, treat and monitor the identified behaviors of pain expression by the Unit Manager or designee.B. Corrective action for residents possibly affected is as follows, Staff Development Cordinator and/or designee have re-inserviced licensed staff on pain assessment/flow sheet and pain policy and procedure. Pain assessment will continue to be completed upon all new adnissions and updated as appropriate. The Unit Managers or designeer has initiated an audit of the medical record for residents identified with pain., The care plans have been reviewed and updated as appropriate.C. The SDC or</p>	06/20/2012			

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	<p>obesity.</p> <p>A recapitulation of March 2012 Physician's Orders indicated there was an order for Norco 5/325 mg (milligram) tab, give 1 tablet po (by mouth) every 6 hours prn (as needed).</p> <p>Also on the March 2012 Physician's Orders, it indicated there was an order for Norco 5/325 mg (milligram) tab, give 2 tablets po (by mouth) every 6 hours prn (as needed).</p> <p>The March 2012 Medication Record indicated 1 tablet of Norco 5/325 mg (milligram) was given on the following dates and times: 3/1/12 (9:00 a.m.), 3/2/12 (11:00 a.m.), 3/3/12 (time indecipherable), 3/4/12 (time indecipherable), 3/5/12 (9:00 a.m.), 3/6/12 (10:00 a.m.), 3/7/12 (10:00 a.m.), 3/8/12 (8:00 a.m.), 3/15/12 (time indecipherable), 3/16/12 (8:00 a.m.), and 3/19/12 (no time indicated).</p> <p>On the March 2012 Medication record, it indicated 2 tablets of Norco 5/325 mg (milligram) was given on 3/9/12 at 2 p.m.</p>		<p>designee will educate licensed staff upon orientation on pain policy and procedure. All licensed staff to be re-inserviced on policy and procedure of pain management by the Unit Manager/SDC or designee for accuracy and completion in a timely manner.D. The DNS or designee will monitor pain management daily on scheduled days of work for four weeks then two times weekly for four weeks and then monthly by monitoring the flow sheets for assessments and documentation of effectiveness of pain medication. The care plans will be updated as needed. The data will be reviewed and analyzed at monthly PI until it is shown through monitoring tools that the policy and procedure of pain management is met.</p>		

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	<p>For the above dates and times, there was no documentation to indicate the resident was assessed for the location/nature and intensity of pain prior to administering pain medication or for the effectiveness of the medication after the pain medication was given.</p> <p>In an interview with the ADON (Assistant Don of Nursing) on 5/17/12 at 12:40 p.m., she indicated that the expectation was for nursing to document an assessment of the location/nature and intensity of pain prior to administering pain medication and how effective the pain medication was, after the pain medication was given.</p> <p>On 5/18/12 at 3:20 p.m., the ADON indicated that no documentation was located to determine why the pain medication was given or the effectiveness of the pain medication given.</p> <p>2. The clinical record for Resident C was reviewed on 5/17/12 at 9:30 a.m.</p> <p>The diagnoses for Resident C included, but were not limited to: hypertension, hip fracture, Parkinson's disease, and anxiety.</p>				

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	<p>An observation of Resident C's upper left arm was made with CNA #10 on 5/17/12 at 10:30 a.m. An area, about the size of a 50 cent coin covered with white and scaly skin that looked like a healing wound, recently scabbed was observed on the upper left arm, about 6 inches above the elbow area. Also observed was an area across the entire inner left elbow, that appeared to be an older bruise that was a dark fading purplish color.</p> <p>A review of the 5/4/12 skin assessment did not indicate the above described area on the upper left arm. The 5/11/12 skin assessment did indicate the area on the upper left arm as a "scab area with bruising."</p> <p>During an interview with Family Member #11 on 5/17/12 at 11:00 a.m., she indicated the facility was not aware of this area on the upper left arm until their family told staff about it.</p> <p>During an interview with the ADON (Assistant Director of Nursing) on 5/17/12 at 2:00 p.m., she indicated the facility was not aware of the area until the family pointed it out to staff on 5/9/12. She indicated the round,</p>						

