

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155784	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/30/2015
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NAME OF PROVIDER OR SUPPLIER MICHIANA HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1420 E DOUGLAS RD MISHAWAKA, IN 46545
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F 000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints #IN00171108 and #IN00171137. This visited in an Extended Survey - Substandard Quality of Care.</p> <p>Complaint #IN00171108 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint #IN00171137 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: April 21, 22, 23, 24, 26, 27, 28 and 29, 2015 Extended survey date: April 30, 2015</p> <p>Facility number: 012329 Provider number: 155784 AIM number: 201002500</p> <p>Census bed type: SNF/NF: 82 Total: 82</p> <p>Census payor type: Medicare: 17 Medicaid: 42 Other: 23</p>	F 000		
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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 225 SS=F Bldg. 00	<p>Total: 82</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in</p>			

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	<p>progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record review, the facility failed to ensure resident's allegations of verbal abuse, physical abuse and misappropriation of property was reported immediately to the Administrator, thoroughly investigated, and reported in a timely manner to the appropriate state agencies. This deficiency affected 7 of 7 allegations of abuse reviewed. (Resident #92, Resident #205, Resident #104, Resident #70, Resident #21, Resident #139, and Resident #55)</p> <p>Findings include:</p> <p>On 4/23/15 at 3:10 P.M., the following abuse allegation investigations were received from the Administrator and reviewed at this time.</p> <p>An undated "Incident Report Form" indicated "Unusual occurrence/incident...incident date: 10/5/2014 about 3:10 a.m., ...Residents</p>	F 225	<p>It is the practice of this facility to ensure alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the Administrator of the facility, thoroughly investigated, and reported in a timely manner to the appropriate state agencies.</p> <p>Allegations of abuse for residents #92, 205, 104, 70, 21, 139, and 55 were reviewed; resident charts and care plans were reviewed to ensure they reflect current status.</p> <p>If abuse/neglect is alleged facility will immediately initiate the 'Prevention and Reporting: Resident mistreatment, neglect, abuse, including injuries of unknown source policy' which includes reporting and investigating process. Facility will ensure alleged allegations are reported immediately to the Administrator of the facility, investigated and reported in a timely manner. Facility will</p>	05/30/2015			

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	Name: [Resident #92's name]...Diagnosis: Adult neglect - nutrition, HTN [hypertension - high blood pressure], COPD [chronic obstructive pulmonary disease], morbid obesity, anxiety, depressive state...Brief Description of Incident: CNA [Certified Nursing Assistant] #21 [name] alleged that CNA #22 [name] acted inappropriately with Resident #92 [name] when they went in together to change [Resident #92's name] and her wet gown and bedding. [CNA #21's name] says that [CNA #22's name] was arguing and tussling with [Resident #92's name] over her sheets and gown as she was trying to remove them and [Resident #92's name] didn't want to cooperate to have them changed. They both left the resident and [CNA #21's name] went to the nurse... [CNA #22] was immediately placed on administrative leave by the nurse on duty, and the Administrator was called...Follow up findings: Interim DON [Director of Nursing] and ADON [Assistant Director of Nursing] interviewed resident in regards to the incident reported on 10/5/2014, as per resident a verbal conflict erupted between her and CNA regarding incontinent care. Resident refused and CNA insisted which resulted in the two of them arguing and tussling over the sheet. Resident reports CNA had her finger in her face, insisting		continue to follow policy and procedure related to Abuse Prohibition. Resident concern reports will be reviewed for the past 30 days for any potential resident abuse. Staff treatment of residents and their right to file grievances was reviewed in the March 18, 2015 Resident Council meeting. In May 13, 2015 the facility Administrator was invited to the Resident Council where the Resident Concern Report used for filing concerns or grievances was discussed and he explained the process of reporting abuse allegations. The Behavior care tracker documentation and concern reports will be reviewed daily during morning stand up for any potential resident abuse. Administrator and/or designee will review daily resident concern forms. Department heads and Nurse Supervisors will receive re-education on following up with concern reports and how they differ from abuse reporting requirements, immediately reporting abuse allegations to the Administrator, immediate actions to take and initiating and documenting a thorough investigation. All staff has received additional education on abuse reporting. Administrator/designee will report, ensure thorough investigation and	

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	<p>to change her and resident states she was not wet....Conclusion:...the reported employee has received additional training on the approach and how to work with a difficult resident...." No documentation was noted related to any investigation, resident or staff statements taken.</p> <p>An "Incident Report Form" indicated "Initial Report: 10/22/14... Follow up report: 10/27/14...Resident Name: [Resident #205's name]...diagnosis: CVA [cerebrovascular accident - stroke], HTN, CKD [chronic kidney disease], diabetes...Staff name: [CNA #23's name]...Brief Description of Incident: Concern form given to social services on 10-22-14 reporting that on 10-21-14 resident voiced concern to therapist that CNA is rough while giving care...Follow up findings: Upon reinterview, [Resident #205's name] reported that [CNA #23's name] grabbed his arm quickly to prevent him from sliding out of his chair...." A written statement from CNA #23, dated 10/22/14, indicated "I, [CNA #23], did nothing to [Resident #205] today or no other day. I treat him with respect. As far as his socks, there is no way I could have been rough with him" A written interview, dated 10/23/14, between SS [Social Services] and Resident #205, indicated "...[CNA #23's name] is awful...she snatched my arm because she</p>		<p>follow up on abuse allegations. Managers routinely monitor for signs of staff burnout and encourage staff to take time off or modify their schedule when changes in work performance are noted.</p> <p>Any identified non-compliance will be addressed with 1-1 remedial education on abuse reporting combined with disciplinary action per policy.</p> <p>Individual staff overtime is monitored each pay period by the facility Administrator. Those with a significant overtime are identified to the department head for schedule modifications as needed. In addition to real-time monitoring of abuse allegations, the facility Administrator will further monitor allegation reporting and investigations through the interdisciplinary QAPI process as follows: To validate continued compliance and identify needs for further education, monitoring, process revision or corrective action, the Social Service Director/designee will report Concern data/trends and the Director of Nursing/designee will report on Facility Reported Incidents in monthly QAPI meetings.</p>		

