STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155132		08/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00178593. Complaint IN00178593 - Substantiated. Federal/state findings cited at F282, F279, F314 and F318. Survey Dates: August 12, 13, 14, 17, 18, 19, 20, and 21, 2015. Facility Number: 000057 Provider Number: 155132 AIM Number: 100266570 Census Bed Type: SNF/NF: 60 Total: 60 Census Payor Type: Medicare: 11 Medicaid: 42 Other: 7 Total: 60 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	The creation and submission ofthis plan of correction does not constitute an admission by this provider ofany conclusion set forth in the statement of deficiencies, or of any violationof regulation.This provider respectfully requests that the 2567 Plan of Correction beconsidered the letter of credible allegation and requests a desk review in lieuof a Post Complaint Survey Revisit on or after.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/21/2015
NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122	

(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
F 0157 SS=D Bldg. 00	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.			
	Based on record review and interview, the facility failed to notify the physician and family of significant change in	F 0157	·whatcorrective action(s) will be accomplished for those residents found to have beenaffected by the deficient practice **The legal**	09/20/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/21/2015
NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122	

(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
	weight and extremity edema for 2 of 3 residents reviewed for physician notification (Residents #79 and #94). Findings include: 1. Resident #79's record was reviewed on 8/18/15 at 2:00 p.m. The vitals report indicated Resident #79 weighed 169 pounds on 6/5/15 and weighed 135 pounds on 7/5/15. The "Food/Fluid Intake Record" for July 2015 indicated Resident #79 consumed 50 percent or less of meals on the following dates: 7/2/15 - breakfast of 50% 7/4/15 - breakfast of 50% 7/5/15 - dinner of 50% 7/6/15 - breakfast of 25% 7/715 - refused breakfast 7/8/15 - breakfast of 25% 7/9/15 - breakfast of 25% 7/16/15 - breakfast and lunch of 50% 7/19/15 - dinner of 50% 7/2015 - dinner of 50% 7/24/15 - breakfast of 50% 7/25/15 - dinner of 50% 7/26/15 - lunch of 50% 7/27/15 - breakfast and lunch of 50% 7/28/15 - dinner of 50% The "CORP-Meal Intake Detail Report" for June 2015 indicated Resident #79		**representatives or family members and physicians for residents #79 and # 94 have been informed of changes in condition.** ·howother residents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken **All residents have the potential to be affected. The records for residents with changes in condition were reviewed by the nurse manager for documentation of notification of changes to the family/legal representative and physician. Education will be provided to the licensed nursing staff by the DNS/designee on or before 9/18/15 regarding the importance of notifying the legal representative/family and physician of changes in condition and documenting this notification in the record.** ·whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur; **The records for residents with changes in condition will be reviewed daily by the nurse manager for documentation of notification of changes to the family/legal representative and physician. Education will be provided to the licensed**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 08/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(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
	consumed 50 percent or less of meals on the following dates: 6/2/15 - ate less than half of dinner (26% -49%) 6/5/15 - refused breakfast and ate less than half of dinner (26%-49%) 6/6/15 - refused most of lunch (1%-25%), and ate less than half of dinner (26% -49%) 6/8/15 - refused breakfast and refused most of dinner (1%-25%) 6/9/15 - ate less than half of breakfast and dinner(26% -49%) 6/11/15 - ate less than half of lunch (26% -49%) 6/12/15 - refused most of breakfast and lunch (1% -25%) 6/13/15 - refused most of lunch (1% -25%) 6/14/15 - refused most of dinner (1% -25%) 6/15/15 - refused most of breakfast, lunch, and dinner (1%-25%) 6/19/15 - refused most of breakfast (1% -25%) and ate less than half of dinner (26%-49%) 6/21/15 - ate less than half of dinner (26%-49%) 6/24/15 - refused most of dinner (1% -25%) 6/26/15 - refused most of breakfast and lunch (1%-25%) 6/29/15 - ate less than half of breakfast (26%-49%), refused most of lunch (1%		**nursing staff by the DNS/designee on or before 9/18/15 regarding the importance of notifying the legal representative/family and physician ofchanges in condition and documenting this notification in the record. Non-compliance with policy will be addressed with additional education and/or disciplinary action as needed.** ·howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place; **·To ensure compliance, the DNS/Designee is responsible for the completion of the Change ofCondition CQI tool weekly times 4 weeks, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(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
	-25%) The nursing progress notes, dated 11/14/14 to 8/5/15, were reviewed on 8/20/15 at 2 p.m. The nursing progress note dated 12/12/14 at 2:30 p.m., was the last progress note that addressed Resident #79's decreased meal intake. The care plan, dated 8/7/15, indicated Resident #79 was at risk for weight loss due to decreased intake and staff was to monitor the Resident's weight and notify the physician and family of significant weight changes. The nursing progress notes, dated 6/1/15 at 2:35 p.m. to 8/5/15 at 2:00 p.m., did not indicate the physician or family was notified of the Resident #79's June-July weight loss. During an interview on 8/20/2015 at 3:10 p.m., the Director of Nursing (DON) indicated she did not find documentation that the physician was notified of Resident #79's weight loss from June to July. She indicated documentation of physician and family notification would be in the nursing progress notes. During an interview on 8/21/2015 at 10:10 a.m., Licensed Practical Nurse (LPN) #22 indicated if a resident had			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/21/2015
NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122	

(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
	weight loss during the month she told the Unit Manager and the Unit Manager contacted the physician and family. During an interview on 8/21/2015 at 10:38 a.m., Unit Manager (UM) #23 indicated she notified the physician and family the same day a resident's weight loss was discovered. Unit Manager (UM) #23 indicated when a resident consumed 50 percent or less of a meal the Certified Nursing Assistant (CNA) notified the charge nurse and the charge nurse notified the physician. She indicated she had recently became the UM for the unit so she did not handle Resident #79's decreased intakes for June or July, and she was unsure what the former UM had done about his reduced intake. 2. Resident C's record was reviewed on 8/18/15 at 9:30 a.m. Resident C had diagnosis which included, but was not limited to, post surgical hip repair. An admission nursing note, dated 4/29/15, indicated Resident C did not have edema. Nurse's notes from admission on 4/29/15 through 5/1/15, lacked indication Resident C had edema. A nurse's note dated 5/2/15 at 1:00 p.m., indicated Resident C's lower extremities were "tight" and "edematous seeping."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155132		08/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(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
	A nurse's note, dated 5/3/15 at 9:00 a.m., indicated Resident C had bilateral lower extremely swelling "when up in a chair." A nurse's note, dated 5/3/15 at 3:45 p.m., indicated Resident C "appeared very pale" had a irregular heart rate of 50 beats per minute and had "3-4 plus pitting edema" to her bilateral lower extremities. This note indicated Resident C's daughter was at the bedside and reported to the nurse her legs had been weeping and her socks were soaked with fluid. A nurse's note, dated 5/3/15 at 7:00 p.m., indicated the physician was notified and new orders were obtained. Prior to this note, the record lacked indication a physician was notified of Resident C's change of condition. During an interview on 8/20/15 at 9:38 a.m., the Nurse Consultant indicated documentation which indicated the physician had been notified of Resident C's change in condition prior to 5/3/15 at 7:00 p.m., was not available. A policy titled "Notification of Resident Change in Condition" identified as current by the Nurse Consultant on 8/20/15 at 9:38 a.m., indicated, "...clinicians will immediately... consult with the resident's physician... when there			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155132		08/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(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
	is a significant change in the resident's physical, mental, or psychosocial status...Notify the Physician... immediately, if there is a significant change in condition, regardless of time...." 3.1-5(a)(2)			
F 0166 SS=D Bldg. 00	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. Based on interview and record review, the facility failed to promptly resolve resident grievances for 1 of 1 resident reviewed for grievances (Resident #90). Findings include: During an interview on 8/14/15 at 11:52 a.m., Resident #90 indicated he had recently returned from an outing with family and was having trouble with his subrapubic catheter. He indicated he had urine on his shorts, lower back discomfort, and his catheter was still leaking. He indicated he told a Certified Nursing Assistant (CNA) that he needed assistance as soon as possible and the CNA told him she would help after she	F 0166	·whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice **· The grievance voiced by resident #90 was documented and investigated per policy and has been resolved to the resident's satisfaction.** ·howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken; **All residents have the potential to be affected. Staff, including Executive Director, will be inserviced on the grievance process by Social Service consultant/designee on or before 9/18/15. The**	09/20/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 08/21/2015
NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122	

(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
	took the residents out to smoke. Resident #90 indicated he told the CNA that would not be soon enough, but he had to wait more than 20 minutes for someone to come in and assist him. He indicated his catheter continued to hurt and leak everywhere during this time frame. He indicated he had respiratory problems and the staff often come in smelling like smoke from taking the smoking residents out. He indicated he had informed staff repeatedly that the smell bothers him. Resident #90 indicated he had informed the Administrator of his grievances a few days ago. During an interview on 8/18/15 at 3:32 p.m., Resident #90 indicated staff still came in smelling like smoke. He indicated no staff had come into to talk to him about his grievance since he had spoken with the Administrator. During an interview on 8/19/15 at 2:14 p.m., the Administrator indicated he remembered speaking with Resident #90 regarding his concern with his catheter leaking while staff took residents outside to smoke. The Administrator indicated he had spoken with the Unit Manager (UM) regarding the issue and had informed her to educate staff that resident care came before taking residents out to smoke. He indicated he was unaware the resident		**Executive Director met with the resident council, with their permission, to ensure the residents are aware of the grievance process. Grievance forms will be posted at each nurses' station for easy access.** ·whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur; **·Staff will be inserviced on the grievance process by Social Services on or before 9/18/15** **Staff who are non-compliant with the policy for grievances will be addressed with additional education and/or disciplinary action as needed. Executive Director/designee will review grievances daily to ensure appropriate investigation and follow up is completed per policy.** ·howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place; **· To ensure compliance, the Social Service Director/designee is responsible for the completion of the Grievance Resolution CQI tool weekly times 4 weeks, monthly times 6 and then quarterly to encompass all shifts until continued**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/21/2015
NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122	

(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
	had a concern with staff smelling like cigarette smoke when they came into his room to provide care. He indicated he did not complete a grievance form or investigation for the concern. He indicated the incident occurred on a Friday and the resident spoke to him on a Tuesday, so it had been a while and he believed the concern had been resolved. He indicated he did grievance investigation for things that were still unresolved such as missing laundry. He indicated he did not follow up with the resident or the situation, but had told Resident #90 the concern would be taken care of. During an interview on 8/19/15 at 4:09 p.m., Unit Manager (UM) #21 indicated she was aware of the resident's concern and had talked to the nurse and CNA. UM #21 indicated the nurse and CNA told her Resident #90 had to wait longer than he preferred, but was told it was not as long as the Resident had said. UM #21 indicated the staff had taken the residents who smoke out due to being short staffed and only having one CNA on the floor. She indicated she was unaware of Resident #90's concern regarding the staff smelling of smoke when they assisted him and she would make a written grievance for the resident. UM #21 indicated any concern a resident tells the		**compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95%is not achieved an action plan will be developed to ensure compliance**.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(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
	staff was considered a grievance and taken to social services. She indicated she had written a grievance form for Resident #90's concern with waiting for assistance while the staff assisted the smoking residents and had given it to the Social Services Director. During an interview on 8/20/15 at 2:46 p.m., the Social Service Director indicated she had just been informed of Resident #90's catheter grievance on 8/19/15 around 5 p.m., and spoke with Resident #90. She indicated the resident had told her he had a leaking catheter and was told he had to wait until the CNA took out the residents to smoke. She indicated he did not inform her of his concern regarding staff smelling like smoke. She indicated his concerns were concerns that should be submitted as grievances. The Nurse Consultant provided the current grievance policy on 8/20/15 at 9:53 a.m. The policy indicated grievance should be handled as soon as possible and the resident should be informed of the resolution. 3.1-7(a)(2)			
F 0223	483.13(b), 483.13(c)(1)(i)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 08/21/2015
NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122	

(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
SS=D Bldg. 00	FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on interview and record review, the facility failed to ensure residents were free from verbal abuse and/or mental abuse for 1 of 1 residents reviewed for abuse (Resident #23). Findings include: During an interview on 8/13/2015 at 9:32 a.m., Resident #23 indicated a former Certified Nursing Assistant (CNA) #33 had been verbally abusive toward her regarding her age and incontinence status. She indicated CNA #33 had "accused" her of having "accidents on purpose." Resident #23's record was reviewed on 8/17/2015 at 9:30 a.m. A Minimum Data Set assessment (MDS), dated 6/17/2015, indicated Resident #23 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 out of 15. During an interview on 8/13/2015 at 10:51 a.m., the Administrator indicated	F 0223	·whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice; **Resident #23 no longer resides in the facility.** ·howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken; **All residents have the potential to be affected. Allegations of abuse are reported in accordance with the state and facility policies. Staff will be educated on the Abuse Prohibition, Reporting and Investigation Policy by Social Service consultant/designee on or before 9/18/15** ·whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur; **Staff will be educated on the Abuse Prohibition, Reporting and Investigation Policy by Social Service consultant/designee on or**	09/20/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 08/21/2015
NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122	