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	<p>scabbed area looked at least 4 or 5 days old when she saw it on 5/10/12. She indicated the entire area on the upper left arm could have been present on 5/4/12 and missed on the 5/4/12 skin assessment.</p> <p>A review of the shower log for Resident C indicated the resident had a full shower on 5/7/12. During interview with the ADON on 5/17/12 at 2:00, she indicated CNA #12 gave this shower.</p> <p>During interview with CNA #12 on 5/21/12 at 7:22 p.m., she indicated she did not notice the area on Resident C's upper arm during the shower on 5/7/12, but did notice the area after the shower and described it as an old marking, maybe a scar or bruise across the arm. She indicated he had a scar in the area where the bruise was, about the size of a quarter and was scabbed around the edges. She indicated she pointed this area out to the nurse on duty as she happened to come in the room at the time she was getting him dressed. She indicated the nurse told her she was familiar with the scabbed area. She indicated she was a new employee and did not know the nurse's name.</p>						

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	<p>During an interview on 5/22/12 at 10:30 a.m. with the ADON, RN #13, LPN #14, and LPN #15 and with CNA #12 on speaker phone, CNA #12 indicated she was unsure of the exact date she pointed Resident C's area out to the nurse on duty and was still unsure of who the nurse was.</p> <p>3.1-37(a) 3.1-48(a)(4)</p>						

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F0315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on record review and interview, the facility failed to ensure that a resident did not continue to use a urinary catheter unless medically necessary for 1 of 4 residents reviewed for urinary catheter use. Resident #300.</p> <p>Findings include:</p> <p>Resident #300's clinical record was reviewed on 5/18/2012 at 11:30 a.m. Resident #300 was admitted to the facility on 3/20/2012. Diagnoses included but were not limited to; tracheostomy, muscle spasms, vitamin D deficiency, anxiety, aspiration pneumonia, gastroesophageal reflux disease, hypertension, acute respiratory failure, hemiplegia, cerebrovascular accident (stroke,) depression, encephalopathy, decreased mental</p>	F0315	<p>A. Resident #300 is no longer in facility.B. All residents who use a urinary catheter are at risk for a UTI or to lose the ability to restore as much as normal bladder function as possible. An audit was done on residents who have catheters to assure orders, careplan, diagnosis, catheter care every shift, and on the aide's assignment sheetC. The Staff Development Coordinator will re-educate licensed nurses on catheter only when medical justification for the use of an indwelling catheter, careplans for an indwelling catheter, catheter care and related documentation upon admission must have orders, medically necessary diagnosis, care plan, catheter care and on the aide assignment worksheet.D. The DNS or designee will audit the clinical records of residents who have catheters to assure accurate documentation for orders, care plans, medical</p>	06/20/2012	

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	<p>status, gastrostomy tube.</p> <p>A 'Patient Nursing Evaluation,' dated 3/20/2012, indicated, "Bladder status screening: check marked for, frequently incontinent and indwelling catheter justification listed, skin breakdown prevention."</p> <p>An admission MDS assessment, dated 3/27/2012, indicated, "CAA's (care area assessments) triggered and addressed in care plan included urinary incontinence and indwelling catheter."</p> <p>No care plans relating to urinary elimination or urinary catheter usage were found in the record.</p> <p>Bladder continence records starting April 17th, 2012 and current for the month of May indicated the resident was incontinent several times per shift for each day. No documentation or MD orders were found regarding why the resident's catheter was removed on this date.</p> <p>Interview with the Assistant Director of Nursing on 5/18/2012 at 3:30 p.m., indicated she was unsure why there weren't any catheter care plans. Additionally, she wasn't sure as to why the resident had a catheter when</p>		<p>necessity, catheter care every shift, and on the assignment sheet daily for four weeks then monthly for three months. The audits will be reviewed in clinical meeting and new admissions will be assessed for all components to assure that all have been completed. The summary of the audit tool findings will be brought to PI meeting monthly for 3 months and then quarterly.</p>				

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	<p>she was first admitted because the rationale didn't even meet their requirements for having a catheter so the nurse or MD should have caught that right away. The catheter was removed on 4/17/2012.</p> <p>3.1-41(a)(2)</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.</p> <p>Based on observation, interview and record review, the facility failed to turn a resident appropriately and to ensure residents were properly transferred to prevent 2 falls and a skin tear for 3 of 3 residents who met the criteria for accidents. (Resident #114, #201, #82,)</p> <p>The facility also failed to ensure the facility was free from potential accident hazards by not having harmful chemicals locked up properly with the potential to affect 2 of 20 residents residing on the hallway (#140, and #73).</p> <p>Findings include:</p> <p>1. The clinical record for Resident #114 was reviewed on 5/18/12 at 10:00 a.m.</p> <p>The diagnoses for Resident #114 included, but were not limited to: hypertension, diabetes mellitus, hyperlipidemia, dementia, and depression.</p> <p>Review of the 2/3/12 Post Fall</p>	F0323	<p>A. During the survey, inservices were given on proper transferring from wheel chairs and locking of the wheels when transfers to prevent accidents such as those that occurred with residents 114 and 201. Turning and positioning to prevent accident as occurred with resident #82; all housekeeping staff on keeping doors locked that contain hazardous materials or chemicals. Cart with broken lock has been removed from the facility. B. Nursing staff were re-inserviced on proper transferring from wheel chairs, locking of wheels, turning and positioning, c.n.a. assignment sheets were also updated identify residents, require two person assist. Housekeeping staff were re-inserviced on keeping doors to all rooms containing hazardous materials locked and on reporting of equipment such as the cart broken to their supervisor immediatly so equipment can be repaired or removed from the facility. C. Unit Managers will check assignment sheets weekly and update any changes as needed including if the resident needs a two person assist. SDC</p>	06/20/2012