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	<p>thought I was going to fall out of my chair...[SS: Do you think [CNA #23] is trying to hurt you?]. Sometimes, I think she is an evil woman...[SS: What would you like to happen to her?]. Want her reported...[SS: do you think she did it fast to keep you from falling?]. Yes, I just didn't like the way she did it...." No documentation was noted to indicate the Administrator had been notified of the allegation immediately.</p> <p>An "Incident Report Form" indicated "Initial Report: 12/31/14...Follow up report: 1/5/15...Resident Name: [Resident #104's name]...Diagnosis: DM [diabetes mellitus], hyperlipidemia, dementia, HTN, osteoporosis...Staff Name: [CNA #24's name]...Brief Description of Incident: Concern form given to social services 12/31/14 reporting that on 12/30/14 resident stated that her evening shift caregiver last evening was allegedly rude. She states she is fearful of her caregiver....Follow up report:...This concern was not an allegation of abuse but poor customer service in the form of rudeness as resident stated the CNA was 'somewhat rude'. The identified CNA who was accused of being rude will be returned to work and given additional training on customer service and politeness...." The "Resident Concern Report" completed by the therapist who</p>			

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	<p>received the allegation indicated "...During ST [Speech Therapy] tx [treatment] session 12/31/14 @ [at] 8:40-9:26 a.m. Pt [patient] appeared to be upset...She kept saying 'it's her, she does this, I don't like it, she got me in the bed and took everything out and then shut the door...." Social Service progress note, dated 12/31/14, indicated "...Therapy Directed notified this writer that [Resident #104] was down in the therapy room speaking with the speech therapist and appeared very upset...I approached [Resident #104] and informed her I was there to speak with her regarding an incident therapy reported. [Resident #104] stated "she did it, it was her, I don't like it." Resident was having a hard time reporting to this writer what actually occurred due to her expressive aphasia [difficulty speaking]. [Resident #104] was able to acknowledge she [CNA #24] was 'short and somewhat rude' to her...When asked if she feels safe at the facility she states she does but she is 'afraid of this aide'...'I should kill myself'...." No documentation was noted to indicate this allegation of abuse was reported to the Administrator immediately or any other staff statements other than the CNA named in the allegation.</p> <p>A "Resident Concern Form," dated</p>			

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	<p>2/9/15, indicated "Name of person filing concern: [Resident #70's name]...Concern filed regarding: missing item...Nature of concern: [Resident #70] reports she is missing a navy blue tapestry coin purse with \$30 in it. She reports she last saw it at Christmas. She reports it was in her top drawer, which was not locked. She reports nurse helped her look through top drawer, but did not find it... [SS] reminded resident to keep top drawer locked and provided c [with] keychain for key, as resident was keeping key in lock...[SS] searched resident room c resident permission...unable to locate purse...Disposition: [SS] spoke with SSD [Social Services Director], who stated that item will not be replaced as cannot prove it was stolen...." No documentation was noted in regard to any notification of this allegation to the Administrator or any investigation that was completed.</p> <p>An "Incident Report Form" indicated "Follow up report: 3/3/15...Incident date: 2/26/15...Resident Name: [Resident #21's name]...Diagnosis: pressure ulcer stage 4, uncontrolled type 2 diabetes, morbid obesity, depression, CHF [congestive heart failure], neurogenic bladder, htn [hypertension], paraplegia, copd [chronic obstructive pulmonary disease], esophageal reflux...Staff Name: [CNA</p>			
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	<p>#25's name]...Brief Description of Incident: Resident reported to restorative that [CNA #25] was being rough with her while she was on the hoyer lift; resident stated that he made her cry yesterday...Follow up: After thorough investigation of allegation of CNA being rough with resident was found to be unsubstantiated. It was found that resident was on the hoyer lift in the midst of being transferred to bed and the motorized w/c [wheelchair] had stopped working (due to a drained battery) causing the CNA's to have to maneuver the hoyer around the chair because it was not movable. This caused the resident to feel as if the transfer was rough compared to what the normal process is...." A written investigation interview with Resident #21, dated 2/26/15, indicated "...[CNA #25] made her cry yesterday...they 'got into it' over her chair... [CNA #25] told her 'I've been doing this for 31 years, so I know what I'm doing'...[CNA #25] being rough c her while in hoyer while getting into bed...rough over time, constantly...always in a hurry...rude...." No documentation was noted related to further investigation regarding residents statement of constant rough treatment or CNA being rude, or that any initial report was completed to local state agencies within 24 hours of allegation.</p>			
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	<p>An "Incident Report Form" indicated "Initial report: 4/22/15...Incident date: on or about 4/18/15...Resident Name: [Resident #139's name]...now discharged...Diagnosis: hip fracture, COPD [Chronic Obstructive Pulmonary Disease], HTN [hypertension], anxiety...Staff Name: [CNA #13's name]...Brief Description of Incident: This Administrator received a call from the Administrator at the resident's new facility stating the resident told them that she was verbally and physically abused one evening a day or so before discharging from Michiana and moving to [other facility name]...Type of Injury/Injuries: alleged bruising under the arms and being called names...Immediate action taken; CNA assignments were checked to find out who worked with this resident in the time frame of the allegation, CNA's were contacted and interviews are being done and statements being obtained...The CNA [CNA #26] who prepared her for a shower the day she discharged [Monday, 4/20/15] states that she had no bruises at that time...Preventative measures taken: This resident had already been discharged..."</p> <p>An undated, written statement by the Administrator indicated "...On Tuesday, April 21, 2015 about mid day I got a phone call from [Administrator of</p>			

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	<p>residents new facility]...stating that a resident who had moved there from Michiana had voiced an allegation of abuse: verbal and physical...The alleged perpetrator was identified as: 'a black woman'. She allegedly called the resident derogatory names and was rough when helping her transfer from/to bed and to toilet. Causing bruises by grabbing her arms. The [residents new facility] Administrator said the resident had bruises under her arms...." A written statement from SS, dated 4/22/15, indicated "Re: [Resident #139], [SS] met with [Resident #139] at [residents new facility] to follow up regarding concerns of treatment while at this facility....She [resident] states she was afraid to use her call light again as she did not want this same aide to come back. She reports she told her husband about this incident and that was reason for leaving facility...[SS] observed multiple bruises on [Resident #139's] lower arms, and [Resident #139] reported there were additional bruises on her upper arms, particularly the right arm. [SS] noted several of the bruises were green/yellow in color on the inside of her arms, and appeared small and round...." A "CNA Shower Report and Check Sheet", dated 4/20/15 at 10 A.M. and signed by CNA #26, indicated "...Resident did not allow aide to help her...." A written statement by CNA #26,</p>			

