

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155733	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/29/2015
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NAME OF PROVIDER OR SUPPLIER COLONIAL NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 119 N INDIANA AVE CROWN POINT, IN 46307
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00187421.</p> <p>Complaint IN00187421-Substantiated. Federal/State deficiencies related to the allegations are cited at F201, F202, F203 and F204.</p> <p>Survey dates: December 15, 16, and 29, 2015.</p> <p>Facility number: 000360 Provider number: 155733 AIM number: 100290370</p> <p>Census bed type: SNF/NF: 24 NF: 15 Total: 39</p> <p>Census payor type: Medicare: 4 Medicaid: 26 Other: 9 Total: 39</p> <p>Sample: 5</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000		
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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 0201 SS=G Bldg. 00	<p>Quality review completed by 26143, on December , 2015.</p> <p>483.12(a)(2) REASONS FOR TRANSFER/DISCHARGE OF RESIDENT</p> <p>The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;</p> <p>The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;</p> <p>The safety of individuals in the facility is endangered;</p> <p>The health of individuals in the facility would otherwise be endangered;</p> <p>The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a nursing facility, the nursing facility may charge a resident only allowable charges under Medicaid; or</p>			

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	<p>The facility ceases to operate.</p> <p>Based on record review and interview, the facility failed to ensure a resident was allowed to remain in the facility which resulted in the resident's decline 21 days after she was discharged to the new facility. This resulted in the resident being admitted to the hospital 21 days after she was transferred to the new facility with sever dehydration and acute renal failure. The resident also had weight loss for 1 of 3 residents reviewed for admission, transfer, discharge in the sample of 5. . (Resident #B)</p> <p>Finding includes:</p> <p>The closed record for Resident #B was reviewed on 12/15/15 at 10:20 a.m. The resident's diagnoses included, but were not limited to, hypertension, dementia, history of stroke, dysphagia (difficulty swallowing), gastroesophageal reflux (GERD), and anemia.</p> <p>The annual Minimum Data Set (MDS) assessment dated 11/4/15, indicated the resident was severely impaired for daily decision making. The resident had no mood or behavior issues and was totally dependent on staff for activities of daily living.</p> <p>An initial notice of transfer or discharge</p>	F 0201	<p>It is the intention of this facility to discuss the aspects of the alleged offenses with the appropriate representatives of the state. Please let this notice serve as our official request for a face to face IDR with legal representation present. We intend to prove to the state that there was missing information and extenuating circumstances that should be considered before these citations become a permanent record.</p> <p>1.The facility is unable to retrospectively address the cited concern related to Resident #B. Resident #B discharged from the facility on December 1, 2015. The initial notice was issued on March 9, 2015, due to the transfer or discharge is necessary because the resident's needs could no longer be met in the facility. A second notice was issued on March 19, 2015 due to the safety of the individuals in the facility was endangered and the health of the individuals in the facility would otherwise be endangered.</p> <p>2.The facility has no current or pending involuntary discharges, therefore the facility is confident that no other residents have been affected by the alleged deficient practice.</p> <p>3.Colonial Nursing and Rehab has a procedure in place for discharge planning that specifically includes involuntary discharges.(Exhibit#1) The MDT</p>	01/28/2016	

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	<p>was issued on March 9, 2015 due to the transfer or discharge was necessary to meet the resident's welfare and the resident's needs could not be met in the facility.</p> <p>Another notice of transfer or discharge was issued on March 19, 2015 due to the safety of the individuals in the facility was endangered and the health of the individuals in the facility would otherwise be endangered.</p> <p>The resident's co-guardians filed an appeal and the appeal was denied on July 16, 2015.</p> <p>The Social Service progress notes dated 8/4/15 (no time), indicated the resident was being transferred to another long term care facility. The next entry completed on 8/4/15 (no time), indicated the resident was not being transferred at the present time. Documentation on 8/27/15 (no time) indicated the resident remained at the facility.</p> <p>An entry completed in the Social Service progress notes by the Administrator on 11/18/15, indicated the resident's son was notified of the resident being accepted by another facility (Facility #B) and the discharge meeting would be held on 11/30/15. The resident was scheduled to</p>		<p>has been re-educated on this policy.(Exhibit#2) Additionally, the facility Discharge CareTransition Summary (Exhibit #3) has been updated to include specific requirements for the 30 day notice of transfer and discharge.</p> <p>4. The Administrator or designee is conducting a Quality Assurance Audit to ensure that residents who are being discharged in the aforementioned manner are provided with at least 30 days notice. All audits will take place 24-48 hours prior to discharge on on-going basis with any negative findings being corrected immediately. The results of this audit will be reviewed with the QA committee on a monthly basis for no less than 6 mos.(Exhibit#4)</p>	