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	Investigation indicated: "Description of Fall: Resident lowered to floor by CNA. Bumped head on CNA shoulder during incident. Some redness (symbol for right) side c/o (complains of) (symbol for right) shoulder pain." The neurological assessment comments indicated "Staff was attempting to transfer resident from toilet to wc (wheelchair), breaks [sic] on wheelchair were not locked properly wc started to roll backwards. Resident was eased to the floor by staff; staff notified nurse resident was eased to the floor. Upon entering room, resident was lying on the floor in a supine position (symbol for with) head in corner of bathroom walls. C/o head pain (symbol for right) upper shoulder pain. Staff stated "she bumped her head on my shoulder when I was easing her down. Resident was able to perform ROM (range of motion) to all extremities (symbol for with) some slight discomfort to (symbol for right) upper shoulder. Neuro's (neurological checks) started. (Name of doctor) office notified spoke (symbol for with) (name of doctor's office staff person). (Symbol for "no") N.O. (new order) at this time. Pain medication offered to resident. Resident refused. Some redness noted to (symbol for right) forehead		will re-inservice any staff member not using proper transferring or turning and positioning and all new c.n.a.'s will be trained on this prior to them starting to work with residents. Housekeeping supervisor will check all doors to hazardous areas on a daily basis to assure that staff are keeping doors locked, this will be done on his regular scheduled days daily rounds. Housekeeping Supervisor will also check all equipment on a weekly basis to assure that all equipment is in good condition. During orientation and periodically during the year staff is instructed on proper transferring. D. DNS or designee will observe to see that proper techniques are being followed for transfers, locking of wheel chairs and turning and position. Staff will be re-inserviced as needed. All falls/accidents will be reviewed on a daily basis during the morning meetings (Mon-Fri) to determine cause. Housekeeping Supervisor will bring his audits to morning meetings to review. Housekeeping will discontinue use of report to PI meeting monthly until 100% compliance is achieved based upon his Housekeeping audit form. Falls will be reviewed at the PI meetings on a monthly basis and then quarterly thereafter.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>area. (Symbol for "no") hematoma or abrasions noted. Will continue to monitor."</p> <p>The 3/29/12 "Fall's" care plan indicated the goal was to "minimize risk for a fall" and an approach was "education provided n (in) locking w/c prior to transferring."</p> <p>During an interview with LPN #1, she indicated LPN #24 was the nurse on duty at the time of the above fall and completed the fall investigation.</p> <p>2. During an interview on 5/16/12 at 3:00 p.m., Resident #201 showed her right leg wrapped in gauze. She indicated this was a wound from an accident that happened the previous evening when she was toileted. Resident #201 indicated that CNA #3 had scraped her leg on the side of her wheelchair while trying to get her to stand up and grab the support bar and was moving too fast.</p> <p>On 5/16 at 3:55 p.m, CNA #3 was interviewed and indicated that on 5/15/12 she and the Charge Nurse, LPN #21, heard Resident #201 screaming. CNA #3 indicated she</p>				