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	<p>dated 4/22/15, indicated "I, [CNA #26's name], helped [Resident #139's name], get set up for her shower on 4/20/15. I left her on the toilet to answer other lights. When I next saw her, she had finished her shower. To my knowledge, she did not have any bruises...." No documentation was noted related to a skin assessment done prior to resident discharging to new facility.</p> <p>An "Incident Report Form" indicated "...Initial Report: 4/23/15...Incident date: 4/21/15...Resident Name: [Resident #55's name]...Diagnosis: Depression, HTN, anemia, vascular dementia, GERD [Gastroesophageal reflux disease], quadriplegia...Staff Name: [CNA #13's name]...Brief Description of Incident: [Resident #55's name] says: On Tuesday, April 21, 2015, [CNA #13's name] came into his room to respond to his bathroom call light and said 'what do you need?' He told her he needed a little help to get cleaned up. He told her 'ow, that hurts!' when she tried to clean him up and [CNA #13's name] said 'What do you want me to do?' He said then he told her he would do it himself and she walked out of the room...Immediate action taken: At the time the resident reported this, two days after it happened, the perpetrating CNA was on suspension related to other allegations. Preventative measures taken:</p>			

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	<p>"This CNA is being terminated" A written statement by LPN (Licensed Practical Nurse) #14, dated 4/24/15, indicated "I went into residents room and asked him about the incident on 4/21/15 with [CNA #13]...I asked resident if he believed it was a customer service problem. Resident stated she has a bad attitude..." No documentation was noted related to any further investigation of this allegation other than LPN #14's statement.</p> <p>On 4/23/15 at 5:00 P.M., an interview was conducted with the DON (Director of Nursing). The DON indicated it was the expectation that a skin assessment is completed before a resident is discharged.</p> <p>On 4/27/15 at 1:57 P.M., an interview was conducted with the SSD (Social Service Director). The SSD indicated he usually receives the "Resident Concern Forms," logs the concern, and then dispenses the form to the appropriate department. The SSD indicated the forms are filled out with any concern, like the food or missing clothes, but if it is rudeness or rough treatment it is supposed to go in the Administrators box so he can sign it, "...Staff is supposed to notify the Administrator immediately...We don't have a policy related to what constitutes customer</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155784	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/30/2015
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NAME OF PROVIDER OR SUPPLIER MICHIANA HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1420 E DOUGLAS RD MISHAWAKA, IN 46545
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	<p>service issues...."</p> <p>On 4/28/15 at 12:00 P.M., an interview with the Administrator was conducted. The Administrator indicated "...We could probably develop a better timeline, notified the DON, etc at this date and this time...I think to make an allegation [of misappropriation of property] you have to say someone stole this, or someone took this from me...I don't actually make the call, I don't make the decision if something is abuse or not...I think there are some things we could do better, as far as notifying and documenting...I could probably be more involved...."</p> <p>On 4/28/15 at 12:15 P.M., an interview with the Corporate Nurse was conducted. The Corporate Nurse indicated they did not have a specific investigating procedure for allegations of abuse, but it was up to the Administrator to determine the investigative process.</p> <p>On 4/28/15 at 3:00 P.M., review of the "Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property" policy, received from the Administrator on 4/21/15 at 11:30 A.M., indicated "...Identify events...bruising of residents, occurrences, patterns, and trends that may</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155784	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/30/2015
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NAME OF PROVIDER OR SUPPLIER MICHIANA HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1420 E DOUGLAS RD MISHAWAKA, IN 46545
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F 226 SS=F Bldg. 00	<p>constitute abuse, neglect, and/or mistreatment...Report the incident immediately to the Administrator and DON/Designee, who will immediately report any allegations of mistreatment, neglect, abuse, including injuries of unknown source, and misappropriation of resident property to applicable state and other agencies...."</p> <p>3.1-28(c) 3.1-28(d)</p> <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. Based on interview and record review, the facility failed to follow their policy and procedure for investigating and reporting allegations of abuse for 7 of 7 allegations reviewed. (Resident #92, Resident #205, Resident #104, Resident #70, Resident #21, Resident #139, and Resident #55)</p> <p>Findings include: On 4/23/15 at 3:10 P.M., the following abuse allegation investigations were</p>	F 226	<p>It is the practice of this facility to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Allegations of abuse for residents #92, 205, 104, 70, 21, 139, and 55 were reviewed; resident charts and care plans were reviewed to ensure they reflect current status.</p> <p>If abuse/neglect is alleged facility will immediately initiate the</p>	05/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155784		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/30/2015	
NAME OF PROVIDER OR SUPPLIER MICHIANA HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1420 E DOUGLAS RD MISHAWAKA, IN 46545			
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	<p>received from the Administrator and reviewed at this time.</p> <p>An undated "Incident Report Form" indicated "Unusual occurrence/incident...incident date: 10/5/2014 about 3:10 a.m.,...Residents Name: [Resident #92's name]...Diagnosis: Adult neglect - nutrition, HTN [hypertension - high blood pressure], COPD [chronic obstructive pulmonary disease], morbid obesity, anxiety, depressive state...Brief Description of Incident: CNA [Certified Nursing Assistant] #21 [name] alleged that CNA #22 [name] acted inappropriately with Resident #92 [name] when they went in together to change [Resident #92's name] and her wet gown and bedding. [CNA #21's name] says that [CNA #22's name] was arguing and tussling with [Resident #92's name] over her sheets and gown as she was trying to remove them and [Resident #92's name] didn't want to cooperate to have them changed. They both left the resident and [CNA #21's name] went to the nurse... [CNA #22] was immediately placed on administrative leave by the nurse on duty, and the Administrator was called...Follow up findings: Interim DON [Director of Nursing] and ADON [Assistant Director of Nursing] interviewed resident in regards to the</p>		<p>'Prevention and Reporting: Resident mistreatment, neglect, abuse, including injuries of unknown source policy' which includes reporting and investigating process. Facility will ensure alleged allegations are reported immediately to the Administrator of the facility, investigated and reported in a timely manner. Facility will continue to follow policy and procedure related to Abuse Prohibition.</p> <p>Resident concern reports will be reviewed for the past 30 days for any potential resident abuse. Staff treatment of residents and their right to file grievances was reviewed in the March 2015 Resident Council meeting. In May 2015 the facility Administrator was invited to the Resident Council and he reviewed the Resident Concern Report available for filing concerns or grievances and he also explained the process of reporting, investigating and following up on abuse allegations. The Behavior care tracker documentation and concern reports will be reviewed daily during morning stand up for any potential resident abuse. Administrator and/or designee will review daily resident concern forms.</p> <p>Department heads and Nurse Supervisors will receive re-education on following up with</p>				

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--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER MICHIANA HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1420 E DOUGLAS RD MISHAWAKA, IN 46545
-------------------------------------------------------------------------------	-----------------------------------------------------------------------------------