(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
	Resident #23's allegations against CNA #33 had been reported to the appropriate entities when the incident occurred on 4/6/2015. CNA #33 had been terminated for serious violation of a residents rights. During an interview on 8/17/2015 at 10:31 a.m., the Administrator indicated he could not provide evidence a thorough investigation that had been conducted for Resident #23's allegations of abuse against CNA #33. He indicated staff and resident interviews regarding knowledge of abuse should have been conducted. During an interview on 8/19/2015 at 9:38 a.m., the Administrator indicated he is the facility's point of contact for abuse allegations. He indicated each reported allegation of abuse should be thoroughly investigated. A policy titled "Abuse Prohibition, Reporting, and Investigation" dated July 2015 and identified by the Director of Nursing (DON) as current on 8/13/2015 at 12:00 p.m., indicated, "...Abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain, or mental anguish. This includes deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, or		**before 9/18/15. Staff non-compliance with policy will be addressed with further education and/or disciplinary action as needed. Executive Director/designee will review each allegation of abuse to ensure the allegation is report and investigated per policy.** ·howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place; **To ensure compliance, the Social Service Director/designee is responsible for the completion of the Abuse Prohibition and Investigation CQI tool, which includes resident and staff interviews, weekly times 4 weeks, monthly times 6 and then quarterly to encompass allshifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance**.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155132		08/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(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
	psychosocial well being. This presumes that instances of abuse of all residents, even those in a coma, cause physical harm, or pain, or mental anguish...Verbal abuse is defined as oral, written, or gestured language that includes disparaging and derogatory terms to residents or their families, or within their hearing, regardless of their age, ability to comprehend, or disability. Examples would include, but are not limited to...scolding and/or speaking to them in harsh voices tones...This facility will not permit residents to be subjected to abuse by anyone, including employees...The Executive Director is the designated individual responsible for coordinating all efforts in the investigation of abuse allegations, and for assuring that all policies and procedures are followed. In the absence of the Executive Director, this responsibility will be delegated to the Director of Nursing Services...A comprehensive record of the abuse investigation is to be kept by the facility Executive Director and/or Director of Nursing Services...An investigation will be done to assure other residents have not been affected by the incident or inappropriate behavior, and the results documented...." 3.1-27(a)(1) 3.1-27(b)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	155132		08/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(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
F 0225 SS=D Bldg. 00	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. 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). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. 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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 08/21/2015
NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122	

(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
	be taken. Based on interview and record review, the facility failed to ensure an allegation of staff abuse to a resident was thoroughly investigated for 2 of 3 residents reviewed for reported alleged abuse violations (Resident #23 and #62). Findings include: 1. During an interview on 8/13/2015 at 9:32 a.m., Resident #23 indicated a former Certified Nursing Assistant (CNA) #33 had been verbally abusive toward her regarding her age and incontinence status. She indicated CNA #33 had "accused" her of having "accidents on purpose." Resident #23's record was reviewed on 8/17/2015 at 9:30 a.m. A Minimum Data Set assessment (MDS), dated 6/17/2015, indicated Resident #23 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 out of 15. 2. An "Incident Report" dated 6/25/2015, and provided by the Administrator for review on 8/18/2015 at 10:55 a.m., indicated Resident #62 had presented with a bruise on her left hand. Resident #62 and her family had indicated the bruise occurred as a result of a transfer the Certified Nursing Assistant (CNA)	F 0225	·whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice; · **Resident #23 no longer resides in the facility. Resident #62 has had no further concerns with care provided bythe staff.** ·howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken; **All residents have the potential to be affected. Allegations of abuse are reported in accordance with the state and facility policies. Staff, including the Executive Director, will be educated on the Abuse Prohibition, Reporting and Investigation Policy by Social Services consultant/designee on or before 9/18/15** ·whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur; · **Staff, including Executive Director, will be educated on the Abuse Prohibition, Reporting and Investigation Policy by Social Services/designee on or before 9/18/15. Staff non-compliance with policy will be addressed**	09/20/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 08/21/2015
NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122	

(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
	#34 had completed. Resident #62 had indicated CNA #34 was too "rough" during the transfer. During an interview on 8/13/2015 at 10:51 a.m., the Administrator indicated Resident #23's allegations against CNA #33 had been reported to the appropriate entities when the incident occurred on 4/6/2015. CNA #33 had been terminated for serious violation of a residents rights. During an interview on 8/17/2015 at 10:31 a.m., the Administrator indicated he could not provide evidence a thorough investigation that had been conducted for Resident #23's allegations of abuse against CNA #33. He indicated staff and resident interviews regarding knowledge of abuse should have been conducted. During an interview on 8/18/2015 at 10:55 a.m., the Administrator indicated he could not provide evidence of a thorough investigation regarding Resident #62's complaint a staff member was "rough" during a transfer. During an interview on 8/19/2015 at 9:38 a.m., the Administrator indicated he was the facility's point of contact for abuse allegations. He indicated each reported allegation of abuse should be thoroughly investigated.		**with further education and/or disciplinary action as needed. ExecutiveDirector/designee will review each allegation of abuse to ensure the allegationis report and investigated per policy.** ·howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place; **To ensure compliance, the Social Service Director/Designee is responsible for the completion of the Abuse Prohibition and Investigation CQI tool, which includes resident and staff interviews, weekly times4 weeks, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an actionplan will be developed to ensure compliance.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/21/2015
NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122	

(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
	A policy titled "Abuse Prohibition, Reporting, and Investigation" dated July 2015 and identified by the Director of Nursing (DON) as current on 8/13/2015 at 12:00 p.m., indicated, "...Abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain, or mental anguish. This includes deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, or psychosocial well being. This presumes that instances of abuse of all residents, even those in a coma, cause physical harm, or pain, or mental anguish...Verbal abuse is defined as oral, written, or gestured language that includes disparaging and derogatory terms to residents or their families, or within their hearing, regardless of their age, ability to comprehend, or disability. Examples would include, but are not limited to...scolding and/or speaking to them in harsh voices tones...This facility will not permit residents to be subjected to abuse by anyone, including employees...The Executive Director is the designated individual responsible for coordinating all efforts in the investigation of abuse allegations, and for assuring that all policies and procedures are followed. In the absence of the Executive Director,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/21/2015
NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122	

(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
	this responsibility will be delegated to the Director of Nursing Services...A comprehensive record of the abuse investigation is to be kept by the facility Executive Director and/or Director of Nursing Services...An investigation will be done to assure other residents have not been affected by the incident or inappropriate behavior, and the results documented...." 3.1-28(d)			
F 0226 SS=D Bldg. 00	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 ensure an allegation of staff abuse to a resident was thoroughly investigated for 2 of 3 residents reviewed for reported alleged abuse violations (Resident #23 and #62). Findings include: 1. During an interview on 8/13/2015 at 9:32 a.m., Resident #23 indicated a former Certified Nursing Assistant (CNA) #33 had been verbally abusive	F 0226	·whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice; **Resident #23 no longer resides in the facility. Resident #62 has had no further concerns with care provided bythe staff.** ·howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken; · **All residents have the potential to beaffected.**	09/20/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 08/21/2015
NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122	

(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
	toward her regarding her age and incontinence status. She indicated CNA #33 had "accused" her of having "accidents on purpose." Resident #23's record was reviewed on 8/17/2015 at 9:30 a.m. A Minimum Data Set assessment (MDS), dated 6/17/2015, indicated Resident #23 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 out of 15. 2. An "Incident Report" dated 6/25/2015, and provided by the Administrator for review on 8/18/2015 at 10:55 a.m., indicated Resident #62 had presented with a bruise on her left hand. Resident #62 and her family had indicated the bruise occurred as a result of a transfer the Certified Nursing Assistant (CNA) #34 had completed. Resident #62 had indicated CNA #34 was too "rough" during the transfer. During an interview on 8/13/2015 at 10:51 a.m., the Administrator indicated Resident #23's allegations against CNA #33 had been reported to the appropriate entities when the incident occurred on 4/6/2015. CNA #33 had been terminated for serious violation of a residents rights. During an interview on 8/17/2015 at 10:31 a.m., the Administrator indicated		**Allegations of abuse are reported inaccordance with the state and facility policies. Staff, including Executive Director, will be educated on the Abuse Prohibition, Reporting and Investigation Policy by Social Service consultant/designee on orbefore 9/18/15** ·whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur; · **Staff, including Executive Director, will be educated on the Abuse Prohibition, Reporting and Investigation Policy by Social Service consultant/designee on or before 9/18/15. Staff non-compliance with policy will be addressed with further education and/or disciplinary action as needed. Executive Director/designee will review each allegation of abuse to ensure the allegation is report and investigated per policy.** ·howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place; · **To ensure compliance, the Social Service Director/Designee is responsible for the completion of the Abuse Prohibition and Investigation CQI tool, which**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155132		08/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(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
	he could not provide evidence a thorough investigation that had been conducted for Resident #23's allegations of abuse against CNA #33. He indicated staff and resident interviews regarding knowledge of abuse should have been conducted. During an interview on 8/18/2015 at 10:55 a.m., the Administrator indicated he could not provide evidence of a thorough investigation regarding Resident #62's complaint a staff member was "rough" during a transfer. During an interview on 8/19/2015 at 9:38 a.m., the Administrator indicated he was the facility's point of contact for abuse allegations. He indicated each reported allegation of abuse should be thoroughly investigated. A policy titled "Abuse Prohibition, Reporting, and Investigation" dated July 2015 and identified by the Director of Nursing (DON) as current on 8/13/2015 at 12:00 p.m., indicated, "...The Executive Director is the designated individual responsible for coordinating all efforts in the investigation of abuse allegations, and for assuring that all policies and procedures are followed. In the absence of the Executive Director, this responsibility will be delegated to the Director of Nursing Services...A		**includes resident and staff interviews, weekly times 4 weeks, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155132		08/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(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
	comprehensive record of the abuse investigation is to be kept by the facility Executive Director and/or Director of Nursing Services...An investigation will be done to assure other residents have not been affected by the incident or inappropriate behavior, and the results documented...." 3.1-28(a) 3.1-28(d)			
F 0241 SS=D Bldg. 00	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, interview, and record review, the facility failed to ensure a resident's Foley catheter collection bag was covered in a dignity pouch while in the dining room, staff announced their presence, and explained care prior to working with a resident for 1 of 3 observations of staff to resident interactions (Resident G). Findings include: On 8/14/2015 at 11:27 a.m., Resident G	F 0241	·whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice; **The catheter for Resident #G is covered with a dignity pouch. Staff are now explaining care to be provided prior to providing care.** ·howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken; · **All catheter bags were inspected by the**	09/20/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/21/2015
NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122	

(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
	was observed in Pathways dining room with his Foley catheter collection bag hanging from his wheelchair without a protective dignity pouch. On 8/14/2015 at 11:29 a.m., Unit Manager (UM) #32 was observed to come up behind Resident G in the Pathways dining room while he was being interviewed. UM #32 placed the Resident's Foley catheter bag into a privacy bag without first announcing her presence to Resident G or explaining the care she was providing. On 8/14/2015 at 11:30 a.m., Resident G asked if someone was behind his wheelchair. UM #32 did not respond to the Resident's question or explain what she was doing. UM #32 indicated she was done working with Resident G while standing behind the resident and without addressing the resident by name. Resident G indicated he was unsure who was talking to him and did not know what was going on. During an interview on 8/19/2015 at 4:16 p.m., UM #32 indicated staff was to explain the tasks or procedures they were going to do to residents before it was done. On 8/21/2015 at 12:02 p.m., the Nurse Consultant indicated the facility did not have a policy regarding dignity with care.		**NurseManager to ensure dignity bag was in place. Staff will be inserviced by Social Services on providing dignity and respect to residents at all times on or by9/18/15.** ·whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur; **Staff will be inserviced by Social Services on providing dignity and respect at all times on or by 9/18/15. Charge nurses, nurse managers and department heads will monitor that staff interactions with residents are appropriate and respectful and that catheter bags have dignity pouches in place on each shift. Inappropriate or disrespectful interactions will be addressed immediately with further education and/or disciplinary action as needed.** ·howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place; · · **To ensure compliance, the DNS/Designee is responsible for the completion of the Dignity and Privacy CQI tool weekly times 4 weeks, monthly times 6 and then quarterly to encompass all shifts until continued compliance is**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155132		08/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(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
	3.1-3(t)		**maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.**	
F 0242 SS=D Bldg. 00	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on interview and record review, the facility failed to ensure residents' choices were honored regarding when to get up in the morning and go to bed at night for 1 of 3 residents reviewed who met the criteria for choices (Resident C). Findings include: During an interview on 8/12/15 at 2:03 p.m., Resident C indicated she had not been asked what her preferred bed times were. She indicated they had her up before 7:00 a.m. and if she had her preference she would sleep "later." She indicated she was put to bed around 7:00 p.m. and she would prefer to stay up a	F 0242	·whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice; **Resident #C was interviewed regarding her preferences for times to get up and to go to bed. The care plan for resident #C has been changed to reflect her preferences for times to get up and to go to bed.** ·howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken; · **All residents have the potential to be affected. All residents will be interviewed for preferences for daily customary routines and the**	09/20/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/21/2015
NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122	

(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
	"little later." She indicated she had not complained she just does what they tell her. Resident C's record was reviewed on 8/18/15 at 9:30 a.m. A Minimum Data Set (MDS) assessment, dated 7/7/15, indicated Resident C had some cognition deficit with a Brief Interview Mental Status (BIMS) score of 7 out of 15. A MDS, dated 5/7/15, indicated Resident C was dependent on staff for transfers and had indicated it was somewhat important to her to choose her bedtime. During an interview on 8/20/2015 at 9:58 a.m., the Nurse Consultant indicated documentation which indicated Resident C had been assessed for bed time preferences was not available. During an interview on 8/20/2015 at 12:21 p.m., the facility's Customer Care Coordinator indicated the facility recently implemented procedures to assess new residents regarding preferences for bed times. She indicated existing residents were being assessed quarterly when their care plans were due to be updated. She indicated she had not assessed Resident C for preferences regarding bed time preferences. During an interview on 8/20/2015 at		**care plans will be up dated to reflect preferences. Staff will be educated by Social Services on or before 9/18/15 regarding honoring resident preferences** · what measures will be put into place orwhat systemic changes will be made to ensure that the deficient practice doesnot recur; **Staff will be educated by Social Services on or before 9/18/15 regarding honoring resident preferences. All residents will be interviewed for preferences for daily customary routines and care plans updated to reflect preferences. Staff non-compliance with honoring preferences will be addressed with further education and/or disciplinary action as needed. DNS/designee will make rounds in the morning and evening to ensure preferences are followed.** ·howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place; · · **To ensure compliance, the Social Service Director /Designee is responsible for the completion of the Accommodation of Needs CQI tool weekly times 4 weeks, monthly times 6 and then quarterly to encompass all**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155132		08/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(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
	12:25 p.m., CNA #80 indicated she got Resident C out of bed "around 7:00 a.m." She indicated she knew residents' preference regarding get up times because she asked them if they "were ready to get up." A procedure titled "Personal Needs" identified as a current procedure by the Nurse Consultant on 8/20/15 at 9:58 a.m., indicated, "...The Plan of Care will address the individual needs and preferences of the resident. ADL (Activity of Daily Living) support will be provided according to the resident's Plan of Care...." 3.1-3(u)(1)		**shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.**	
F 0279 SS=E Bldg. 00	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/21/2015
NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122	