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	<p>went in to assist, and while she was toileting the resident she forgot to remove the foot rests from the wheelchair causing the resident's leg to be scraped and bleeding.</p> <p>A review of clinical records on 5/17/12 at 2:00 p.m., including a statement by CNA # 3 indicated that Resident #201's injury occurred when she was toileting her on 5/15/12.</p> <p>Charge Nurse, LPN #21 was interviewed on 5/16/12 at 4:44 p.m. and indicated she had told CNA #3 to assist Resident #201 with toileting on 5/15/12 and the resident should have had a 2 person assist due to her right shoulder pain. A facility follow-up report, dated 5/18/12, by the DON indicated that on 5/15/12 LPN#21 told CNA #3 Resident #201 was to have been a 2 person assist.</p> <p>3. A clinical record review of nursing notes and a radiology report on 5/17/12 at 10:00 a.m., indicated Resident #82 slid out of her bed while being cleaned and turned by CNA# 23 on 4/20/12.</p> <p>The ADON was interviewed on 5/17/12 at 5:30 p.m., and indicated CNA# 23 was turning Resident #82 to remove a wet pad when the resident</p>						

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	<p>slid out of the bed onto the floor, resulting in x-rays taken of the right hip, right forearm, tibia and fibula. The ADON indicated this resident was a 2 person assist and the CNA should have had another person helping her with this resident's care. The ADON indicated that CNA's should carry instructions for resident care listing the number of assistants needed. The CNA assignment sheet, dated 4/20/12, reviewed on 5/17/12, listed Resident #82 as a 2 person assist. The ADON indicated that she didn't know if CNA #23 was not carrying an instruction card the day of the accident or if she failed to read it.</p> <p>4. During the initial tour of the facility, a mechanical room was found unlocked in the 000 hallway at 5/14/12 at 10:45 a.m.</p> <p>An unlocked cleaning cart was observed in the mechanical room with 3M brand Quat disinfectant cleaner. There was no staff in the vicinity of the mechanical room. The mechanical room door was easily opened and the chemical storage on the housekeeping cart was opened.</p> <p>In an interview with Housekeeper #9 at 10:51 a.m., on 5/14/12, she</p>			

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	<p>indicated the mechanical room is supposed to be locked and the cleaning cart in the mechanical room was her "old" cart. She has a new cart now since the chemical compartment, on the cleaning cart, no longer locked. She was unable to determine how long she has had a new cart.</p> <p>On review of the MSDS (material safety data sheet) for 3M brand Quat disinfectant cleaner concentrate, provided by the Administrator on 5/14/12 at 2:25 p.m., it indicated the cleaner is harmful or fatal if swallowed.</p> <p>A list of the residents on the 000 hall was provided by the Administrator, on 5/14/12 at 2:25 p.m., with the resident's BIMS (brief interview mental status) score listed. Resident #140 and Resident #73 both had a BIMS score of 3 (indicative of cognitively impaired).</p> <p>On a list of residents residing on the 000 hall provided by the Unit Manager for the hall, on 5/16/12 at 3:55 p.m., it indicated that Resident #140 and Resident #73 were able to ambulate independently in their room and were mobile with a wheelchair in the hallway.</p>						

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	3.1-45(a)(1) 3.-1-45(a)(2)			

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F0327 SS=G	<p>483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION</p> <p>The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.</p> <p>Based on interview and record review, the facility failed to ensure adequate hydration needs were met for 1 of 2 residents reviewed for hydration, resulting in a primary diagnosis of dehydration during a hospital stay. (Resident A).</p> <p>Findings include:</p> <p>The clinical record for Resident A was reviewed on 5/17/12 at 2:00 p.m.</p> <p>The diagnoses for Resident A included, but are not limited to: dementia, urosepsis, delirium, benign prostatic hyperplasia, and urinary retention.</p> <p>Resident A was admitted to the facility on 3/22/12 and a Patient Nursing Evaluation was completed the same day. The Patient Nursing Evaluation indicated, in the dehydration screening section, that the resident was dependent on others for fluids.</p> <p>In an interview with the ADoN (Assistant Director of Nursing), on</p>	F0327	<p>A. Resident A. is no longer in the facility B. Residents dependent on nursing to provide fluids have the potential for dehydration. An audit was done on dependent residents that rely on others for fluids to be completed and care plans and aide assignment sheets to be updated. Fluids given with med pass will be documented every shift to ensure extra fluids are to be given along with meal consumption. C. The SDC will re-educate nursing staff on monitoring residents who are dependent on others to provide fluids. D. The Unit Managers or designee will audit dependent residents for appropriate hydration by auditing the MAR's, food consumption log and reviewing the hydration risk assessment upon admission. The data will be reviewed and analyzed in clinical meeting with nursing and the dietician for further interventions to prevent dehydration. The audits will be done daily for four weeks then 2 times weekly for four weeks and then monthly for 3 months. The audits are to be reviewed in PI monthly and then quarterly until audits show that 100% compliance is achieved.</p>	06/20/2012	