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	<p>incident reported on 10/5/2014, as per resident a verbal conflict erupted between her and CNA regarding incontinent care. Resident refused and CNA insisted which resulted in the two of them arguing and tussling over the sheet. Resident reports CNA had her finger in her face, insisting to change her and resident states she was not wet....Conclusion:...the reported employee has received additional training on the approach and how to work with a difficult resident...." No documentation was noted related to any investigation, resident or staff statements taken.</p> <p>An "Incident Report Form" indicated "Initial Report: 10/22/14... Follow up report: 10/27/14...Resident Name: [Resident #205's name]...diagnosis: CVA [cerebrovascular accident - stroke], HTN [hypertension], CKD [chronic kidney disease], diabetes...Staff name: [CNA #23's name]...Brief Description of Incident: Concern form given to social services on 10-22-14 reporting that on 10-21-14 resident voiced concern to therapist that CNA is rough while giving care...Follow up findings: Upon reinterview, [Resident #205's name] reported that [CNA #23's name] grabbed his arm quickly to prevent him from sliding out of his chair...." A written statement from CNA #23, dated 10/22/14, indicated "I, [CNA #23], did</p>		<p>concern reports and how they differ from abuse reporting requirements, immediately reporting abuse allegations to the Administrator, immediate actions to take and initiating and documenting a thorough investigation. All staff has received additional education on abuse reporting. Administrator/designee will report, ensure thorough investigation and follow up on abuse allegations. Managers routinely monitor for signs of staff burnout and encourage staff to take time off or modify their schedule when changes in work performance are noted.</p> <p>Any identified non-compliance will be addressed with 1-1 remedial education on abuse reporting combined with disciplinary action per policy.</p> <p>Individual staff overtime is monitored each pay period by the facility Administrator. Those with a significant overtime are identified to the department head for schedule modifications as needed. In addition to real-time monitoring of abuse allegations, the facility Administrator will further monitor allegation reporting and investigations through the interdisciplinary QAPI process as follows: To validate continued compliance and identify needs for further education, monitoring, process revision or</p>	

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NAME OF PROVIDER OR SUPPLIER MICHIANA HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1420 E DOUGLAS RD MISHAWAKA, IN 46545			
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	<p>nothing to [Resident #205] today or no other day. I treat him with respect. As far as his socks, there is no way I could have been rough with him" A written interview, dated 10/23/14, between SS (Social Services) and Resident #205, indicated "...[CNA #23's name] is awful...she snatched my arm because she thought I was going to fall out of my chair...[SS: Do you think [CNA #23] is trying to hurt you?]. Sometimes, I think she is an evil woman...[SS: What would you like to happen to her?]. Want her reported...[SS: do you think she did it fast to keep you from falling?]. Yes, I just didn't like the way she did it..." No documentation was noted to indicate the Administrator had been notified of the allegation immediately.</p> <p>An "Incident Report Form" indicated "Initial Report: 12/31/14...Follow up report: 1/5/15...Resident Name: [Resident #104's name]...Diagnosis: DM [diabetes mellitus], hyperlipidemia, dementia, HTN, osteoporosis...Staff Name: [CNA #24's name]...Brief Description of Incident: Concern form given to social services 12/31/14 reporting that on 12/30/14 resident stated that her evening shift caregiver last evening was allegedly rude. She states she is fearful of her caregiver....Follow up report:...This concern was not an allegation of abuse</p>		corrective action, the Social Service Director/designee will report Concern data/trends and the Director of Nursing/designee will report on Facility Reported Incidents in monthly QAPI meetings.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155784	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/30/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER MICHIANA HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1420 E DOUGLAS RD MISHAWAKA, IN 46545
-------------------------------------------------------------------------------	-----------------------------------------------------------------------------------

(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>but poor customer service in the form of rudeness as resident stated the CNA was 'somewhat rude'. The identified CNA who was accused of being rude will be returned to work and given additional training on customer service and politeness...." The "Resident Concern Report" completed by the therapist who received the allegation indicated "...During ST [Speech Therapy] tx [treatment] session 12/31/14 @ [at] 8:40-9:26 a.m. Pt [patient] appeared to be upset...She kept saying 'it's her, she does this, I don't like it, she got me in the bed and took everything out and then shut the door...." Social Service progress note dated 12/31/14 indicated "...Therapy Directed notified this writer that [Resident #104] was down in the therapy room speaking with the speech therapist and appeared very upset...I approached [Resident #104] and informed her I was there to speak with her regarding an incident therapy reported. [Resident #104] stated "she did it, it was her, I don't like it." Resident was having a hard time reporting to this writer what actually occurred due to her expressive aphasia [difficulty speaking]. [Resident #104] was able to acknowledge she [CNA #24] was 'short and somewhat rude' to her...When asked if she feels safe at the facility she states she does but she is 'afraid of this aide'...'I should kill</p>			

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--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER MICHIANA HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1420 E DOUGLAS RD MISHAWAKA, IN 46545
-------------------------------------------------------------------------------	-----------------------------------------------------------------------------------

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	<p>myself...." No documentation was noted to indicate this allegation of abuse was reported to the Administrator immediately or any other staff statements other than the CNA named in the allegation.</p> <p>A "Resident Concern Form," dated 2/9/15, indicated "Name of person filing concern: [Resident #70's name]...Concern filed regarding: missing item...Nature of concern: [Resident #70] reports she is missing a navy blue tapestry coin purse with \$30 in it. She reports she last saw it at Christmas. She reports it was in her top drawer, which was not locked. She reports nurse helped her look through top drawer, but did not find it... [SS] reminded resident to keep top drawer locked and provided c [with] keychain for key, as resident was keeping key in lock...[SS] searched resident room c resident permission...unable to locate purse...Disposition: [SS] spoke with SSD [Social Services Director], who stated that item will not be replaced as cannot prove it was stolen...." No documentation was noted in regards to any notification of this allegation to the Administrator or any investigation that was completed.</p> <p>An "Incident Report Form" indicated "Follow up report: 3/3/15...Incident date: 2/26/15...Resident Name: [Resident #21's</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155784	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/30/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER MICHIANA HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1420 E DOUGLAS RD MISHAWAKA, IN 46545
-------------------------------------------------------------------------------	-----------------------------------------------------------------------------------

(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>name]...Diagnosis: pressure ulcer stage 4, uncontrolled type 2 diabetes, morbid obesity, depression, CHF [congestive heart failure], neurogenic bladder, htn [hypertension], paraplegia, copd [chronic obstructive pulmonary disease], esophageal reflux...Staff Name: [CNA #25's name]...Brief Description of Incident: Resident reported to restorative that [CNA #25] was being rough with her while she was on the hooyer lift; resident stated that he made her cry yesterday...Follow up: After thorough investigation of allegation of CNA being rough with resident was found to be unsubstantiated. It was found that resident was on the hooyer lift in the midst of being transferred to bed and the motorized w/c [wheelchair] had stopped working (due to a drained battery) causing the CNA's to have to maneuver the hooyer around the chair because it was not movable. This caused the resident to feel as if the transfer was rough compared to what the normal process is...." A written investigation interview with Resident #21, dated 2/26/15, indicated "...[CNA #25] made her cry yesterday...they 'got into it' over her chair... [CNA #25] told her 'I've been doing this for 31 years, so I know what I'm doing'...[CNA #25] being rough c her while in hooyer while getting into bed...rough over time, constantly...always</p>			