(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
	mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).			
	A. Based on observation, interview, and record review, the facility failed to ensure residents' care plans addressed individualized interventions to reduce pressure and promote healing of pressure ulcers for 2 of 2 residents reviewed for care plans related to pressure ulcers (Resident F and G). B. Based on observation, interview, and record review, the facility failed to ensure a resident's care plan specified individual preferences related to catheter care for 1 of 3 residents reviewed for catheters (Resident G). Findings include: A1. During an interview on 8/13/2015 at 9:24 a.m., Licensed Practical Nurse (LPN) #31 indicated Resident F had a stage 3 pressure ulcer (full thickness skin loss) to her 5th metatarsal (toe) on the right foot. During an observation on 8/13/15 at 1:48 p.m., Resident F was observed to wear bilateral foam boots to both feet, with her	F 0279	·whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice; **The care plans for resident #F and resident #G have been updated withindividualized interventions that reduce pressure and promote healing ofwounds. Resident G's care plan was alsoupdated to reflect his individual preferences regarding catheter care.** ·howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken; · **·Residents withwounds and catheters have the potential to be affected.** **·The care plansfor residents with wounds and catheters have been reviewed and updated toreflect interventions that reduce pressure and promote healing of wounds andwith individualized interventions for catheter care.** **·Staff will beinserviced by the DNS/designee regarding including individualized interventionsand/or**	09/20/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/21/2015
NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122	

(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
	right leg contracted, bent outward toward the right. The right side of her foot and right 5h metatarsal was observed laying flat against a heel lift device that was beneath her foot. During an observation on 8/17/2015 at 11:12 a.m., with Wound Nurse #35 present, Resident F's right leg was observed to be contracted, bent outward toward the right, with a foam boot on her right foot. The right side of Resident F's foot was observed laying flat against a heel lift device that had been in place under her foot. Resident F's pressure ulcer was observed. Wound Nurse #35 measured the pressure ulcer and indicated the pressure ulcer measured 2.2 centimeters by 1.5 centimeters with a depth of 1.9 centimeters with 0.2 centimeters of bone exposed on the distal edge. She indicated the pressure ulcer had changed from a stage 3 pressure ulcer to a stage 4 pressure ulcer (full thickness tissue loss). During an observation on 8/17/2015 at 2:35 p.m., with Registered Nurse (RN) #36 present, Resident F's right foot was observed in a foam boot, with the right side of the foot laying flat against the heel lift device on her bed. During an observation on 8/19/2015 at		**preferences related to wound healing and catheter care.** ·whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur; . **·Staff will beinserviced by the DNS/designee regarding including individualized interventionsand/or preferences related to wound healing and catheter care on care plans.** **·The care plansfor residents with wounds will be reviewed weekly by the Interdisciplinary Teamand will be updated to reflect interventions to promote wound healing.** **·Newly admittedresidents with catheters will be reviewed using the Interdisciplinary TeamAdmission Review tool to ensure the care plan reflects individualizedinterventions regarding catheter care.** **·Currentresidents who receive a new order to place a catheter will have a care plandeveloped that reflects individualized interventions for catheter care** ·howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place; **· To ensure compliance, the**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 08/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(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
	10:32 a.m., with Certified Nursing Assistant (CNA) #34 present, Resident F was observed positioned on her left side, with her right leg contracted outward, toward the right. Her right foot was observed in a foam boot, with the right side of the foot laying flat against the heel lift device under her foot on the bed. Resident F's record was reviewed on 8/17/2015 at 11:40 a.m. Resident F's diagnoses included, but were not limited to, cerebrovascular accident (CVA), hemiplegia (paralysis of one side), and renal (kidney) failure, A Quarterly Minimum Data Set assessment (MDS), dated 3/10/2015, indicated Resident F was at risk for development of pressure ulcers by clinical assessment. Skin treatments included turning and repositioning. A Significant Change MDS, dated 6/25/15, indicated Resident F had a Stage 3 pressure ulcer with measurements of 1.8 centimeters by 2.4 centimeters with a depth of 0.8 centimeters. Skin and ulcer treatment included a pressure reducing device for her bed. Resident F was totally dependent upon the assistance of at least two employees for bed mobility, which included turning side to side and positioning body while in bed. Resident F had functional limitation in range of motion, with impairment on both sides of		**DNS/Designee is responsible for thecompletion of the Skin Management CQItool and Catheter CQI tool weekly times 4 weeks, monthly times 6 and thenquarterly to encompass all shifts until continued compliance is maintained for2 consecutive quarters. The results of these audits will be reviewed by the CQIcommittee overseen by the ED. Ifthreshold of 95% is not achieved an action plan will be developed to ensurecompliance.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/21/2015
NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122	

(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
	her lower extremities, which included her hip, knee, ankle and foot. A skin integrity care plan, dated 6/22/2015, indicated Resident F was at high risk for skin breakdown and required increased frequency of turning and a pressure reduction support surface. Interventions included implementing an individualized turning schedule if applicable and to protect heels if exposed to friction. During an interview on 8/17/2015 at 11:19 a.m., Wound Nurse #35 indicated a heel lift device was placed under Resident F's legs to off-load her heels. She indicated Resident F was not capable of staying in this position for long due to her leg contractures. She indicated her pressure ulcer had received pressure from improper positioning of her right foot laying flat on the heel lift device when she moved her leg and staff were unable to continually watch her to ensure she had not caused pressure to her right 5th metatarsal by moving her legs. During an interview on 8/17/2015 at 2:35 p.m., RN #36 indicated Resident F's right foot had not been properly positioned with the right side of her foot laying flat against the heel lift device. She indicated Resident F should have been			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(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
	repositioned. During an interview on 8/17/2015 at 3:22 p.m., Resident F's Physician indicated her heels were to remain off-loaded and pressure was to be kept off of the area of her right 5th metatarsal in order to promote healing. During an interview on 8/17/2015 at 3:36 p.m., Wound Nurse #35 indicated a specialized turning schedule had been recommended for Resident F, but Resident F had been put on an every 2 hour turn and reposition program. She indicated turning and repositioning Resident F every 2 hours had been too long of a time lapse due to the Resident would pull her contracted right leg out of position and cause pressure to her right 5th metatarsal pressure ulcer. She indicated the resident should not have any pressure on that area. A2. During an interview on 8/12/15 at 2:03 p.m., Licensed Practical Nurse #24 indicated Resident G had a stage 3 pressure ulcer on his left heel. On 8/19/2015 at 10:31 a.m., Resident G was observed in bed with a bridge pillow under his legs, his heels laying against the mattress, and no boots were observed on his feet.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(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
	The form titled,"Skin Grid-Pressure/Venous Insufficiency Ulcer/Other" form, dated 2/8/15, indicated Resident G had a new stage 2 pressure ulcer on his left heel. The "Skin Grid-Pressure/Venous Insufficiency Ulcer/Other" form, dated 5/18/15, indicated the stage 2 pressure ulcer on the resident's left heel had become a full thickness stage 3 pressure ulcer. The physician telephone orders, dated 8/5/15, ordered a Podus boot to be wore when Resident G was out of bed and was to have his heel up in bed due to his left heel stage 3 pressure ulcer. The physician order summary, dated 8/11/15, indicated the resident had an order from 2/10/15 to bridge heels up in bed and wear bilateral boots while in bed. The "Skin Integrity Assessment: Prevention and Treatment Plan of Care," 7/14/15, indicated Resident G was at moderate risk for skin integrity issues, the resident was to be on a turn schedule, the resident's heels were to be protected, was to wear a Podus boot on the his left foot, and use a Trapeze when indicated. The care plan did not indicate how often the resident was to be turned, when the Podus boot was to be wore, or to bridge the resident's heels up in bed.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(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
	B 1. During an interview on 8/12/15 at 2:03 p.m., Licensed Practical Nurse #24 indicated Resident G had a indwelling urinary catheter. During an interview on 8/19/15 at 10:46 a.m., LPN #24 indicated Resident G's penis had a skin split and he did not like to wear a leg catheter strap to secure device the catheter tubing. She indicated both the alteration in the resident's anatomy and his preference to not wear the catheter strap were or were to be included in the care plan. On 8/19/2015 at 10:46 a.m., Resident G was observed in bed during catheter care without a urinary leg secure strap for the Foley tubing, and his penis skin was observed to be split. Resident G's record was reviewed on 8/18/15 at 10:07 a.m. The physician order summary, dated 8/11/15, ordered an indwelling urinary catheter due to chronic urinary retention, the urinary catheter was to be changed monthly on the 2nd of the month, and catheter care was to be done every shift. The physician telephone order, dated 8/6/15 ordered the rocephin (antibiotic) 1 gram intramuscularly now for a urinary			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(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
	tract infection. The physician telephone order indicated the resident's care plan needed to be updated to include the following interventions: give antibiotics, monitor urine output, and perform catheter care every shift. The physician telephone order, dated 8/8/15 ordered the rocephin (antibiotic) 1 gram intramuscularly daily for 8 days for a urinary tract infection. The physician telephone order indicated the resident's care plan needed to be updated to include the following interventions: give antibiotics, monitor urine output, and perform catheter care every shift. The physician telephone order, dated 8/10/15 ordered the rocephin (antibiotic) 1 gram intramuscularly daily for 5 days for a urinary tract infection. The physician telephone order indicated the resident's care plan needed to be updated to include the following interventions: give antibiotics, obtain a follow up urine culture and urinalysis, and use sterile technique to change the urinary catheter. The "Catheter Plan of Care," revised on 6/4/15, indicated Resident G had urinary retention that could not be corrected surgically or medically. The care plans interventions were last updated on 5/7/15. The care plan did not include			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(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
	care plan updates listed on physician telephone orders. The care plan did not include the information regarding Resident G altered anatomy or his preference to not wear the catheter secure device. The Care Plan for "Indwelling Catheter," dated 8/14/15, indicated Resident G had a indwelling catheter, but did not include interventions regarding the Resident G's antibiotic treatment, the resident's altered anatomy, or the resident's preference not to wear the catheter secure device. The current care plan policy was provided on 8/20/15 at 9:55 a.m., by the Nurse Consultant. The policy indicated care plans should "document additional resident information that is not included in other assessments/plans of care" and include "specific individualized interventions." This Federal tag relates to Complaint IN00178593. 3.1-35(a)			
F 0282 SS=E Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/21/2015
NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122	

(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
	facility must be provided by qualified persons in accordance with each resident's written plan of care.			
	Based on observation, record review, and interview, the facility failed to follow physician's orders for daily weights and range of motion for 3 of 24 residents reviewed for following physician's orders (Residents B, C, and D). Findings include: 1. Resident C's record was reviewed on 8/18/15 at 9:30 a.m. Resident C had diagnoses which included, but were not limited to, post surgical hip repair, edema, and pneumonia. A physician's order, dated 5/29/15, indicated an order for Lasix (diuretic) 40 mg (milligrams) now, Lasix 40 mg daily, and daily weights. The record lacked indication the facility obtained daily weights as ordered. 2. Resident D's record was reviewed on 8/18/2015 at 1:50 p.m. Resident D had diagnoses which included, but were not limited to, heart failure and kidney failure. An acute care discharge note, dated 6/24/15, indicated Resident D was admitted to the hospital from the facility	F 0282	·whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice; **Physician orders are being followed for resident #B's ROM daily and forresidents #C and D's daily weights.** ·howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken; · **All residents have the potential to be affected. Physician orders are reviewed by the Nurse Manager to ensure physician orders were followed and documented. Nursing staff will be educated regarding following physician orders by the DNS/designee on or before 9/18/15** ·whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur; · **Nursing staff will be educated regarding following physician orders by the DNS/designee on or before 9/18/15 Residents' records will be monitored daily by a nurse manager for documentation to support that physician's orders will be followed. Records that lack documentation will be**	09/20/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/21/2015
NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122	

(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
	on 6/22/15 due to "acute on chronic systolic congestive heart failure." This note indicated she presented with fluid overload and was diuresed during her hospital stay. This note indicated she was discharged back to the facility on 6/24/15, with orders that included "Weights will be monitored daily at the nursing home and her physician will be notified of greater than 5 pounds of weight gain." The record lacked indication Resident D's weight was monitored daily as ordered. During an interview on 8/20/15 at 11:58 a.m., Registered Nurse #92 indicated when a resident was admitted all admission orders should be reviewed and verified with a physician. During an interview on 8/21/15 at 10:26 a.m., the Nurse Consultant indicated documentation which indicated Resident C's or Resident D's weight was monitored daily as ordered was not available. A procedure titled "Admission Orders" identified as current by the Nurse Consultant on 8/20/15 at 3:57 p.m., indicated, "...Resident Admitted from hospital, LTC center, ER, etc. Review the transfer orders (if from another		**addressed with the nurse responsible and will include further education and disciplinary action if indicated.** ·howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place; · **To ensure compliance, the DNS/Designee is responsible for the completion of the Refusal of Medication/Treatment CQI tool weekly times 4 weeks, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155132		08/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(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
	long-term care center or hospital). Contact the attending Physician as soon as possible upon admission (if attending Physician is not the transferring Physician) to confirm orders... Review the transfer orders with the attending Physician and obtain approval... Transcribe the approved transfer orders and any further orders onto the Physician's Order Sheet...." 3. Resident B's record was reviewed on 8/14/15 at 10:03 a.m. Resident B had diagnoses which included, but were not limited to, quadriplegic and contractures. A Minimum Data Set (MDS) assessment, dated 6/24/15, indicated Resident B was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 out of 15, had functional limitation range of motion (ROM) impairment on both sides to his upper and lower extremities, and was totally dependent on two plus staff for mobility. An untimed physician's order, dated 2/19/15, indicated Resident B had an order for full body range of motion for twenty minutes every day. The record lacked indication ROM/RNP (Range of Motion/Restorative Nursing Services) were provided as recommended by therapy and ordered by the physician.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/21/2015
NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122	