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	<p>5/21/12 at 1:40 p.m., she indicated that the Patient Nursing Evaluation is done upon admission to the facility. The ADoN also indicated that an Interim Plan of Care is done after the Patient Nursing Evaluation is completed.</p> <p>On an Interim Plan of Care, dated 3/23/12, there was no indication that Resident A was dependent on others for fluids.</p> <p>The ADoN indicated, on 5/21/12 at 1:45 p.m., there should have been an indication that Resident A was dependent on others for fluids on the Interim Plan of Care.</p> <p>In an interview with RN #16, 5/21/12 at 2:30 p.m., she indicated that if a resident is dependent on others for fluids, that information should be placed in the section titled fluids.</p> <p>A review of the Admission MDS (Minimum Data Set), dated 3/29/12, for Resident A, indicated that dehydration/fluid maintenance triggered as a care area for the resident. Care Areas are triggered by MDS item responses and indicate the need for additional assessment based on problem identification.</p>			

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	<p>On 5/22/12 at 9:00 a.m., the MDS Coordinator indicated that facilities have 14 days to complete care plans after the admission MDS is completed. He indicated that a dehydration care plan was completed for Resident A after he discharged to the hospital.</p> <p>A Medical Nutrition Therapy Assessment, dated 4/3/12, was completed by the Registered Dietician. The Assessment indicated that the estimated fluid needs for Resident A were 1680-2100 ml (milliliters), based on 20-25 ml/kg (kilogram).</p> <p>On 5/21/12 at 2:35 p.m., RN #16 indicated that if a resident is dependent on others for fluids, that information is passed on to the rest of the staff, working on the unit, the same day as the Patient Nursing Evaluation is completed. RN #16 also indicated that if staff is off the day the Patient Nursing Evaluation is completed or has not worked on the unit since the Patient Nursing Evaluation, staff are told when they work next, if a new resident is dependent on others for fluids. RN #16 also indicated that fluids that are given throughout the day are documented on the Comprehensive</p>			

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	<p>Intake-Output Record, when staff tells nursing how much was given throughout the shift. She also indicated it's an expectation for staff to tell nursing when fluids are given, so the amount can be documented.</p> <p>The DoN (Director of Nursing) and ADoN indicated, on 5/21/12 at 1:45 p.m., that it's the expectation of staff to assist residents throughout their shift with fluids.</p> <p>On 5/22/12 at 11:25 a.m., LPN #1 indicated that all staff are expected to tell nursing how much fluids were given throughout the shift and then nursing is to document how many milliliters were given on the Comprehensive Intake-Output Record.</p> <p>A review of the Comprehensive Intake-Output Record indicated that the resident received less than the estimated fluid needs on the following dates until the Resident A's hospitalization, on 4/5/12: 3/24/12=intake of 180 ml 3/25/12=intake of 360 ml 3/26/12=intake of 420 ml 3/27/12=intake of 420 ml 3/28/12=intake of 180 ml 3/29/12=intake of 600 ml 3/30/12=intake of 720 ml</p>						

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	<p>3/31/12=intake of 300 ml 4/1/12=intake of 300 ml 4/2/12=no ml indicated 4/3/12=intake of 540 ml 4/4/12=intake of 300 ml 4/5/12=intake of 300 ml</p> <p>On 5/21/12 at 1:45 p.m., more information was requested on the amount of fluids Resident A received while in the facility.</p> <p>On an Emergency Room Report, dated 4/5/12, it indicated that Resident A's primary diagnosis was dehydration.</p> <p>The HPI (history of present illness) from the ER, was on a progress note from the hospital, dated 4/6/12 at 3:00 a.m. It indicated that, "Asking patient questions with 'yes' and 'no' as possible answers I am able to determine that he is not hurting anywhere, he is not SOB (short of breath), has no CP (chest pain), N/V (nausea/vomiting), but that he is indeed very thirsty." The GI (gastrointestinal) section of the HPI also indicated that the resident was thirsty. The HPI also indicated hydration was started immediately.</p> <p>A dictated note, dated 4/8/12, from Resident A's admission to the</p>						