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	<p>be discharged on 12/1/15.</p> <p>A Physician's order dated 11/30/15, indicated the resident was to transfer to another long term care facility (Facility #B).</p> <p>A Resident Transfer form dated 12/1/15 indicated the resident was being transferred to Facility #B.</p> <p>Review of the record indicated no concerns in regards to individual's safety in the facility and there were no other notices of transfer/discharge completed after the one dated 3/19/15 .</p> <p>The Emergency Room Physician's Note, dated 12/22/15 at 1:01 p.m., indicated the resident had an associated diagnosis of dehydration and character symptoms were failure to thrive. The laboratory tests, dated 12/22/15 at 3:56 p.m., indicated the resident's white blood count was 14.9 (normal 4.8-10.8), urine was yellow and cloudy. The resident's sodium was 181 (normal 135-147), BUN (kidney function) 156 (normal 7-22), and Creatinine (kidney function) 3.6 (normal 0.4-1.5).</p> <p>The hospital History and Physical, dated 12/23/15, indicated the resident had severe hypernatremia, lethargy/metabolic</p>			

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	<p>encephalopathy, severe dehydration/AKI (acute kidney injury) (kidney failure), and leukocytosis. The plan indicated intravenous fluids, "do not want to lower the Na [sodium] to acutely [cerebral edema would be a concern]...."</p> <p>During an interview on 12/23/15 at 1 p.m., the Hospital Physician indicated the resident was very dehydrated upon admission to the ICU. He indicated this was due to not enough fluid intake.</p> <p>Review of the resident's record form Facility #B on 12/29/15 indicated, Speech Therapy Note, dated 12/15/15, "...Dietary spoke with therapist today regarding patient's progress with current diet...Therapist also informed dietary that amount consumed by patient is decreased d/t [due to] difficulty initiating swallow...which creates concern for patient meeting daily nutritional/hydration needs."</p> <p>A Speech Therapy Note, dated 12/17/15, indicated, "Therapist education to LPN [Licensed Practical Nurse] as patient was placed in a semi laying position in an attempt to feed her. This was being done to prevent anterior spillage to increase intake. Unfortunately, irregardless of position, the patient was unable to consume an adequate amount of food for</p>			

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	<p>nutrition/hydration. Consulted with nursing on feeding techniques including the possible use of a controlled bolus via a syringe. Nursing to track intake for the next 4 days and will speak with family about alternative feeding if patient continues to display an inability to swallow sufficiently to maintain weight and hydration...This appears to be related to an overall decline in medical status related to advancing dementia."</p> <p>The Nurses' Progress Notes indicated: 12/17/15 at 7:54 p.m.- "resident consumed 0-25% of her evening meal...." 12/18/15 at 2:01 p.m.- (Written by LPN #1) "Resident [sic] did not eat at am [morning] meal, kept pushing food out of her mouth. Resident did eat approx. [approximately] 50% of noon meal." 12/18/14 at 10:06 p.m.- (Written by RN, Registered Nurse, #4) "Res. [resident] ate only a couple of bites at dinner. She pushes food out of her mouth and takes in very little." 12/19/15 at 4:04 p.m.- (Written by LPN #1) "Resident at approx 50% of am meal, at noon meal resident did not swallow any food writer put in her mouth, resident held head down and food slid out of mouth." 12/19/15 at 10:16 p.m.- (Written by RN #4) "Res. had poor food consumption this shift. She ate only bites at dinner even</p>			