(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
	A nurse's not dated, 8/5/15 at 2:00 a.m., indicated, "...Resident inquired about ROM. Writer informed Res [Resident] that with 1 nurse and 1 cna we would not be able to perform ROM, writer told res writer would pass it on for day shift to do...." The record lacked indication ROM/RNP was provided to Resident B prior to 8/7/15 at 3:00 a.m. During an interview on 8/17/2015 at 12:55 p.m., Registered Nurse (RN) # 61 indicated she was unable to locate Resident B's RNP. She further indicated CNAs did not document ROM/restorative services provided to residents. During an interview on 8/17/2015 at 1:37 p.m., the Director of Nursing (DON) indicated the facility did not have a system to ensure the ROM was done. During an interview on 8/17/15 at 2:30 p.m., the MDS Nurse indicated she was currently responsible for the Restorative Program. She indicated she was unable to find documentation which indicated Resident B had been provided PROM per therapy's recommendations. She further indicated the facility had not had someone to monitor the system to ensure restorative programs/ROM were being			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 08/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(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
	done, done correctly, or CNAs were trained to do it correctly. She indicated the current system "was broken" and they were not being trained on the new system until September 1, 2015. This Federal tag relates to Complaint IN00178593. 3.1-35(g)(2)			
F 0309 SS=D Bldg. 00	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on record review and interview, the facility failed to ensure assessments and communication of care and health status for 1 of 1 resident reviewed for dialysis (Resident #16). Findings include: Resident #16's record was reviewed on 8/20/15 at 12:25 p.m. Resident #16 had a diagnosis which included, but was not limited to, kidney failure.	F 0309	·whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice; **Resident16 receives pre and post-dialysis assessments per physician orders.** ·howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken; **All other residents with physician orders for pre and post dialysis assessments were reviewed by**	09/20/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/21/2015
NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122	

(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
	A physician's order dated 8/11/10, indicated a dialysis order for Resident #16. A physician's order dated 8/27/14, indicated an order for pre and post weights on dialysis days on Monday, Wednesday, and Friday. The record lacked indication pre and post weights on dialysis days had consistently been obtained or communication between the dialysis provider and the facility had consistently occurred. Resident #16's record lacked indication the following assessments had been obtained: Dialysis date 7/6/15, a post dialysis weight. Dialysis date 7/15/15, a post dialysis or an assessment of Resident #16 access site post dialysis. Dialysis date 7/17/15, a pre dialysis weight or a post dialysis assessment of Resident #16's access site. Dialysis date 7/22/15, a pre dialysis weight or an assessment of Resident #16's access site post dialysis. Dialysis date 7/29/15, assessment by the dialysis provider, pre or post dialysis weights, or an assessment post dialysis by		**the nurse manager to ensure physician orders are being followed. Licensed nursing staff will be educated regarding completing pre and post-dialysis assessments per the physician orders and obtaining health information from the dialysis center by the DNS/designee on or before 9/18/15.** ·whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur; · **Licensed nursing staff will be educated regarding completing pre and post-dialysis assessments per the physician orders and obtaining health information from the dialysis center by the DNS/designee on or before 9/20/15. Nurse Manager will review documentation of pre and post-dialysis assessments and completion of dialysis appointment form, which includes pre and post-dialysis vital signs and other communication completed by dialysis. Dialysis will be contacted by the nurse on duty if dialysis information is not completed. If documentation is incomplete, the nurse responsible will be addressed with further education and disciplinary action if needed.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/21/2015
NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122	

(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
	the facility. Dialysis date 8/3/15, assessment by the dialysis provider. A dialysis date 8/10/15, a post dialysis weight. Dialysis date 8/19/15, an assessment by the dialysis provider or pre and post dialysis weights. During an interview on 8/20/2015 at 12:34 p.m., Registered Nurse (RN) #85 indicated the facility utilized a dialysis communication form. She indicated the facility sent the form with the resident and upon the residents return it was reviewed for completion. RN #85 indicated if was not completed they would contact the Dialysis provider and obtain the missing information. She indicated in addition, the facility documented the residents post dialysis status on the form and all forms were kept in the dialysis communication book. RN #85 indicated Resident #16 attended Dialysis three days a week on Monday, Tuesday, and Wednesday. During an interview on 8/21/15 at 9:45 p.m., the Director of Nursing indicated no further documentation regarding Resident #16's dialysis assessments were		·howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place; · **To ensure compliance, the DNS/Designee is responsible for the completion of the Dialysis CQI tool weekly times 4 weeks, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 08/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(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
	located. A procedure titled "Dialysis Management" identified as current by the Nurse Consultant on 8/20/15 at 3:19 p.m., indicated, "...implemented processes which strive to ensure the comfort, safety, and appropriate management of hemodialysis resident regardless if the procedure is performed at the dialysis center or... facility... will utilize the Dialysis Center Communication Record for continuity of care between the facility and dialysis unit...Assure daily assessment and documentation of fistula or graft site. Document the post dialysis (dry weight) obtained by the dialysis center... after each dialysis treatment, or as determined by the Interdisciplinary Team (IDT) in collaboration with the dialysis center...Check AV fistula/graft site function by palpating thrill and listening for bruit daily and upon return post dialysis and document on TAR (treatment administration records). 3.1-37(a)			
F 0312 SS=D Bldg. 00	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/21/2015
NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122	

(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
	A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, record review, and interview, the facility failed to ensure residents who were unable to carry out activities of daily living received oral care for 1 of 2 residents reviewed for activity of daily living. (Resident #55). Findings include: Resident #55's teeth were observed to have a large amounts of yellow and debris on and around his teeth and gum line on 8/13/15 at 9:54 a.m., 8/18/15 at 10:55 a.m., 8/19/15 at 10:50 a.m., and 8/20/15 at 8:27 a.m. Resident #55's record was reviewed on 08/18/2015 at 8:33 a.m. Resident #55 had diagnoses which included, but were not limited to, contractures and easily fatigued. A Minimum Data Set (MDS) assessment, dated 6/25/15, indicated Resident #55 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 out of 15 and required extensive physical assistance of one staff for personal hygiene. A care plan, dated 6/26/15, indicated Resident #55 had an activities of daily	F 0312	·whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice; **Resident #55 is receiving oral care per his preference.** ·howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken; · **·All residentswere interviewed by Customer Care Representative to ensure residents arereceiving oral care per the residents' preferences.** **·Nursing staffwill be educated on providing oral care daily per the resident's preference bythe DNS/designee on or before 9/18/15.** ·whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur; **·Nursing staffwill be educated on providing oral care daily per the resident's preference bythe DNS/designee on or before 9/18/15. Residentswill be observed daily for evidence of oral care by the charge nurses, customercare representatives and nurse managers. Oral care**	09/20/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 08/21/2015
NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122	

(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
	living deficit related to generalized weakness. Interventions to ensure his personal hygiene was provided included oral care daily and as needed. During an interview on 8/18/2015 at 10:55, Resident #55 indicated he did not receive the assistance from staff for oral care. He indicated staff "never" brushed his teeth. During an interview on 8/19/2015 at 10:50 a.m., Unit Manager #70 indicated day shift was responsible for Resident #55's a.m., care. During an interview on 8/20/2015 at 8:27 a.m., Registered Nurse (RN) #71 indicated she was working as the aide and she had provided Resident #55 with a.m., care. She indicated she had not brushed his teeth During an interview on 8/20/2015 at 8:27 a.m., the Director of Nursing indicated documentation of oral care was not available. She indicated staff documented when a.m., care was provided and a.m., care included oral care. During an interview on 8/20/2015 at 8:29 a.m., Resident #55 indicated he used to brush his teeth in the evening but he		**will be provided right awayfor residents in need of oral care.** ·howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place; · **To ensure compliance, the Social Service Director/Designee isresponsible for the completion of the Accommodation of Needs CQI tool weeklytimes 4 weeks, monthly times 6 and then quarterly to encompass all shifts untilcontinued compliance is maintained for 2 consecutive quarters. The results ofthese audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an actionplan will be developed to ensure compliance.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155132		08/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(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
	could no longer reach the tooth brush or turn the water on. He indicated his teeth had not been brushed that morning. During an interview on 8/20/2015 at 8:30 a.m., RN #71 indicated Resident #55 had declined physically and couldn't brush his own teeth even if he was able to reach the brush and water. During an interview on 8/20/2015 at 11:36 a.m., CNA #80 indicated she had not provided oral care to Resident #55 during a.m., care. A procedure titled "Personal Needs" identified as a current procedure by the Nurse Consultant on 8/20/15 at 9:58 a.m., indicated, "...ADL (Activity of Daily Living) support will be provided according to the resident's Plan of Care... Personal care and support includes but is not limited to the following:...Mouth Care...." 3.1-38(3)(C)			
F 0314 SS=G Bldg. 00	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/21/2015
NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122	

(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
	sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, interview, and record review, the facility failed to ensure individualized interventions were implemented and pressure reducing devices were placed effectively to reduce pressure and prevent an increase from a stage 3 pressure ulcer (full thickness skin loss) to a stage 4 pressure ulcer (full thickness tissue loss) for 1 of 2 residents reviewed for pressure ulcers that had developed within the facility (Resident F), and failed to prevent an increase from a stage 2 pressure ulcer (partial thickness) to a stage 3 pressure ulcer for 1 of 2 residents reviewed for pressure ulcers (Resident G). Findings include: 1. During an interview on 8/13/2015 at 9:24 a.m., Licensed Practical Nurse (LPN) #31 indicated Resident F had a stage 3 pressure ulcer (full thickness skin loss) to her 5th metatarsal (toe) on the right foot. During an observation on 8/13/15 at 1:48 p.m., Resident F was observed to wear	F 0314	·whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice; **Interventions to promote wound healing were reviewed for resident #Fand resident #G. Interventions to promote wound healing are in place forresident #F and resident #G per physicians' orders.** ·howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken; · **Residents with wounds were reviewed by theNurse Manager to ensure interventions are in place per physician orders andcare plan.** **Nursing staff will be educatedregarding wound prevention and interventions to promote wound healing by theDNS/designee on or before 9/18/15** ·whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur; · **Nursing staff will be educated regardingwound prevention and interventions to**	09/20/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 08/21/2015
NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122	

(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
	bilateral foam boots to both feet, with her right leg contracted, bent outward toward the right. The right side of her foot was observed laying flat against a heel lift device device on the bed beneath her foot. During an observation on 8/17/2015 at 11:12 a.m., with Wound Nurse #35 present, Resident F's right leg was observed to be contracted, bent outward toward the right, with a foam boot on her right foot. The right side of Resident F's foot was observed laying flat against a heel lift device that had been in place under her foot. Resident F's pressure ulcer was observed. Wound Nurse #35 measured the pressure ulcer and indicated the pressure ulcer measured 2.2 centimeters by 1.5 centimeters with a depth of 1.9 centimeters with 0.2 centimeters of bone exposed on the distal edge. She indicated the pressure ulcer had changed from a stage 3 pressure ulcer to a stage 4 pressure ulcer (full thickness tissue loss). During an observation on 8/17/2015 at 2:35 p.m., with Registered Nurse (RN) #36 present, Resident F's right foot was observed in a foam boot, with the right side of her foot laying flat against the heel lift device under her foot.		**promote wound healing by the DNS/designeeon or before 9/18/15 Residents with wounds will bereviewed by the Interdisciplinary Team weekly. Care plans and aide assignmentsheets will be updated to reflect interventions to prevent and/or promote woundhealing. DNS/designee will conduct rounds oneach shift to ensure wound prevention interventions are in place per physicianorders and care plan. Staff found not following theresident's care plan will be addressed with further education and/ordisciplinary action if needed.** ·howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place; · **To ensure compliance, the DNS/Designee is responsible for thecompletion of the Skin ManagementProgram CQI tool weekly times 4 weeks, monthly times 6 and then quarterly toencompass all shifts until continued compliance is maintained for 2 consecutivequarters. The results of these audits will be reviewed by the CQI committeeoverseen by the ED. If threshold of 95%is not achieved an action plan will be**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(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
	During an observation on 8/19/2015 at 10:32 a.m., with Certified Nursing Assistant (CNA) #34 present, Resident F was observed positioned on her left side, with her right leg contracted outward toward the right. Her right foot was observed in a foam boot, with the right side of her foot laying flat against the heel lift device under her foot. Resident F's record was reviewed on 8/17/2015 at 11:40 a.m., Resident F's diagnoses included, but were not limited to, cerebrovascular accident (CVA), hemiplegia (paralysis of one side), and renal (kidney) failure. A Quarterly Minimum Data Set assessment (MDS), dated 3/10/2015, indicated Resident #18 was at risk for development of pressure ulcers by clinical assessment. Skin treatments included turning and repositioning. A Significant Change MDS, dated 6/25/15, indicated Resident F had a Stage 3 pressure ulcer with measurements of 1.8 centimeters by 2.4 centimeters with a depth of 0.8 centimeters. Skin and ulcer treatment included a pressure reducing device for her bed. Resident F was totally dependent upon the assistance of at least two employees for bed mobility, which included turning side to side and positioning body while in bed. Resident F had functional limitation in range of		**developed to ensure compliance.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/21/2015
NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122	