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--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER MICHIANA HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1420 E DOUGLAS RD MISHAWAKA, IN 46545
-------------------------------------------------------------------------------	-----------------------------------------------------------------------------------

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	<p>in a hurry...rude...." No documentation was noted related to further investigation regarding residents statement of constant rough treatment or CNA being rude, or that any initial report was completed to local state agencies within 24 hours of allegation.</p> <p>An "Incident Report Form" indicated "Initial report: 4/22/15...Incident date: on or about 4/18/15...Resident Name: [Resident #139's name]...now discharged...Diagnosis: hip fracture, COPD, HTN, anxiety...Staff Name: [CNA #13's name]...Brief Description of Incident: This Administrator received a call from the Administrator at the resident's new facility stating the resident told them that she was verbally and physically abused one evening a day or so before discharging from Michiana and moving to [other facility name]...Type of Injury/Injuries: alleged bruising under the arms and being called names...Immediate action taken; CNA assignments were checked to find out who worked with this resident in the time frame of the allegation, CNA's were contacted and interviews are being done and statements being obtained...The CNA [CNA #26] who prepared her for a shower the day she discharged [Monday, 4/20/15] states that she had no bruises at that time...Preventative measures taken: This</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155784	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/30/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER MICHIANA HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1420 E DOUGLAS RD MISHAWAKA, IN 46545
-------------------------------------------------------------------------------	-----------------------------------------------------------------------------------

(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>resident had already been discharged...."</p> <p>An undated, written statement by the Administrator indicated "...On Tuesday, April 21, 2015 about mid day I got a phone call from [Administrator of residents new facility]...stating that a resident who had moved there from Michiana had voiced an allegation of abuse: verbal and physical...The alleged perpetrator was identified as: 'a black woman'. She allegedly called the resident derogatory names and was rough when helping her transfer from/to bed and to toilet. Causing bruises by grabbing her arms. The [residents new facility] Administrator said the resident had bruises under her arms...." A written statement from SS, dated 4/22/15, indicated "Re: [Resident #139], [SS] met with [Resident #139] at [residents new facility] to follow up regarding concerns of treatment while at this facility....[SS] observed multiple bruises on [Resident #139's] lower arms, and [Resident #139] reported there were additional bruises on her upper arms, particularly the right arm. [SS] noted several of the bruises were green/yellow in color on the inside of her arms, and appeared small and round...."</p> <p>A "CNA Shower Report and Check Sheet," dated 4/20/15 at 10 A.M. and signed by CNA #26, indicated "...Resident did not allow aide to help her...." A written statement by CNA #26,</p>			

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--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER MICHIANA HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1420 E DOUGLAS RD MISHAWAKA, IN 46545
-------------------------------------------------------------------------------	-----------------------------------------------------------------------------------

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	<p>dated 4/22/15, indicated "I, [CNA #26's name], helped [Resident #139's name], get set up for her shower on 4/20/15. I left her on the toilet to answer other lights. When I next saw her, she had finished her shower. To my knowledge, she did not have any bruises...." No documentation was noted related to a skin assessment done prior to resident discharging to new facility.</p> <p>An "Incident Report Form" indicated "...Initial Report: 4/23/15...Incident date: 4/21/15...Resident Name: [Resident #55's name]...Diagnosis: Depression, HTN, anemia, vascular dementia, GERD [Gastroesophageal reflux disease], quadriplegia...Staff Name: [CNA #13's name]...Brief Description of Incident: [Resident #55's name] says: On Tuesday, April 21, 2015, [CNA #13's name] came into his room to respond to his bathroom call light and said 'what do you need?' He told her he needed a little help to get cleaned up. He told her 'ow, that hurts!' when she tried to clean him up and [CNA #13's name] said 'What do you want me to do?' He said then he told her he would do it himself and she walked out of the room...Immediate action taken: At the time the resident reported this, two days after it happened, the perpetrating CNA was on suspension related to other allegations. Preventative measures taken:</p>			

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--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER MICHIANA HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1420 E DOUGLAS RD MISHAWAKA, IN 46545
-------------------------------------------------------------------------------	-----------------------------------------------------------------------------------

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	<p>"This CNA is being terminated" A written statement by LPN (Licensed Practical Nurse) #14, dated 4/24/15, indicated "I went into residents room and asked him about the incident on 4/21/15 with [CNA #13]...I asked resident if he believed it was a customer service problem. Resident stated she has a bad attitude...." No documentation was noted related to any further investigation of this allegation other than LPN #14's statement.</p> <p>On 4/23/15 at 5:00 P.M., an interview was conducted with the DON (Director of Nursing). The DON indicated it was the expectation that a skin assessment is completed before a resident is discharged.</p> <p>On 4/27/15 at 1:57 P.M., an interview was conducted with the SSD (Social Service Director). The SSD indicated he usually receives the "Resident Concern Forms," logs the concern, and then dispenses the form to the appropriate department. The SSD indicated the forms are filled out with any concern, like the food or missing clothes, but if it is rudeness or rough treatment it is supposed to go in the Administrators box so he can sign it, "...Staff is supposed to notify the Administrator immediately...We don't have a policy related to what constitutes customer</p>			