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	<p>with many attempts to get her to eat. Res. had some sips of liquid but only very little. Res. had a dry brief at the end of shift...Res. has poor skin turgor as evidenced by tenting [skin pinched up] of the hands and sternum greater than a [sic] 3 second return [amount of time it takes for skin to return to normal after being pinched up] [test for dehydration]; fluids were offered and resident did not drink well...."</p> <p>A Weight and Vitals Summary in the record, indicated resident's weights were 12/2/15-147 pounds, 12/9/15-146.8 pounds, and 12/16/15-144.6 pounds at the facility.</p> <p>The Emergency Room Physician's Note, dated 12/22/15 at 1:01 p.m. indicated the residents weight was 144 pounds.</p> <p>Interview with the Administrator on 12/16/15 at 12:30 p.m., indicated the co-guardian was notified of the transfer on 11/18/15. She indicated another 30 day notice was not issued at the time due to being advised it was not necessary since the facility won their appeal in July. The Administrator also indicated the official notice of transfer or discharge was not issued on 11/18/15. She indicated the resident was being transferred due to the safety of</p>			

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	<p>individuals in the facility was felt to be endanger.</p> <p>Interview with the Administrator on 12/29/15 at 2:06 p.m., indicate the resident was transferred due to the safety of the individual in the facility. She indicated she had no information of anything that had occurred in the facility after the appeals hearing in regards to the safety of the individual in the facility being at risk.</p> <p>This Federal tag relates to complaint IN00187421.</p> <p>3.1-12(a)(6)(A) 3.1-12(a)(7)</p>			

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F 0202 SS=D Bldg. 00	<p>483.12(a)(3) DOCUMENTATION FOR TRANSFER/DISCHARGE OF RES</p> <p>When the facility transfers or discharges a resident under any of the circumstances specified in paragraph (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by the resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and a physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section.</p> <p>Based on record review and interview, the facility failed to ensure documentation was completed by the Physician prior to an involuntary discharge as for the reason for the discharge for 1 of 3 residents reviewed for admission, transfer, discharge in the sample of 5. (Resident #B)</p> <p>Finding includes:</p> <p>The closed record for Resident #B was reviewed on 12/15/15 at 10:20 a.m. The resident's diagnoses included, but were not limited to, hypertension, dementia, history of stroke, dysphagia (difficulty swallowing), gastroesophageal reflux (GERD), and anemia.</p>	F 0202	<p>The facility is unable to retrospectively address the cited concern related to Resident #B. Resident #B discharged from the facility on December 1, 2015. The facility has no current or pending involuntary discharges. Therefore the facility is confident that no other residents were affected by the alleged deficient practice. Colonial Nursing and Rehab has a procedure in place for discharge planning that specifically includes involuntary discharges. (Exhibit#1) The MDT has been re-educated on this policy. (Exhibit#2) Additionally, the facility Discharge Care Transition Summary (Exhibit #3) has been updated to include specific requirements for the 30 day notice of transfer and discharge, including the</p>	01/28/2016

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	<p>A Physician's order dated 11/30/15, indicated the resident was to transfer to another long term care facility.</p> <p>An entry completed in the Social Service progress notes by the Administrator on 11/18/15, indicated the resident's son was notified of the resident being accepted by another facility and the discharge meeting would be held on 11/30/15 and the resident was to be discharged on 12/1/15.</p> <p>The resident's Physician was notified on 11/25/15 of the discharge meeting scheduled for 11/30/15. The discharge meeting was attended by the Administrator, Director of Nursing, Minimum Data Set (MDS) Coordinator, Activity Director and Dietary Manager. There was no documentation to indicate if the resident's Physician attended the meeting.</p> <p>The resident was seen by the Nurse Practitioner on 11/27/15 for lab orders and a skin evaluation. There was no documentation completed related to a reason for the upcoming discharge.</p> <p>Interview with the Administrator on 12/16/15 at 12:30 p.m., indicated the resident's Physician did not attend the discharge meeting and there was no</p>		<p>requirement for the physician to document in the clinical record the reason for the discharge in the event that an involuntary discharge is necessary. The Administrator or designee will conduct an audit that includes physician documentation related to the reason for discharge in medical record prior to an involuntary discharge. This information will be identical to the information provided in the notice of transfer or discharge. This audit will take place 24-48 hours prior to discharge with negative findings being corrected immediately on an on-going basis. This audit will be completed for each discharge and reviewed by the by the QA Committee on a monthly basis for no less than 6 months.(Exhibit #4)</p>	

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	<p>documentation completed by the Physician to indicate the reason for the resident's discharge. The Administrator indicated the resident was being transferred due to the safety of individuals in the facility was felt to be endangered.</p> <p>This Federal tag relates to complaint IN00187421.</p> <p>3.1-12(a)(5)(A)</p>				