(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
	motion, with impairment on both sides of her lower extremities, which included her hip, knee, ankle and foot. Skin Grids for Resident F's pressure ulcer to her right 5th metatarsal included the following measurements: 3/23/2015: unstageable pressure ulcer (suspected deep tissue injury) with measurements of 1 centimeter by 0.8 centimeters with no depth. 3/30/2015: unstageable pressure ulcer with measurements of 1.5 centimeters by 1 centimeters with no depth. 4/6/2015: unstageable pressure ulcer with measurements of 1.2 centimeters by 0.6 centimeters with no depth. 4/14/2015: unstageable pressure ulcer with measurements of 1.5 centimeters by 1 centimeter with no depth. 4/21/2015: unstageable pressure ulcer with measurements of 1 centimeter by 0.5 centimeters with no depth. 4/27/2015: unstageable pressure ulcer with measurements of 0.5 centimeters by 0.5 centimeters with no depth. 5/4/2015: unstageable pressure ulcer with measurements of 0.8 centimeters by 0.5 centimeters with no depth. 5/11/2015: unstageable pressure ulcer with measurements of 2.5 centimeters by 3 centimeters with no depth. 5/18/2015: unstageable pressure ulcer with measurements of 3 centimeters by 3			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 08/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(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
	centimeters with no depth. 5/25/2015: unstageable pressure ulcer with measurements of 3 centimeters by 1.5 centimeters with no depth. 6/1/2015: unstageable pressure ulcer with measurements of 1.5 centimeters by 1.7 centimeters with no depth 6/8/2015: unstageable pressure ulcer with measurements of 2 centimeters by 2 centimeters with 0.3 centimeters of depth. 6/15/2015: stage 2 pressure ulcer (partial thickness loss of dermis) with measurements of 3.5 centimeters by 2 centimeters with 0.7 centimeters of depth. 6/22/2015: stage 3 pressure ulcer with measurements of 1.8 centimeters by 2.4 centimeters with 0.5 centimeters of depth. 6/29/2015: stage 3 pressure ulcer with measurements of 2.2 centimeters by 2.5 centimeters with 0.6 centimeters of depth. 7/6/2015: stage 3 pressure ulcer with measurements of 2 centimeters by 2.2 centimeters with 0.3 centimeters of depth. 7/13/2015: stage 3 pressure ulcer with measurements of 2 centimeters by 2 centimeters with 0.2 centimeters of depth. 8/3/2015: stage 3 pressure ulcer with measurements of 2.5 centimeters by 2			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/21/2015
NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122	

(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
	centimeters with 0.1 centimeters of depth. 8/10/2015: stage 3 pressure ulcer with measurements of 1.5 centimeters by 1.5 centimeters with 0.1 centimeters of depth. 8/17/2015: stage 4 pressure ulcer with measurements of 2.2 centimeters by 1.5 centimeters with 0.1 centimeters of depth. A Braden Risk Assessment scale, dated 6/2/2015, indicated Resident F had a high risk score of 11 for skin breakdown. A skin integrity care plan, dated 6/22/2015, indicated Resident F was at high risk for skin breakdown and required increased frequency of turning and a pressure reduction support surface. Interventions included implementing an individualized turning schedule if applicable and protect heels if exposed to friction. A CNA assignment sheet, dated 8/10/2015, indicated Resident F required her heels to be elevated. A Physical Therapy treatment note, dated 7/6/2015 at 12:32 p.m., indicated it was discussed with Resident F's caregivers how important continued pressure relief was to improve wound healing.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/21/2015
NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122	

(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
	A Physical Therapy progress note, dated 7/8/2015, indicated Resident F's caregiver training on the importance of pressure relief to hasten wound healing remained ongoing. A Physical Therapy progress note, dated 7/17/2015 at 12:00 p.m., indicated Resident F exhibited continued hyptertonicity (extreme muscle tension) and muscle shortening while lying in bed but was able to tolerate heel lift and accomodate pressure relief. Resident F's caregivers were trained to continue with pressure relief. A physician's telephone order, dated 8/4/2015, indicated an order to cleanse Resident F's stage 3 pressure ulcer to right 5th metatarsal with normal saline. Apply foam nonadhesive wrap Kerlix and Mefix every other day for 21 days. A physician's telephone order, dated 8/13/2015, indicated an order for Resident F to have a heel up device while in bed for positioning, and to turn and position with pillows and wedges. A nurse's progress note, dated 8/14/2015 at 6:45 a.m., indicated Resident F's right 5th metatarsal had increased from a stage 3 pressure ulcer to a stage 4 pressure			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(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
	ulcer with measurements of 1.5 centimeters by 1.5 centimeters with a depth of 0.1 centimeters and 0.1 cm of bone exposed on the distal edge. A physician's telephone order, dated 8/17/2015, indicated an order to cleanse Resident F's right 5th metatarsal stage 4 ulcer with normal saline and apply a foam dressing wrap with kerlix daily for 21 days. Pressure is to be kept off of Resident F's right foot. During an interview on 8/17/2015 at 11:19 a.m., Wound Nurse #35 indicated a heel lift device was placed under Resident F's legs to off-load her heels. She indicated Resident F was not capable of staying in this position for long due to her leg contractures. She indicated her pressure ulcer had received pressure from improper positioning of her right foot laying flat on the heel lift when she moved her leg and staff are unable to continually watch her to ensure she had not caused pressure to her right 5th metatarsal by moving her legs. During an interview on 8/17/2015 at 2:35 p.m., RN #36 indicated Resident F's right foot had not been properly positioned with the right side of her foot laying flat against the heel lift device. She indicated Resident F should have been			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 08/21/2015
NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122	

(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
	repositioned. During a telephone interview on 8/17/2015 at 3:22 p.m., Resident F's Physician indicated her heels were to remain off-loaded and pressure was to be kept off of the area of her right 5th metatarsal in order to promote healing. During an interview on 8/17/2015 at 3:36 p.m., Wound Nurse #35 indicated a specialized turning schedule had been recommended for Resident F but she had been put on an every 2 hour turn and reposition program. She indicated turning and repositioning Resident F every 2 hours had been too long of a time lapse if the Resident would pull her contracted right leg out of position and cause pressure to her right 5th metatarsal pressure ulcer. She indicated resident should not have any pressure on that area. 2. During an interview on 8/12/15 at 2:03 p.m., Licensed Practical Nurse (LPN) #24 indicated Resident G had a stage 3 pressure ulcer on his left heel. On 8/19/15 from 10:24 a.m. to 10:54 a.m., a dressing change and Foley catheter care was observed for Resident G. Licensed Practical Nurse (LPN) #24 used hand sanitizer prior to the entry of Resident G's room and put on disposable gloves. LPN #24 removed the old			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/21/2015
NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122	

(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
	pressure ulcer dressing from his heel ulcer, cleansed the pressure ulcer with wound cleaner, and then removed her gloves. LPN #24 washed her hands with soap and water for 20 seconds, turned the water faucet off with her bare hand, and dried her hands with paper towels. Soap suds were observed on LPN #24's left forearm as she put on new gloves and completed the dressing change. After the new pressure ulcer dressing was secured, LPN #24 washed her hands with soap and water for 20 seconds, turned the water off with her bare hand, and dried her hands with a paper towel. During an interview on 8/19/2015 at 10:54 a.m., LPN #24 indicated she washed her hands before and after providing care to residents, when her hands were contaminated with bodily fluids, and after disposing of gloves. She indicated she used a paper towel to turn off the water faucet after she washed her hands and dried her hands. Resident G's record was reviewed on 8/18/15 at 10:07 a.m. The quarterly Minimum Data Set (MDS), dated 6/8/15, indicated Resident G was an extensive assistant of 2 or more people for bed mobility and transfer. The MDS indicated the resident had one stage 3 pressure ulcer.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(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
	The form titled,"Skin Grid-Pressure/Venous Insufficiency Ulcer/Other" form, dated 2/8/15, indicated Resident G had a new stage 2 pressure ulcer on his left heel. The form titled,"Skin Grid-Pressure/Venous Insufficiency Ulcer/Other" form, dated The "Skin Grid-Pressure/Venous Insufficiency Ulcer/Other" form, dated 5/18/15, indicated the stage 2 pressure ulcer on the resident's left heel had become a full thickness stage 3 pressure ulcer. The physician telephone orders, dated 8/5/15, ordered a Podus boot to be wore when Resident G was out of bed and was to have his heel up in bed due to his left heel stage 3 pressure ulcer. The physician order summary, dated 8/11/15, indicated the resident had an order from 2/10/15 to bridge heels up in bed and wear bilateral boots while in bed. The "Skin Integrity Assessment: Prevention and Treatment Plan of Care," 7/14/15, indicated Resident G was at moderate risk for skin integrity issues, the resident was to be on a turn schedule, the resident's heels were to be protected, was to wear a Podus boot on the his left foot, and use a Trapeze when indicated. The care plan did not indicate how often the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/21/2015
NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122	

(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
	resident was to be turned, when the Podus boot was to be wore, or to bridge the resident's heels up in bed. The Certified Nursing Assistant (CNA) assignment sheet provided on 8/18/15 at 2:15 p.m. ,by LPN #24, indicated the resident used a trapeze to assist with bed mobility, and the resident's heels were to be floated. The assignment sheet did not indicate resident needed to be turned. During an interview on 8/18/15 at 11:36 a.m., Licensed Practical Nurse (LPN) #24 indicated she needed to get clarification on the Resident G's boot order. She indicated she believed the boot was ordered for day and night but was not sure why. She indicated she believed he should only have it during the day. On 8/19/2015 at 10:31 a.m., Resident G was observed in bed with a bridge pillow under his legs, his heels laying against the mattress, and no boots were observed on his feet. During an interview on 8/19/15 at 10:33 a.m., Certified Nursing Assistant (CNA) # 25 indicated Resident G's bridge pillow was in it's normal position and his heels would occasionally lay against the mattress. LPN #24 indicated sometimes they place pillows under his lower legs to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(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
	help off load the pressure off of the resident's heels. During an interview on 8/19/15 at 3:01 p.m., the Wound Nurse #35 indicated Resident G indicated the resident had an order for a trapeze over the his bed to assist with bed mobility, but the trapeze was removed because he was using his heel to help him push. She indicated the resident was unable to reposition by himself and was to be turned every 2 hours. She indicated she was unsure how the CNAs were supposed to know the resident required turning because the facility had removed the yellow dots from the doors and she was unaware the turning schedule was not listed on the CNA assignment sheet. During an interview on 8/19/15 at 3:48 p.m., the Wound Nurse #35 indicated Resident G was supposed to have boots on in bed and in up in chair until new sleeping boots came. She indicated the resident was supposed to have his heels floated off the mattress. She indicated she was unaware the resident did not have boots on in bed and was unaware the CNA assignment sheet indicated boots were to be wore when out of bed only. During an interview on 8/20/15 at 9:46			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(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
	a.m., CNA #25 indicated Resident G was to be turned and repositioned every 2 hours. She indicated the resident turning schedule was not on the CNA assignment sheet, but there used to be dots on the doors next to the residents' names which indicated who was on a turn every 2 hours schedule. On 8/19/15 at 10:00 a.m., the Administrator provided the current pressure ulcer policy. The policy indicated care plans should include interventions for residents at risk of skin impairment may include but were not limited to: frequent turning and repositioning, and off loading pressure to heels. The policy indicated residents at moderate risk should have a turning schedule with foam wedges for lateral positioning. The policy indicated residents at high risk should have an increased turning schedule, use foam wedges for lateral positioning, and reduce pressure to heels. The policy indicated very high risk residents should have all treatments. The policy indicated the interventions should be communicated to the staff. This Federal tag relates to Complaint IN00178593. 3.1-40(a)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 08/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(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
F 0315 SS=D Bldg. 00	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on observation, record review, and interview the facility failed to ensure an indication for the use of a indwelling catheter and ensure hand hygiene during catheter care for 2 of 3 residents for catheters (Residents D & G). Findings include: Resident D's record was reviewed on 8/18/2015 at 1:50 p.m. Resident D had diagnoses which included, but were not limited to, heart failure and kidney failure. Physician's recapitulation orders, dated August 2015, indicated an order for a Foley catheter due to urine retention. The record lack indication of failed attempts to discontinue the catheter.	F 0315	·whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice; **The catheter for resident #D has been removed without complications andresident #G is receiving catheter care following proper infection controlpractices.** ·howother residents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken; · **Residents with catheters have the potentialto be affected. The records for residents with catheters have been reviewed andupdated to reflect the indication for the catheter use. Nursing staff will be educatedregarding indications for catheter use**	09/20/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/21/2015
NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122	

(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
	During an interview on 8/13/15 at 8:43 a.m., Unit Manager #99 indicated Resident D had a indwelling catheter due to urinary retention. During an Interview on 8/20/2015 at 11:46 a.m., RN (registered nurse) #99 was overheard asking Resident D if she knew why she had the catheter and if she could tell when she had to urinate. Resident D indicated she did not know why it was ordered when she was in the hospital and yes she could tell when she needed to urinate. During an interview on 8/20/2015 at 9:58 a.m., the Nurse Consultant indicated residents admitted to the facility with a catheter should be consulted along with their physician to determine indication for use of a catheter. She indicated in the absence of a clear indication for the use of a catheter the catheter should be discontinued. She further indicated urinary retention without a urologist consult was not indication for the use of a catheter. She indicated Resident D was originally admitted to the facility with a catheter and it was discontinued with success. She indicated Resident D was hospitalized again in June 2015, and readmitted with a catheter and this time they had not yet attempted to remove it.		**and proper infection control proceduresfor catheter care by the DNS/designee on or before 9/18/15.** ·whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur; · **Nursing staff will be educated regardingindications for catheter use and proper infection control procedures forcatheter care by the DNS/designee on or before 9/18/15.** **·Newly admittedresidents with catheters will be reviewed by the IDT using theInterdisciplinary Team Admission Review tool to ensure there is an indicationfor catheter use.** **·Currentresidents who receive a new order to place a catheter will be reviewed by theDNS/designee for documentation of an indication for the catheter use.** **·Charge nursesand nurse managers will observe for appropriate catheter care during theirdaily rounds** ·howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place; · **To ensure compliance, theDNS/Designee is**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 08/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(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
	2. On 8/19/15 from 10:24 a.m. to 10:54 a.m., a dressing change and Foley catheter care was observed for Resident G. Licensed Practical Nurse (LPN) #24 set up the supplies for Resident G's catheter care and went into the bathroom to fill a water basin. LPN #24 turned the water faucet on and off with her bare hand, and then put on a new pair of disposable gloves. LPN #24 lowered Resident G's bed and repositioned his lower extremity bridge pillow with her gloved hands. Next, LPN #24 used her left gloved hand to reposition the Resident's soiled incontinence pad and changed her disposable gloves without washing her hands. Then, she used her left gloved hand to grab wash clothes out of the basin of water and cleansed around the Resident's catheter. LPN #24 completed Resident G's catheter care, washed her hands with soap and water for 15 seconds, turned the water faucet off with her bare hand, and dried her hands with a paper towel. LPN #24 used hand sanitizer as she exited Resident G's room. During an interview on 8/19/2015 at 10:54 a.m., Licensed Practical Nurse (LPN) #24 indicated she washed her hands before and after providing care to residents, when her hands were contaminated with bodily fluids, and after		**responsible for the completion of the Catheter CQI tool weekly times 4 weeks,monthly times 6 and then quarterly to encompass all shifts until continuedcompliance is maintained for 2 consecutive quarters. The results of theseaudits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an actionplan will be developed to ensure compliance.** **Catheter care skills validation check will be completedon all shifts daily for one week, bi weekly for 1 week, weekly times 2 week,and monthly for six months by DNS/Designee . Results of the skills validationwill be reviewed by the CQI committee overseen by the ED. If 95% compliance isnot achieved an action plan will be developed to ensure compliance.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/21/2015
NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122	