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--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER MICHIANA HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1420 E DOUGLAS RD MISHAWAKA, IN 46545
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	<p>service issues...."</p> <p>On 4/28/15 at 12:00 P.M., an interview with the Administrator was conducted. The Administrator indicated "...We could probably develop a better timeline, notified the DON, etc at this date and this time...I think to make an allegation [of misappropriation of property] you have to say someone stole this, or someone took this from me...I don't actually make the call, I don't make the decision if something is abuse or not...I think there are some things we could do better, as far as notifying and documenting...I could probably be more involved...."</p> <p>On 4/28/15 at 3:00 P.M., review of the "Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property" policy, received from the Administrator on 4/21/15 at 11:30 A.M., indicated "...Identify events...bruising of residents, occurrences, patterns, and trends that may constitute abuse, neglect, and/or mistreatment...Report the incident immediately to the Administrator and DON/Designee, who will immediately report any allegations of mistreatment, neglect, abuse, including injuries of unknown source, and misappropriation of resident property to applicable state and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155784	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/30/2015
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NAME OF PROVIDER OR SUPPLIER MICHIANA HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1420 E DOUGLAS RD MISHAWAKA, IN 46545
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F 282 SS=D Bldg. 00	<p>other agencies...."</p> <p>3.1-28(a)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review, and interviews, the facility failed to follow the physician's order related to assessment and documentation for a hemodialysis fistula in 1 of 1 residents reviewed for hemodialysis. (Resident #196)</p> <p>Finding includes:</p> <p>On 04/27/2015 at 9:19 A.M., the clinical record for Resident #196 was reviewed. The resident was admitted to the facility on 04/02/2015 with diagnoses including but not limited to chronic kidney disease, type 2 diabetes, hypertension, hyperlipidemia, gout, vitamin A deficiency, and left foot ulcer.</p> <p>The physician's orders, dated 04/02/2015 indicated nursing staff was to check bruit</p>	F 282	<p>It is the practice of the facility to ensure physician orders are followed related to assessment and documentation of a hemodialysis fistula.</p> <p>Resident #196 has discharged from the facility.</p> <p>Residents residing in the facility, receiving hemodialysis, will be addressed by following policy and procedure.</p> <p>Licensed nurses were re-educated on assessment and documentation of hemodialysis fistula.</p> <p>Unit Managers will audit resident records daily (Monday through Friday) for documented fistula assessments on every shift. Audits will be done for 4 weeks and then weekly thereafter.</p>	05/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155784	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/30/2015
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NAME OF PROVIDER OR SUPPLIER MICHIANA HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1420 E DOUGLAS RD MISHAWAKA, IN 46545
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F 309 SS=D Bldg. 00	<p>at fistula site every shift, and feel for thrill at fistula site every shift.</p> <p>A review of the TAR (Treatment Administration Record), indicated no record of assessments where done as ordered.</p> <p>On 04/27/2015 at 1:59 P.M., an interview with LPN (Licensed Practical Nurse) #4, indicated the resident's fistula site assessments should be documented in the treatment book, or in the progress notes, but at the time the only documented assessments were in the resident's hemodialysis book and only noted on dialysis days, Tuesdays, Thursdays, and Saturdays.</p> <p>3.1-35(g)(2)</p> <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</p>		<p>Identified non-compliance will result in one to one re-education with repeat non-compliance resulting in disciplinary action per policy.</p> <p>The Director of Nursing Services/designee will present compliance data for review in monthly QAPI meetings for 3 months and quarterly thereafter to validate continued compliance and determine further education or monitoring needs, or corrective actions.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155784	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/30/2015
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NAME OF PROVIDER OR SUPPLIER MICHIANA HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1420 E DOUGLAS RD MISHAWAKA, IN 46545
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	<p>practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to develop and implement a care plan for the assessment and monitoring of a resident receiving dialysis for 1 of 1 residents assessed for dialysis. (Resident #196)</p> <p>Findings include:</p> <p>On 04/27/2015 at 9:19 A.M., the clinical record for Resident #196 was reviewed. The resident was admitted to the facility on 04/02/2015 with diagnoses including but not limited to chronic kidney disease, type 2 diabetes, hypertension, hyperlipidemia, gout, vitamin A deficiency, and left foot ulcer.</p> <p>A physician's orders, dated 04/02/2015, indicated nursing staff to check bruit at fistula site every shift, and feel for thrill at fistula site every shift.</p> <p>Resident #196's current health care plans, developed on 04/03/2015, indicated there was no plan of care related to hemodialysis including fistula care and complications related to routine hemodialysis.</p> <p>On 04/27/2015 at 1:59 P.M., an interview</p>	F 309	<p>It is the practice of the facility to ensure that residents receiving dialysis have fistula site assessed and monitored.</p> <p>Resident #196 has discharged from the facility.</p> <p>Residents residing in the facility receiving hemodialysis/with a fistula site will be assessed and monitored per policy and procedure with care plan implemented by nursing staff to reflect current status.</p> <p>Licensed nurses were re-educated on assessing and monitoring fistulas per policy and procedure and development of care plan to reflect current status.</p> <p>Unit Managers will audit resident records daily (Monday through Friday) for documented fistula assessments on every shift. Audits will be done for 4 weeks and then weekly thereafter. Care plan accuracy was verified and will be revised by nursing staff upon change of condition, monitoring will be done by the Unit Manager/designee. Identified non-compliance will result in one to one re-education with repeat non-compliance resulting in disciplinary action per policy.</p>	05/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155784	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/30/2015
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NAME OF PROVIDER OR SUPPLIER MICHIANA HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1420 E DOUGLAS RD MISHAWAKA, IN 46545
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F 356 SS=C Bldg. 00	<p>with LPN (Licensed Practical Nurse) #4, indicated the resident's fistula site assessments should be documented in the treatment book, or in the progress notes, but at the time the only documented assessments were in the resident's hemodialysis book and only noted on dialysis days, Tuesdays, Thursdays, and Saturdays. In an interview at this time with RN (Registered Nurse) #8, indicated fistula care and assessments should be care planned for Resident #196, but are not.</p> <p>3.1-37(a)</p> <p>483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). 		The Director of Nursing Services/designee will present compliance data for review in monthly QAPI meetings for 3 months and quarterly thereafter to validate continued compliance and determine further education or monitoring needs, or corrective actions.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155784	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/30/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER MICHIANA HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1420 E DOUGLAS RD MISHAWAKA, IN 46545
-------------------------------------------------------------------------------	-----------------------------------------------------------------------------------