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	<p>hospital, indicated the resident was admitted with a sodium level of 162 and had hypernatremia (high sodium). D5 half-normal saline (an intravenous fluid) at 130 ml (milliliters) per hour was ordered as treatment. After 4 hours, labs were redrawn and there was no improvement of the sodium level. D5W (an intravenous fluid) at 136 ml per hour was ordered. The rate of infusion was based on the water deficit formula, as indicated by the dictated note.</p> <p>On a progress note, dated 4/7/12 at 2:17 p.m., it indicated that hypernatremia was secondary to dehydration and to continue IVF (intravenous fluids).</p> <p>The Transfer/Referral Form for Resident A's return back to the facility, from Resident A's stay, dated 4/11/12, indicated the primary diagnosis, for the hospital stay starting 4/5/11, was dehydration.</p> <p>On 5/21/12 at 2:15 p.m., the ADoN indicated that Resident A was dehydrated and that the "system," to ensure hydration needs were met, was broken.</p> <p>Upon exit on 5/22/12 at 4:30 p.m., no more information was provided on the</p>						

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	amount of fluids Resident A received while in the facility. 3.1-46(b)				

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F0514 SS=D	<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 organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to ensure accurate documentation was maintained and recorded for 2 of 3 residents reviewed for accurate catheter care documentation (Resident B and A).</p> <p>Findings include:</p> <p>1. The clinical record for Resident B was reviewed on 5/17/12 at 2:00 p.m.</p> <p>The diagnoses for Resident B include, but are not limited to: hypertension, diabetes, and morbid obesity.</p> <p>A review of the February, March, and April 2012 Physician Orders indicated that catheter care is to be provided</p>	F0514	<p>A. Resident B and A are no longer in the facility.B. Residents having a foley cateter have the potential to be affected. An audit was completed on residents with foley catheter to assure orders for foley care every shift for complete and accurate records.C. The Staff Development Cordinatorwill re-educate all nurses for accurate documentation to be maintained and documented for foley care every shift.Fluid intake will be audited and documentation reviewed daily.D. The DNS or designee will audit the clinical records for all residents having cathetersto assure accurate documentation daily for 4 weeks, then 2 times a weeks and then mothly for 3 months. The audits will be reviewed weekly in clinical meeting then forwarded to the ED as they are comnplete. The audits will be reviewed and analyzed nonthly for 3 months</p>	06/20/2012			

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	<p>every shift.</p> <p>On the February, March, and April Treatment Records, there were blank spaces on the treatment record which would indicate that catheter care was not provided as ordered, on the following dates and shifts: 2/26/12-evening shift, 2/28/12-evening shift, 2/29-day shift, 3/26/12-evening shift, 3/31/12-day and evening shift, 4/27/12-evening shift, 4/28-evening shift, and 4/29/12-day and evening shift.</p> <p>Information was requested, on 5/17/12 at 2:25 p.m. to determine if catheter care was completed on the above dates and shifts.</p> <p>The ADON indicated, on 5/18/12 at 10:00 a.m., that she was unable to provide any information or documentation that catheter care was provided, as ordered, on the dates listed above.</p> <p>2. The clinical record for Resident A was reviewed on 5/17/12 at 2:00 p.m.</p> <p>The diagnoses for Resident A included, but are not limited to: dehydration, benign prostatic</p>		and then quarterly at the PI meeting (QA) for 3 months and then quarterly at the PI meeting until full compliance is obtained.		

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	<p>hyperplasia, and urinary retention.</p> <p>A review of the April 2012 Physician's Orders, indicated that catheter care is to be provided every shift.</p> <p>On the treatment record for April 2012, there were blank spaces on the treatment record which would indicate that catheter care was not provided as ordered, on the following dates and shifts: 4/13/12-day, evening, and night shift, 4/14/12-day and night shift, 4/15/12-day and night shift, 4/16/12-day and night shift, 4/17/12-day, evening, and night shift, 4/18/12-day and night shift, 4/19-day and night shift, 4/20/12-day and night shift, 4/21/12-day, evening, and night shift, 4/22/12-day, evening, and night shift, 4/23/12-day, evening, and night shift, 4/24/12-day and night shift, 4/25/12-day and night shift, 4/26/12-day and night shift, 4/27/12-day, evening, and night shift, and 4/30/12-day shift.</p> <p>On 5/21/12 at 4:45 p.m., information was requested for missing catheter care documentation to determine if catheter care was provided as ordered.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155334	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/22/2012
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-WILDWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 7301 E 16TH ST INDIANAPOLIS, IN 46219		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>The DoN (Director of Nursing) indicated on 5/21/12 at 11:00 a.m., that nursing is expected to follow physician's orders as written.</p> <p>As of exit from the facility on 5/22/12 at 4:30 p.m., the facility was not able to provide any documentation or other information that catheter care was provided on the above dates and shifts, as ordered.</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>				