(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
	disposing of gloves. She indicated she used a paper towel to turn off the water faucet after she washed her hands and dried her hands. A procedure titled "Indwelling Urinary Catheters" identified as current by the Nurse Consultant on 8/20/15 at 3:54 p.m., indicated ,"...All residents with an indwelling catheter require a medical justification for the initiation and continuing need for catheter use. A comprehensive assessment includes underlying factors supporting medical justification, determination of which factors can be reversed and development of a plan for appropriate indications for continuing use of an indwelling catheter beyond 14 days. This may include: Urinary retention that cannot be treated or corrected medically or surgically, for which alternative therapy is not feasible, and which is characterized by: Documented post void residual volumes in a range over 200 ml... Residents admitted to the center with an indwelling catheter that was placed elsewhere need a provider order and medical justification for the catheter to remain in place...." 3.1-41(a)(1)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/21/2015
NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122	

(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
F 0318 SS=D Bldg. 00	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Based on record review and interview, the facility failed to ensure restorative nursing services were provided at the recommended frequency and failed to ensure staff were adequately trained to provide the ROM (range of motion) for 1 of 3 residents reviewed with contractures (Resident B). Findings include: Resident B's record was reviewed on 8/14/15 at 10:03 a.m. Resident B had diagnoses which included, but were not limited to, quadriplegic and contractures. During an observation on 8/18/15 at 3:19 p.m., LPN #67 and LPN #68 performed ROM on Resident B. During the observation Resident B was heard to correct staff when they failed to ensure his shoulders were positioned flat on the bed during ROM. After upper extremely ROM was performed weights were placed on Resident B's arms. At 3:46 p.m., LPN #67 and LPN #68 began lower extremity ROM. At 4:05 p.m., the	F 0318	·whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice; **Resident #B has received therapy services per physician order and isreceiving restorative nursing services for range of motion after nursing staffwere trained on the procedure.** ·howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken; · **All residents receiving restorative range of motion exercises have been reviewed by the MDS Coordinator to ensure thereare receiving ROM per physician orders. Restorative nursing staff has be reeducated on the proper procedures for restorative range of motion by theTherapy Services Manager/designee on or before 9/18/15.** ·whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur;	09/20/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/21/2015
NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122	

(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
	weight fell off of Resident B's right arm and onto the floor. LPN #67 looked over at the weight on the floor and continued with lower extremity ROM. At 4:10 p.m., Resident B asked LPN #67 if she would stop a second and put the weight back on his arm. She did. ROM was completed at 4:12 p.m. A Minimum Data Set (MDS) assessment, dated 6/24/15, indicated Resident B was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 out of 15, had functional limitation range of motion (ROM) impairment on both sides to his upper and lower extremities, and was totally dependent on two plus staff for mobility. An Occupational Therapy (OT) discharge note, dated 12/15/14, indicated care givers were educated regarding Resident B's functional maintenance program for contracture prevention which included a modified technique to ensure Resident B's shoulders remained in a dislocated position to prevent pain during ROM. The restorative plan indicated Passive Range of Motion (prom) was to be provided "daily" for contracture prevention. A physical therapy (PT) discharge note, dated 12/15/15, indicated staff were		· **Restorative nursing staff has been educated on the proper procedures for restorative range of motion by the Therapy Services Manager/designee on or before 9/18/15. The MDS Coordinator will develop a careplan with individualized interventions for residents requiring restorative range of motion exercises. Restorative nursing staff will document the completion of the range of motion exercises on an individual flowsheet for each resident who requires restorative range of motion exercises. TheMDS Coordinator/designee will check the flow sheet daily to ensure theresidents are receiving ROM per physician orders.** ·howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place; · **To ensure compliance, the RSM/designee is responsible for the completion of the ROM CQI tool, which includes observation, weekly times 4 weeks, monthly times 6 and then quarterly to encompass allshifts until continued compliance is maintained for 2 consecutive quarters. Theresults of these audits will be reviewed by the**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(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
	trained on Resident B's prom functional nursing program (fnp). The program included a modified technique to ensure Resident B's shoulders were dislocated at the shoulder joints to prevent increased pain during ROM. This note indicated Resident B was compliant with treatments and was helpful in directing his needs to be met by therapy staff. An untimed physician's order, dated 2/19/15, indicated Resident B had an order for full body range of motion for twenty minutes every day. The record lacked indication ROM/RNP (Restorative Nursing Plan) services were provided as recommended by therapy and ordered by the physician. A care plan note, dated 5/11/15, indicated Resident B reported concerns regarding the lack of knowledge of the staff regarding his specific ROM. This note indicated staff would be trained regarding ROM. A document titled "Training Log/Sign in Sheet," dated 5/12/15 and 5/15/15 at 2:00 p.m., provided by the Administrator on 8/17/15 at 10:00 a.m., indicated seventeen employees were trained on Resident B's ROM/RNP. Nurse's notes, dated 5/11/15 through		**CQI committee overseen by theED. If threshold of 95% is not achievedan action plan will be developed to ensure compliance.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/21/2015
NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122	

(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
	8/18/15, were reviewed on 8/17/15 at 10:30 p.m. The following nurse's notes indicated Resident B had voiced concerns regarding staffs' lack of knowledge of his ROM/RNP: 5/13/15 at 11:30 p.m., 6/4/15 at 12:30 a.m., 6/12/15 at 1:00 p.m., 6/4/15 at 4:45 p.m., 6/12/15 at 11:00 p.m., 6/16/15 at 11:30 p.m., 6/17/15 at 3:00 p.m., 6/18/15 at 6:45 p.m., 6/18/2015 at 10:00 p.m., 6/22/15 at 9 a.m., 6/24/15 untimed, 7/4/15 at 1:00 a.m., 7/23/15 at 2:00 a.m., 8/7/15 at 3:00 a.m., and 8/18/15 at 2:00 a.m. A list of employees who provided ROM/RNP services to Resident B from 8/3/15 through 8/16/15, was provided by the Director of Nursing on 8/17/15 at 2:00 p.m. This list indicated twelve staff had provided ROM services to Resident B during this time. The list indicated staff who were not trained regarding Resident B's RNP/ROM had provided RNP/ROM services for him on the following dates: 8/5, 8/8, 8/9, 8/10, 8/11, 8/12, 8/14, and 8/15/2015. A nurse's not dated, 8/5/15 at 2:00 a.m., indicated, "...Resident inquired about ROM. Writer informed Res [Resident] that with 1 nurse and 1 cna we would not be able to perform ROM, writer told res writer would pass it on for day shift to do...." The record lacked indication			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/21/2015
NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122	

(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
	ROM/RNP was provided to Resident B prior to 8/7/15 at 3:00 a.m. During an interview on 8/17/2015 at 12:50 p.m., CNA #65 and CNA #66 both indicated they had worked nights and had provided ROM to Resident B. They both indicated they had not been inserviced about his specific RNP and it was not written "anywhere." They indicated Resident B told them how to do it. CNA #66 indicated their assignment sheet indicated ROM for Resident B and the care plan in the Kiosk indicated ROM for Resident B however his specific RNP was not written anywhere. During an interview on 8/17/2015 at 12:55 p.m., Registered Nurse (RN) # 61 indicated she was unable to locate Resident B's RNP. She further indicated CNAs did not document ROM/restorative services provided to residents. During an interview on 8/17/15 at 1:00 p.m., Physical Therapist (PT) #62 indicated he remembered developing Resident #B's RNP and training CNAs on day shift. He indicated he did not remember who he trained nor did he have documentation which indicated who he had trained. He further indicated he was unable to locate Resident B's RNP.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(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
	During an interview on 8/17/2015 at 1:37 p.m., the Director of Nursing (DON) indicated the facility did not have a system to ensure the ROM was done according to residents' RNP. She indicated she was unable to locate Resident B's RNP. During an interview on 8/17/15 at 2:30 p.m., the MDS Nurse indicated she was currently responsible for the Restorative Program. She indicated she was unable to find documentation which indicated Resident B had been provided PROM per therapy's recommendations. She further indicated the facility had not had someone to monitor the system to ensure restorative programs/ROM were being done, done correctly, or CNAs were trained to do it correctly. She indicated the current system "was broken" and they were not being trained on the new system until September 1, 2015. . During an interview on 8/17/2015 at 2:22 p.m., CNA #63 indicated he frequently provided ROM to Resident B. He indicated he had not been inserviced and there wasn't anything written he could follow. He indicated the way he learned was by Resident B "telling him." He indicated it took over an hour to complete everything and Resident B instructed him			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 08/21/2015
NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122	

(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
	on what needed to be done. He indicated Resident B tolerated the ROM "if they kept his arms out of socket." He indicated if they didn't keep his arms out of socket or if they failed to "hold the stretches for 10 seconds" Resident B would became upset. He further indicated he felt if they had been trained on his specific needs and had "clear concise instructions" for everyone to follow "they" wouldn't have to "argue" with Resident B and he couldn't "argue" with them about how it was supposed to be done. He indicated he had not documented he had provided ROM to Resident B. During an interview on 8/18/2015 at 10:33:a.m., Resident B indicated Licensed Practical Nurse #67 and CNA #63 had "popped" his shoulder out during ROM. He indicated LPN #67 had not properly held his shoulder out and when it popped in it "hurt" him. He indicated it happened three times and he told her to get out of his room. He indicated ROM was not provided to him every day. Resident B stated, "I don't mind telling people how to do it if they are new. I get frustrated when the same people, day in and day out, cant get it right. It gets old." He further indicated he was fearful of becoming more contracted and he had no intentions of "backing off" of staff			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155132		08/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(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
	regarding his quality of care. He further indicated staff frequently forgot to put the weights back on his arms after they were done with upper ROM. He indicated the "chances" of his shoulders "popping in" and causing him "pain" were less likely with the weights in place. During an interview on 8/19/15 at 1:15 p.m., the Administrator indicated CNAs were trained on ROM but Resident B's ROM was "above and beyond" standard ROM due to his shoulders. A procedure titled "Restorative Nursing Program" identified as a current procedure by the Nurse Consultant on 8/20/15 at 9:53 a.m., indicated, "...promotes the Restorative Nursing Program to enable residents to attain or maintain their highest practicable level of physical, mental, and psychosocial functioning. Increased independence fosters self-esteem and promotes positive quality of life for residents...." This Federal tag relates to Complaint IN00178593. 3.1-42(a)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(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
F 0323 SS=D Bldg. 00	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to ensure preventative fall measures were followed in the prevention of a fall for 1 of 1 residents reviewed for falls (Resident #53). Findings include: During an interview on 8/13/2015 at 9:21 a.m., Licensed Practical Nurse (LPN) #31 indicated Resident #53 had one fall during the last 30 days. Resident #53's record was reviewed on 8/17/2015 at 9:30 a.m. A Minimum Data Set assessment (MDS), dated 6/23/2015 indicated resident #53 was cognitively intact, required extensive assistance of one person with transfers, supervision of staff while walking in room, unsteady with walking and moving from sitting to standing, and was only able to stabilize with human assistance during surface to surface transfers. A care plan, dated 8/4/2015, indicated Resident #53 was at risk for falls and fall	F 0323	·whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice; **Staffis following the preventative fall interventions per care plan for Resident #53.** ·howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken; · **Residents who have had a fall within thepast 30 days were reviewed by the Nurse Manager to ensure preventative fallinterventions were in place**. **Staff will be inserviced on the fallmanagement program by the DNS/designee on or before 9/18/15.** ·whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur; · **Staff will be inserviced on the fallmanagement program by the DNS/designee on or before 9/18/15. TheCARE representatives will observe assigned residents daily for fall preventioninterventions per**	09/20/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/21/2015
NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122	

(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
	risk factors would be reduced in an attempt to avoid significant fall related injury. Interventions included an alarming floor mat at bedside. An "SBAR (Situation, Background, Assessment Request) Communication" document, dated 8/5/2015, indicated Resident #53 had a fall on 8/5/2015. Assessment of the fall indicated Resident #53's alarming floor mat had not been in proper position and the resident had not used his call light for assistance. A "Fall Event" form, dated 8/5/2015, indicated Resident #53 had fallen when walking from the bathroom back to his bed. Resident 53's alarming floor mat had not been placed on the floor next to his bed before the fall. A nursing progress note, dated 8/6/2015, indicated Resident #53's alarming floor mat had not been in place as ordered before he sustained his fall. During an interview on 8/19/2015 at 12:01 p.m., the Director of Nursing (DON) indicated she expected all facility staff to be aware of Resident #53's fall interventions to ensure his alarming floor mat had been in the proper position. A policy titled "Fall Management		**care plan and any incorrect observations will be correctedimmediately and DNS/designee will be notified of findings. DNS/Designee will conduct roundseach shift to ensure fall interventions/supervision are in place per plan ofcare/C.N.A. assignment sheets. The DNS/designee will review the 24hour report sheet, physician orders, and CARE Rep/designee observation roundinglogs daily to ensure supervision needs are adequate and/or if new interventionsare needed.** ·howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place; · **To ensure compliance, the DNS/Designee is responsible for thecompletion of the Fall Program CQI tool weekly times 4 weeks, monthly times 6and then quarterly to encompass all shifts until continued compliance ismaintained for 2 consecutive quarters. The results of these audits will bereviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an actionplan will be developed to ensure compliance.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155132		08/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(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
	Program" dated February 2015, and identified as current by the DON on 8/19/2015 at 12:00 p.m., indicated, "...A care plan will be developed at the time of admission specific to each resident's fall risk factors. The resident specific care requirements will be communicated to the assigned caregiver utilizing resident profile or Certified Nursing Assistant (CNA) assignment sheet...The care plan will be reviewed and updated, as necessary...." 3.1-45(a)(2)			
F 0325 SS=G Bldg. 00	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on record review and interview, the facility failed to prevent a resident's significant weight loss of 20 percent in 30 days, and failed to provide nursing, dietary, or physician's assessments after the 20 percent weight loss for 1 of 3 residents reviewed for nutrition (Resident #79).	F 0325	·whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice; **Resident #79 has been evaluated by the Interdisciplinary Team and interventions have been added to address nutritional concerns.** ·howother residents having the	09/20/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/21/2015
NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122	