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	<p>- Certified nurse aides.</p> <p>o Resident census.</p> <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <p>o Clear and readable format.</p> <p>o In a prominent place readily accessible to residents and visitors.</p> <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation and interview, the facility failed to post the Daily Nurse Staffing Report on a daily basis. (4/21, 4/22, 4/23, 4/24, 4/26, 4/27, 4/28, 4/29 and 4/30/15)</p> <p>Finding includes:</p> <p>On 4/21, 4/22, 4/23, 4/24, 4/26, 4/27, 4/28 and 4/29/2015, no "Daily Nurse Staffing Report" was observed to be posted in the facility.</p> <p>On 4/29/15 at 1:52 P.M., an interview with the DON (Director of Nursing) was conducted. The DON indicated the Staff Coordinator was not aware she was responsible for posting that form every</p>	F 356	<p>It is the practice of this facility to post the nurse staffing information on a daily basis.</p> <p>No resident was harmed by this practice.</p> <p>Residents who reside in the facility have potential to be affected.</p> <p>Director of Nursing Services, Education Director and Staffing Coordinator were informed of the specifics to be posted on the nurse staffing information form daily. Postings will be filed and retained by the Director of Nursing Services/designee for at least 18 months.</p> <p>Administrator and/or designee will</p>	05/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155784	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/30/2015
NAME OF PROVIDER OR SUPPLIER MICHIANA HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1420 E DOUGLAS RD MISHAWAKA, IN 46545		
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F 371 SS=F Bldg. 00	<p>day.</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview and record review, the facility failed to serve food in a sanitary manner for 1 of 1 kitchens and 2 of 2 dining rooms.</p> <p>Findings Include: On 4/21/15 between 9:27 A.M., and 10:15 A.M., during the initial kitchen</p>	F 371	<p>monitor daily (Monday through Friday). The 100 Unit Nurse will monitor after-hours and on weekends. Identified non-compliance will result in one to one re-education with repeat non-compliance resulting in disciplinary action per policy.</p> <p>Any identified process breakdown will be documented and communicated to the Administrator for review/action and presented to QAPI monthly for 3 months and quarterly thereafter by the Director of Nursing Services/designee to validate continued compliance and determine further educational needs or corrective actions.</p> <p>It is the practice of this facility to prepare and serve food in sanitary manner in kitchen and dining rooms hand-washing, proper use of hairnets and storage of food and serving items.</p> <p>Staff will be re-educated on appropriate hand-washing technique, hairnet/beardnet use while preparing/serving food,</p>	05/30/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155784	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/30/2015
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NAME OF PROVIDER OR SUPPLIER MICHIANA HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1420 E DOUGLAS RD MISHAWAKA, IN 46545
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	<p>tour the following was observed:</p> <p>At 9:27 A.M., Dietary Assistant #9 was observed in the kitchen with no beard net on.</p> <p>At 9:28 A.M., on the prep table, 30 dinner plates were observed stored upright.</p> <p>At 9:30 A.M., on a wheeled cart at the end of the steam table, 40 soup and dessert bowls were observed stored uncovered and upright.</p> <p>At 9:31 A.M., on the steam table, 20 plates and 6 bowls were stored upright on the steam table.</p> <p>At 9:35 A.M., a container of Dip It grill cleaner and a 2 gallon container of Lime Away was observed stored under the end of the 3 compartment sink, next to the plate cover rack.</p> <p>At 9:40 A.M., in the reach in freezer: 23 frozen hamburger patties, undated, open to air. 3 hot dogs, undated, open to air. 2 -3 gallon containers of vanilla ice cream, open and undated. Dietary Assistant #9 indicated at this time "yes, the food should be closed and dated."</p> <p>At 9:45 A.M., in the main freezer a 65.3</p>		<p>proper storage and handling of plates, cups and glasses, proper food storage and dating/labeling requirements.</p> <p>Residents residing in the facility will be addressed by following policy and procedure.</p> <p>The Dietary manager/designee will monitor dining room service for hand-washing techniques and hairnet use daily (Monday through Friday) for 2 weeks, 3 times per week for 2 weeks, weekly for 2 months and then monthly for 3 months. Proper storage is monitored with the Daily Rounds Sheets completed by the Dietary manager/designee at least daily (Monday through Friday). Identified non-compliance will result in one on one re-education with repeat non-compliance resulting in disciplinary action per policy.</p> <p>Any identified process breakdown will be documented and communicated to the Administrator for review/action and presented to QAPI monthly for 3 months and quarterly thereafter by the Dietary Manager/designee to validate continued compliance and determine further educational needs or corrective actions.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155784	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/30/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER MICHIANA HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1420 E DOUGLAS RD MISHAWAKA, IN 46545
-------------------------------------------------------------------------------	-----------------------------------------------------------------------------------

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	<p>pound box of beef ribs,undated, and open to air.</p> <p>At 9:55 A.M., Cook # 15 was observed in the kitchen without beard net on while prepping food</p> <p>At 9:56 A.M., 2 large trays of cooked bacon, uncovered on a large rack by the stove.</p> <p>On 4/21/15 at 11:48 A.M., Employee # 17 was observed in the kitchen at the prep table without a hair net on.</p> <p>On 4/21/15 between 12:20 P.M., and 1:00 P.M., during observation of the lunch meal in the main dining room the following was observed</p> <p>At 12:35 P.M., LPN # 5 was observed exiting the kitchen with her hairnet back off the front of here head, bangs hanging out the front of the hairnet. She then was observed serving a lunch plate to a resident with her thumb on the inside rim.</p> <p>At 12:39 P.M., CNA #19 was observed coming out of the kitchen with braids hanging out of the back of her hairnet.</p> <p>At 12:41 P.M., LPN #5 was observed serving 2 lunch plates to residents with</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155784	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/30/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER MICHIANA HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1420 E DOUGLAS RD MISHAWAKA, IN 46545
-------------------------------------------------------------------------------	-----------------------------------------------------------------------------------

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	<p>thumbs on inside rim of plates.</p> <p>At 12:42 P.M., Dietary Assistant #9 was observed serving 2 residents lunch plates with thumbs on the inside edge of the plates.</p> <p>At 12:43 P.M., LPN #18 was observed coming out of the kitchen with a plate in each hand, thumbs on both rims and served them to residents.</p> <p>At 12:50 P.M., LPN #5 was observed serving a resident a hamburger and chips with her thumb on the rim of the plate.</p> <p>During an interview on 4/28/15 at 10:30 A.M., the DM (Dietary Manager) indicated, food that has been opened should be dated and not open to air. Cooked food that is on racks in the prep area should be covered. Plates and bowls should be stored upside down or when stored upright should be covered. Hairnets should cover hear completely. Beards should be covered if over 1/4 inches long. When serving bowls and plates, thumbs should not be on the plate or bowl it should be carried underneath. Glasses should be carried by the middle to lower edge. Fingers should never touch the top rim. Hands should be washed for 30 seconds.</p>			