(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
	Findings include: Resident #79's record was reviewed on 8/18/15 at 2:00 p.m. The vitals report indicated Resident #79 weighed 161 pounds on 5/5/15, 169 pounds on 6/5/15, 135 pounds on 7/5/15, and 137 pounds on 8/2/15. The "Nutritional Risk Data Collection and Assessment," dated 11/26/14, indicated Resident #79 had decreased intake and averaged less than 50 percentage intake at meals for five days. The assessment indicated the Registered Dietician (RD) recommended a regular diet to liberalize the resident's diet. The "Nutritional Risk Data Collection and Assessment," dated 12/5/14, indicated the physician had discontinued Resident #79's regular diet and resumed the limited high fat food diet. The nursing progress notes, dated 11/14/14 to 8/5/15, were reviewed on 8/20/15 at 2 p.m. The nursing progress note dated 12/12/14 at 2:30 p.m., was the last progress note that addressed Resident #79's decreased meal intake. The nursing progress notes, dated 6/1/15 at 2:35 p.m., to 8/5/15 at 2:00 p.m., did not indicate the physician or family was notified of the Resident #79's June-July weight loss.		potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken; · **All residents have the potential to be affected. Staff will be educated on monitoring for changes in nutritional status, promoting meal intake and notifying the physician and family or legal representative of significant weight changes by the DNS/designee on or before 9/18/15 Residents with nutritional concerns will be reviewed weekly in the Nutrition atRisk interdisciplinary meeting** ·whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur; · **Staff will be educated on monitoring for changes in nutritional status,promoting meal intake and notifying the physician and family or legal representative of significant weight changes by the DNS/designee on or before9/18/15.** **·Resident meal consumptions are reviewed daily M-F during clinical meeting. Residents with consistently low intake will be reviewed during the weekly IDT NAR meeting. Residents that are nutritionally at risk will be reviewed at least weekly in**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 08/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(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
	The nursing progress notes, dated 6/1/15 at 2:35 p.m., to 8/5/15 at 2:00 p.m., did not indicate Resident #79 had been assessed by nursing or dietary for his significant weight loss. The "CORP-Meal Intake Detail Report" for June 2015 indicated Resident #79 consumed 50 percent or less of meals on the following dates: 6/2/15 - ate less than half of dinner (26% -49%) 6/5/15 - refused breakfast and ate less than half of dinner (26%-49%) 6/6/15 - refused most of lunch (1%-25%), and ate less than half of dinner (26% -49%) 6/8/15 - refused breakfast and refused most of dinner (1%-25%) 6/9/15 - ate less than half of breakfast and dinner(26% -49%) 6/11/15 - ate less than half of lunch (26% -49%) 6/12/15 - refused most of breakfast and lunch (1% -25%) 6/13/15 - refused most of lunch (1% -25%) 6/14/15 - refused most of dinner (1% -25%) 6/15/15 - refused most of breakfast, lunch, and dinner (1%-25%) 6/19/15 - refused most of breakfast (1% -25%) and ate less than half of dinner (26%-49%)		**Nutrition as Risk interdisciplinary meeting to ensure nutritional interventions are monitored and revised based on effectiveness. All residents with significant weight loss will be weighed weekly to closely monitor weight trend.** ·howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place; · **To ensure compliance, the DNS/Designee is responsible for the completion of the Resident Weights CQI tool weekly times 4 weeks, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. Theresults of these audits will be reviewed by the CQI committee overseen by theED. If threshold of 95% is not achievedan action plan will be developed to ensure compliance.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 08/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(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
	6/21/15 - ate less than half of dinner (26%-49%) 6/24/15 - refused most of dinner (1% -25%) 6/26/15 - refused most of breakfast and lunch (1%-25%) 6/29/15 - ate less than half of breakfast (26%-49%), refused most of lunch (1% -25%) The "Nutrition Risk Care Plan", dated 6/25/15, indicated Resident #79 was at risk for weight loss due to decreased intake of less than 75 percent. The goals were for the resident to consume at least 70% of meals, and his weight would remain within 3% of current weight. The care plans interventions indicated staff was to monitor the Resident's weight per protocol, monitor intake of meals, and notify the physician and family of significant weight changes. The "Food/Fluid Intake Record" for July 2015 indicated Resident #79 consumed 50 percent or less of meals on the following dates: 7/2/15 - breakfast of 50% 7/4/15 - breakfast of 50% 7/5/15 - dinner of 50% 7/6/15 - breakfast of 25% 7/715 - refused breakfast 7/8/15 - breakfast of 25% 7/9/15 - breakfast of 25%			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 08/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(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
	7/16/15 - breakfast and lunch of 50% 7/19/15 - dinner of 50% 7/2015 - dinner of 50% 7/24/15 - breakfast of 50% 7/25/15 - dinner of 50% 7/26/15 - lunch of 50% 7/27/15 - breakfast and lunch of 50% 7/28/15 - dinner of 50% The physician telephone order, dated 7/20/15, ordered a diet change to a regular diet. The physician order summary, dated 8/11/15, indicated Resident #79 was on a diet of limited high fat foods and was allowed two free meals every month. Resident #79 was observed and interviewed in the dining room on the following dates and times: 8/12/15 at 12:04 p.m.-- Resident observed in dining room. Indicated the food was good and he was excited to have a hot dog for lunch. 8/18/15 at 11:51 a.m.-- Resident in dining room. Alert and indicated he was ready to eat. 8/20/15 at 11:58 a.m.-- Resident observed in dining room. Indicated excited for lunch at 12:05 p.m., received food. 12:15 p.m., offered alternative meal 12:20 p.m., received substitute. CNAs observed to encourage eating throughout			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 08/21/2015
NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122	

(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
	meal. Resident observed to feed self without limitation. During an interview on 8/19/2015 at 4:07 p.m., the Registered Dietician indicated he was unfamiliar with Resident #79 and his weight loss. He indicated he would look into his weight loss. During an interview on 8/20/2015 at 3:10 p.m., the Director of Nursing (DON) indicated she did not find documentation that the physician was notified of Resident #79's weight loss from June to July. She indicated documentation of physician and family notification would be in the nursing progress notes. She indicated the diet order in July came from the Dietary Manager's recommendation. During an interview on 8/21/2015 at 10:10 a.m., Licensed Practical Nurse (LPN) #22 indicated if a resident had weight loss during the month she told the Unit Manager and the Unit Manager contacted the physician and family. During an interview on 8/21/2015 at 10:38 a.m.,Unit Manager (UM) #23 indicated she notified the physician and family the same day a resident's weight loss was discovered. Unit Manager (UM) #23 indicated when a resident consumed 50 percent or less of a meal the Certified			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155132		08/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(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
	Nursing Assistant (CNA) notified the charge nurse and the charge nurse notified the physician. She indicated she had recently became the UM for the unit so she did not handle Resident #79's decreased intakes for June or July, and she was unsure what the former UM had done about his reduced intake. On 8/21/15 at 12:00 p.m., the Nurse Consultant indicated the facility did not have a nutrition policy. 3.1-46(a)(1)			
F 0329 SS=D Bldg. 00	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/21/2015
NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122	

(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
	residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on record review and interview, the facility failed to attempt non-pharmacological interventions prior to administering as needed anti-anxiety medication, assess efficacy of the medication, or ensure behavioral monitoring for psychotropic medication for 1 of 5 residents reviewed for unnecessary medications (Resident #48). Findings include: Resident #48's record was reviewed on 8/20/15 at 4:25:19 p.m. Resident #48 had diagnoses which included, but were not limited to, anxiety and depression. A physician's order, dated 7/31/15 indicated an order for Alprazolam (anti-anxiety benzodiazipine) 1 milligram administered as needed up to four times a day for anxiety. The narcotic reconciliation record, dated August 2015, was reviewed on 8/20/15 at 4:45 p.m. The record indicated Resident #48 was administered Alprazolam for anxiety eighteen times from August 1 through August 20, 2015.	F 0329	·whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice; **The Social service Director interviewed Resident #48 and assisted in identifyingnon-pharmacological interventions that are effective for reducing his feelingsof anxiety. These interventions are care planned. The licensed nurse isdocumenting non-pharmacological interventions attempted before administering aPRN anti-anxiety medication and the effectiveness of the medication.** ·howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken; · **Residents who received PRN psychotropicmedications were reviewed by DNS/designee to ensure non-pharmacologicalinterventions were identified on the resident's care plan. Social services staff and licensednursing staff will be educated by the Social Services consultant/designee**	09/20/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 08/21/2015
NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122	

(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
	The medication administration record (MAR), dated August 2015, was reviewed on 8/20/15 at 4:45 p.m. The record indicated Resident #48 was administered Alprazolam for anxiety four times from August 1 through August 20, 2015. A behavior monitoring record, dated August 2015, indicated non pharmacological interventions were attempted prior to administering Alprazolam on three occasions from August 1 through August 20, 2015. The August 1-20, 2015 record lacked indication of administration times for thirteen of the eighteen doses of Alprazolam administered. The record lacked indication of attempts of non pharmacological interventions prior to the administration for 15 out of 18 doses of Alprazolam the medication administered from August 1 through August 20, 2015. The record lacked indication of the efficacy of the medication for 16 of the 18 times it was administered. During an interview on 8/20/15 at 5:21 p.m., the Director of Nursing (DON) indicated staff should have documented the time the medication was administered, ensured non		**on orbefore 9/18/15 about the behavior monitoring program and about attempting anddocumenting non-pharmacological interventions before administering PRNpsychotropic medications. The licensed nursing staff will beeducated by the DNS/designee on or before 9/18/15 about documenting theeffectiveness of the PRN psychotropic medication.** ·whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur; · **Social services staff and licensed nursingstaff will be educated by the Social Services consultant/designee on or before9/18/15 about the behavior monitoring program and about attempting anddocumenting non-pharmacological interventions before administering PRNpsychotropic medications. The licensed nursing staff will beeducated by the DNS/designee on or before 9/18/15 about documentationrequirements for administering PRN psychotropic medications. The DNS/designee will review thedocumentation of administration of PRN psychotropic medications daily**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/21/2015
NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122	

(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
	pharmacological interventions were attempted prior to the administration of the medication, and assessed the efficacy of the medication. She indicated further documentation which indicated all this was done for the eighteen doses of Alprazolam administered in August 2015, was not available. A policy titled "Behavior Management Policy" identified as current by the DON on 8/21/15 at 10:09 a.m., indicated, "...Interventions provided are both individualized and non pharmacological and part of a supportive physical and psychosocial environment that is directed toward preventing, relieving and/or accommodating a resident's distressed behavior... When a behavior occurs, the staff communicates to the nurse what behavior occurred. The nurse records the behavior on the monitoring form including what interventions were attempted during the episode and whether or not they were effective...Psychoactive Medication. Document the following using the appropriate Mood and Behavior Symptom Assessment Plan of Care... Non drug approaches. PRN (as needed) medication use as applicable. Resident responses to interventions...." A procedure titled "Medication Administration" identified as current by		**to ensurenon-pharmacological interventions were attempted prior to medicationadministration. Non-compliance with documentation requirements will beaddressed with further education and disciplinary action if needed.** ·howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place; · **To ensure compliance, the Social Services Director/Designee isresponsible for the completion of the PsychoactiveManagement CQI tool weekly times 4 weeks, monthly times 6 and then quarterly toencompass all shifts until continued compliance is maintained for 2 consecutivequarters. The results of these audits will be reviewed by the CQI committeeoverseen by the ED. If threshold of 95%is not achieved an action plan will be developed to ensure compliance.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155132		08/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(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
	the DON on 8/21/15 at 10:09 a.m., indicated, "...to provide safe administration all medications. The licensed nurse and/or medication assistant will administer medication according to State specific regulation... Document the following as applicable: Administration medication the MAR as soon as the medications are given... Indicate reason for administration and effectiveness of PRN medication in the Nursing Progress Notes or on the back of the MAR...." A procedure titled "Target Behavior/Target Mood Occurrence" identified as current by the DON on 8/21/15 at 10:09 a.m., indicated, "...Record occurrences of target behavior... rule out possible causes of behavior symptoms such as: pain, medical illness, other residents, other treatable/preventable causes... document interventions...." 3.1-48(a)(3) 3.1-48(a)(4)			
F 0371 SS=F Bldg. 00	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must -			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/21/2015
NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122	