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--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER MICHIANA HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1420 E DOUGLAS RD MISHAWAKA, IN 46545
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F 456 SS=D Bldg. 00	<p>On 4/28/15 at 10:40 A.M., the current policy "Personal Hygiene," dated November 2000 and revised April 2015, was provided by the Dietary Manger. The policy indicated " ... F. Rub hands together vigorously for 20 seconds... 3. Wear hairnets at all times...Cover all of hair... including facial hair...Beards must be covered...."</p> <p>On 4/28/15 at 11:43 A.M., the current policy "Storage," dated November 200 and revised 2011, was provided by the corporate nurse. the policy indicated "... Chemical Storage... 2. Store chemicals separate from food, equipment , utensils and linens...."</p> <p>On 4/29/15 at 10 :30 A.M., the current policy "Serving," dated November 2000 and revised July 2011, was provided by the corporate nurse. The policy indicated "... 5...b. Hold dishes by the bottom or the edge..."</p> <p>3.1-21(i)(2)</p> <p>483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155784	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/30/2015
NAME OF PROVIDER OR SUPPLIER MICHIANA HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1420 E DOUGLAS RD MISHAWAKA, IN 46545		
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	<p>equipment in safe operating condition.</p> <p>Based on observation and interview the facility failed to ensure the high temperature dishwasher was in maintained in safe operating condition in 1 of 1 kitchens.</p> <p>Finding Includes:</p> <p>On 4/21/15 at 11:48 A.M., Dietary Assistant #9 ran the dishwasher, wash temperature registered 112 degrees and rinse temperature registered 112 degrees. Employee # 9 indicated at this time "... the sensor inside the dishwasher gets dirty and the dishwasher won't get up to the right temperature... I have to clean the the sensor when we first run the machine... we replaced the sensor but it didn't help...."</p> <p>During an interview on 4/30/15 at 11:55 A.M., the Maintenance Director indicated "... we have replaced the temperature sensor but metal shavings collect in the sensor causing the temperature gauge not to work...."</p> <p>3.1-19(bb)</p>	F 456	<p>It is the practice of this facility to maintain safe operating condition of high temperature dishwasher.</p> <p>No negative outcome from this practice.</p> <p>Machine has been assessed for safe operating condition when used properly.</p> <p>Residents residing in the facility will be addressed by following policy and procedure.</p> <p>Dietary manager and cooks will be re-educated to report unsafe operating machinery to be fixed or replaced.</p> <p>Signage instructing that the sensor be cleaned and the machine be pre-heated by running 3 full cycles prior to the first tray of dishes has been prominently posted. All users have been inserviced on this requirement. It is believed that metal shavings were coming from metal scratch pads being used to scrub pots and pans, all staff have been instructed that these scratch pads are not to be used in the dish machine area.</p> <p>Dietary Manager and /or designee will monitor dietary machines/equipment for safe operating condition daily (Monday through Friday) for 30 days, then 3 times a week for 1 month, and</p>	05/30/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155784	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/30/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER MICHIANA HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1420 E DOUGLAS RD MISHAWAKA, IN 46545
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F 999 Bldg. 00	3.1-14 PERSONNEL (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date,	F 999	then once a week thereafter. Identified non-compliance will result in one to one re-education with repeat non-compliance resulting in disciplinary action per policy. Any identified process breakdown will be documented and communicated to the Administrator for review/action and presented to QAPI monthly for 3 months and quarterly thereafter by the Dietary Manager/designee to validate continued compliance and determine further educational needs or corrective actions. 3.1-14 Personnel It is the practice of this facility to maintain current and accurate personnel records for all employees. Active employee personnel files will be audited to ensure employee required health screenings are completed. The Educational Training Director and the Human Resources staff will develop and maintain a tracking checklist to ensure that all required pre-employment screenings are completed before being allowed to work. The tracking system will be checked	05/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155784	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/30/2015
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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>given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. The facility must assure the following:</p> <p>(1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be preformed one (1) to three(3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure documentation of TB (tuberculin) testing and references were complete for 1 of 10 employee records reviewed (Employee #8)</p> <p>Finding includes:</p>		<p>twice-monthly for 3 months and then monthly for compliance by the Business Office Manager. The Administrator will validate monthly.</p> <p>Any identified process breakdown will be documented and communicated to the Administrator for review/action and presented to QAPI monthly for 3 months and quarterly thereafter by the Business Office Manager/designee to validate continued compliance and determine further educational needs or corrective actions.</p> <p>3.1-19 Environmental and Physical Standards</p> <p>It is the practice of this facility to provide sufficient closet space for resident needs and to meet or exceed regulatory size requirements while doing so.</p> <p>Current resident needs have been recognized and appropriate actions taken to meet those needs.</p> <p>Closets will be replaced or additional ones added to provide adequate storage space. Larger closet units have been ordered and each resident will have either an oversized closet or two of the current units in their living space to provide substantially more than the minimum required closet</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155784	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/30/2015
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	<p>On 4/28/15 at 2:30 P.M., review of the employment file for LPN #8, date of hire 1/21/15, indicated that TB testing was missing from her employee file.</p> <p>On 4/29/15 at 2:15 review of the current policy "Tuberculin Skin Test [Purified Protein Derivative, PPD]" received from the Corporate nurse dated April 1999, revised November 2013, indicated "Extencicare Health Services, Inc (EHSI) centers will administer the Tuberculin Skin Test (TST) to all...employees...."</p> <p>During an interview on 4/29/15 at 3:30 P.M., the Payroll Director indicated that "... all employees should have a TB test at the start of their employment... I do not have a the TB testing for LPN #8...."</p> <p>3.1-14(t)(1)</p> <p>3.1-19 ENVIRONMENTAL AND PHYSICAL STANDARDS</p> <p>(m)The facility must provide each resident with the following:</p> <p>(5)Each resident room shall have clothing storage, which includes a closet at least two (2) feet wide and two(2) feet deep,</p>		<p>space. Confirmation of the closet unit order is provided at attachment 2 to this POC.</p> <p>Closet space needs will be monitored through Concern Report communications, Care Conference discussions and visual observations. Issues will be communicated by Social Service staff at monthly QAPI committee meetings where concerns/trends will be reviewed and corrective actions identified and implemented.</p> <p>Estimated delivery date for additional closet units: June 30, 2015.</p>	

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	<p>equipped with an easily opened door and a closet rod at least eighteen (18) inches long of adjustable height to provide access by residents in wheelchairs. The closet should be tall enough that clothing does not drag on the floor and to provide air circulation. A dresser, or its equivalent in shelf and drawer space equal to a dresser with an area of at least four hundred thirty two (432) square inches, equipped with at least two (2) drawers six(6) inches deep to provide for clothing, toilet articles and other personal belongings shall also be provided.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on observation and interview, the facility failed to ensure proper closet space was provided for 82 of 82 residents.</p> <p>Finding includes:</p> <p>During an interview on 04/22/2015 at 1:46 P.M., Resident #12 indicated "...the closet's are too small... my clothes have to hang on the shower rod in the bathroom... the girls have to lay my clothes on my bed when I get my showerthey shouldn't have to do that...."</p>			

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	<p>During an interview on 4/23/15 at 10:00 A.M., Resident #48 indicated "...there is not enough closed space ...there is no room for winter and summer clothes... my daughter had to go out and buy a clothes rack and dresser...."</p> <p>On 4/27/15 at 11:25 A.M., during the Environmental tour with the Maintenance Director measurement of the free standing closets indicated, closets measured 21-3/4" wide, 72" high and 24" deep. The Maintenance Director indicated at this time the closets have been here since we opened. It is the only closet that is available for me to purchase from the Extended Care supply company when I buy new closets. I was unaware there was a regulation on closet sizes . All residents have the same exact closet.</p> <p>3.1-19(m)(5)</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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