(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
	(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 Based on observation, interview, and record review, the facility failed to ensure proper food storage, a sanitary kitchen environment, and adequate hand sanitation for 2 of 2 kitchen observations. This deficient practice had the potential to affect 56 of 60 residents who received food from the kitchen. Finding includes: During an initial kitchen tour with the Dietary Manager (DM) and Dietary Consultant (DC) on 08/12/2015 from 11:12 a.m. - 12:10 p.m., flying insects were in the dry food storage area and kitchen near the food serving tables. A cigarette butt was on the floor near a door that led to the outdoors and tree leaf was on the floor by the entrance door to the dry food storage room. Two blankets were on the floor under storage racks containing gallons of water in the dry food storage room. Two trays with bowls containing watermelon were stored uncovered in the walk in freezer. At 11:53 a.m., Cook #1 dipped food from the serving line and placed it on residents' food trays. She wiped her forehead with her bare hand and resumed dipping food	F 0371	·whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice; · **No residents were found to be affected Steri-Tech was in the building andexterminated flying pests Cigarette butts were removed Blankets under storage rack wereremoved Watermelon in the bowl were destroyed** ·howother residents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken; **Allresidents have the potential to be affected. All food was inspected by theDietary Manager to ensure food was stored properly. Any food identified as notstored properly was discarded. Additionalinsect light traps were placed and an air screen will be installed to reducepests from entering the kitchen and the facility. Thefloor drain was repaired. Dietarystaff will be in-serviced on techniques to ensure utensils and equipment remainsanitary during food preparation by the DM/designee on or before**	09/20/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/21/2015
NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122	

(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
	without washing her hands. During an interview on 08/12/2015 at 11:12 a.m., the DM indicated the uncovered watermelon from the walk in freezer would be served at the noon meal. She indicated the blankets on the floor were absorbing leaking water and indicated she thought the leak originated in an adjacent room and had been present for a few days. During an interview on 08/12/2015 at 1:25 p.m., the DC indicated a backed up drain caused the water to leak into the dry food storage area. He indicated a repair service was scheduled at 2:30 p.m., that day. During a kitchen observation on 08/13/2015 from 11:02 a.m. -11:33 a.m., flies were in the area where food was being pureed. Dietary Aide (DA) #2 placed measuring utensils directly on the counter. The utensils were used to obtain thickener, returned to the counter, and used again to obtain additional thickener. DA #2 carried the lid for the puree machine from the dishwashing area to the food preparation counter. She touched the inside surface of the lid with her hands before placing it on the puree container. Tongs were laid on the counter with the end used to retrieve food		**9/18/15. Dietary staff will be in-serviced by the DietaryManager on or before 9/18/15 regarding proper food storage and sanitation inthe kitchen and hand washing. The staffmembers responsible for specific sanitation tasks will initial the tasks whencompleted. The Dietary Manger/Designee will review dailycleaning schedules daily to ensure appropriate tasks have been completed.** ·whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur; · **The dietary staff will be in-serviced on proper food storage,sanitation requirements and hand sanitation by the DM on or before 9/18/15. The DM has updated kitchen cleaning schedules tobetter cover all areas of the kitchen. The staff members responsible forspecific sanitation tasks will initial the tasks when completed. The Dietary Manger/Designee will review cleaningschedules daily to ensure that all required sanitation items are completedappropriately and sign when tasks are completed. The DM/Designee will conduct a walk-through of thekitchen at least daily to ensure checklists are**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 08/21/2015
NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122	

(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
	touching the menu book. The DA picked up sausage with the tongs and placed it in the puree machine. The tongs were returned to the counter. The DA aide measured food and added an additional piece of meat using the contaminated tongs from the counter. Food splattered and touched the inside of the lid while being pureed. During an interview on 08/13/15 at 11:02 a.m., DA #2 indicated flies had been a problem in the kitchen this summer. During an interview with the DC and DM on 08/13/2015 at 1:43 p.m., the DC indicated flies in the kitchen were a recent issue. He indicated pest control identified the issue the previous week. The DC indicated a screen would be placed at the outside entrance door to the kitchen. The DM indicated staff smoked cigarettes in an outside designated smoking area around the corner from the kitchen entry door. She indicated she believed staff may have carried the cigarette into the kitchen and stated, they were "always sweeping because the leaves blow in." The DM indicated staff should have washed hands after touching skin and before resuming food service. She indicated utensils were normally kept in a drawer and retrieved when needed and indicated the watermelon should		**complete, and kitchen is cleanand sanitary. The DM will observe for proper hand sanitationduring food serving.** ·howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place; **To ensure compliance, the Dietary Manager/Designeeis responsible for the completion of the Kitchen Sanitation/ Environmentalreview log CQI tool daily 5 times a week for 4 weeks, 3 times a week for 4 weeks and then weekly for two weeks to encompass all shifts and to maintaincontinued compliance. The results willbe reviewed by CQI Committee overseen by the ED. If 95% is not achieved anaction plan will be developed.** **·TheSafety and Sanitation Review will be completed weekly times 4 weeks, bi monthlyfor one month and then monthly thereafter by the RD Consultant/Designee. Theresults of these audits will be reviewed by the CQI committee overseen by theED. If threshold of 95% is not achievedan action plan will be developed to ensure compliance.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 08/21/2015
NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122	

(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
	have been covered before storing in the walk in freezer. During an interview on 08/13/2015 at 2:00 p.m., the Maintenance Supervisor indicated he "snaked" the drain on 8/10/15 and 8/11/15 and was unable to remove the clog. He indicated a large air handler in a room next to dry storage emptied approximately 5-6 gallons of water into the drain and indicated 2-3 gallons of water could end up on floor when the drain was clogged. The Maintenance Supervisor indicated the drain was repaired by an outside service on 8/12/15. A "Refrigerator Storage" policy, revised October 2011, and identified by the DC as current, indicated, "...Cover all pre-dished and pre-poured items to prevent off flavors, drying, and/or cross contamination...." A "BUILDING SERVICE WORK ORDER REQUEST," indicated maintenance staff was notified of the leak on 8/10/15. A "Hand Washing" policy, updated 11/2014, and identified as current by the DC, indicated, "...Dietary staff will wash hands after touching bare human body parts other than clean hands and clean,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155132		08/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(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
	exposed portions of arms...." A "PEST CONTROL" policy, dated 02/2012, and identified by the DC as current, indicated, "...All staff should practice pest prevention, including but not limited to: a. Keep food storage and preparation areas clean...." 3.1-21(i)(3)			
F 0441 SS=D Bldg. 00	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/21/2015
NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122	

(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
	prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation, interview, and record review, the facility failed to ensure staff washed their hands properly for 1 of 2 pressure dressing change observations, and 1 of 3 indwelling urinary catheter care observations observed for infection control (Resident G). Findings include: On 8/19/15 from 10:24 a.m. to 10:54 a.m., a dressing change and Foley catheter care was observed for Resident G. Licensed Practical Nurse (LPN) #24 used hand sanitizer prior to the entry of Resident G's room and put on disposable gloves. LPN #24 removed the old pressure ulcer dressing, cleansed the pressure ulcer with wound cleaner, and then removed her gloves. LPN #24 washed her hands with soap and water	F 0441	·whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice; · **Resident #G has had no changes in his condition and staff is completing correct hand hygiene before providing care. The DNS/designee completed hand washing validation for LPN#24.** ·howother residents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken; **All residents have the potential to be affected. Staff will be inserviced on the correct procedure for hand hygiene by the DNS/designee on or before 9/18/15.** ·whatmeasures will be put into place or what systemic changes will be made to ensurethat the	09/20/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 08/21/2015
NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122	

(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
	for 20 seconds, turned the water faucet off with her bare hand, and dried her hands with paper towels. Soap suds were observed on LPN #24's left forearm as she put on new gloves and completed the dressing change. After the new pressure ulcer dressing was secured, LPN #24 washed her hands with soap and water for 20 seconds, turned the water off with her bare hand, and dried her hands with a paper towel. LPN #24 set up the supplies for Resident G's catheter care and went into the bathroom to fill a water basin. LPN #24 turned the water faucet on and off with her bare hand, and then put on a new pair of disposable gloves. LPN #24 lowered Resident G's bed and repositioned his lower extremity bridge pillow with her gloved hands. Next, LPN #24 used her left gloved hand to reposition the Resident's soiled incontinence pad and changed her disposable gloves without washing her hands. Then, she used her left gloved hand to grab wash clothes out of the basin of water and cleansed around the Resident's catheter. LPN #24 completed Resident G's catheter care, washed her hands with soap and water for 15 seconds, turned the water faucet off with her bare hand, and dried her hands with a paper towel. LPN #24 used hand sanitizer as she exited Resident G's		deficient practice does not recur; · **Staff will be inserviced on the correct procedure for hand hygiene by the DNS/designee on or before 9/18/15. Nurse managers will observe for correct hand hygiene during dressing changes and catheter care on each shift. Non-compliance with correct procedure will be addressed immediately with further education and will be reported to the DNS. Continued non-compliancewill be addressed with disciplinary action if needed.** ·howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place; **·To ensure compliance of infection control measures during dressing changes and catheter care, dressing change and catheter care skills validation checks will be completed on all shifts daily for one week, biweekly for 1 week, weekly times 2 weeks, and monthly for six months by DNS/Designee . Results of the skills validation will be reviewed by the CQI committee overseen by the ED. If 95% compliance is not achieved an action plan will be developed to ensure compliance.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/21/2015
NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122	

(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
	room. During an interview on 8/19/2015 at 10:54 a.m., LPN #24 indicated she washed her hands before and after providing care to residents, when her hands were contaminated with bodily fluids, and after disposing of gloves. She indicated she used a paper towel to turn off the water faucet after she washed her hands and dried her hands. On 8/21/15 at 12:00 p.m., the Nurse Consultant provided the current policy for indwelling urinary catheter care. The policy indicated staff was to perform hand hygiene prior to putting on gloves and after removing gloves. On 8/21/15 at 12:00 p.m., the Nurse Consultant provided the current policy on hand hygiene. The policy titled, "Hand Hygiene-Plain Soap and Water Handwash," indicated staff was to use soap and water or alcohol hand rub under the following circumstances: "If hands are not visibly soiled, before having direct contact with residents...", after contact with resident's skin or body fluids, "...During resident care if moving from a contaminated-body site to a clean-body site, after contact with inanimate objects (including medical equipment) in the immediate vicinity of the resident, after removing gloves." The			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 08/21/2015
NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122	

(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
	policy indicated staff was to scrub hands with soap for 15-20 seconds, rinse hands to ensure no residual soap, dry hands, and then turn off faucets with a paper towel. 3.1-18(l)			
F 0465 SS=D Bldg. 00	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to ensure a functional and sanitary environment for 3 of 30 resident rooms observed (Resident #4, Resident #33, and Room #203) and maintenance of a resident's wheelchair (Resident #33). 1. On 8/19/15 at 4:46 p.m., a dark substance was observed behind Resident #4's bed and dresser and along the floor boards. The window was observed to have a sticky spill on the upper window and long sticky drips observed down the lower window. The wall next to the window had a large sticky area and the calendar on the wall had a sticky stain. The wall behind the bed was observed to have a stain of liquid splashed on the wall above and below the right side of the mounted light.	F 0465	·whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice; · **Resident #4'sroom is being cleaned daily. Resident #33's bathroom and bed room are beingcleaned daily. Resident 33's wheelchair is being cleaned at least weekly anddaily, as needed.** how other residents having the potentialto be affected by the same deficient practice will be identified and whatcorrective action(s) will be taken; **Allresident rooms and bathrooms have been inspected to ensure they are functionaland sanitary. All wheelchairs were inspected to ensure cleanliness byhousekeeping.** **Housekeeping staff will beinserviced on resident room and bathroom cleaning schedules and procedures**	09/20/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 08/21/2015
NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122	

(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
	During an interview on 8/19/2015 at 4:46 p.m., Resident #4's Power of Attorney (POA) indicated the Resident's room was usually not cleaned well. She indicated it did not help to inform staff that the room was not cleaned and she usually cleaned it herself. On 8/19/15 at 5:08 p.m., the Director of Nursing (DON) toured Resident #4's room and indicated she was unaware of the dust and dark substance buildup under the bed and dresser, and along the baseboards. She indicated she was also unaware of the sticky stains on the walls and windows. 2a. On 8/19/15 at 4:56 p.m., Resident #33's bathroom was observed to have stains around toilet, dust and a dark substance around the floor boards and a strong odor of urine. The floor under the window bed was observed to have large pieces of food and crumbs. Dust and a dark substance was observed along the baseboard behind both beds. A dark substance was observed in the corner of room. A white substance and cobwebs were observed behind the room's door. During an interview on 8/19/15 at 4:56 p.m., Resident # 33's Power of Attorney (POA) indicated the resident's bathroom smelled strongly of urine all the time and		**bythe Housekeeping Supervisor on or before 9/18/15. Nursing staff will be inserviced onwheelchair cleaning schedules by the DNS/designee on or before 9/18/15.** ·whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur; · **Housekeeping staff will be inserviced on resident room and bathroom cleaning schedules and procedures by the Housekeeping Supervisor on or before 9/18/15. Nursing staff will be inserviced on wheelchair cleaning schedules by the DNS/designee on or before 9/18/15. Customer care representatives will check the rooms and wheelchairs for their assigned residents daily for cleanliness. Any areas needing attention will be corrected as soon as possible. Non-compliance with cleaning schedules will be addressed with further education and disciplinary action if needed. The Housekeeping Supervisor/designee will check 5 resident rooms daily for cleanliness. Resident rooms and bathrooms are cleaned daily Resident adaptive equipment will be cleaned weekly or more often if needed**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155132		08/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(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
	the floor never looked clean around the toilet, sink, and walls. She indicated she was in the facility daily and knew that it was not cleaned well. She indicated there would not be cobwebs and buildup along the floors if the room was thoroughly cleaned. On 8/19/15 at 5:10 p.m., the Director of Nursing (DON) toured Resident #33's room and indicated she was unaware of the dust and dark substance buildup under the beds and along the baseboards. She indicated she was also unaware of the odor in the bathroom and the condition of the bathroom floor. 2b. On 8/19/15 at 5:13 p.m., Resident #33's wheelchair was observed with a layer of a white substance and crumbs on the lower rails and bars on both sides. The left wheel had a white substance visible on the outer bars. During an interview on 8/19/15 at 5:14 p.m., Resident #33's POA indicated the resident's wheelchair was always dirty and the staff never cleaned it. On 8/20/15 at 2:03 p.m., Resident #33's wheelchair was observed with white material on the left wheel and bilateral lower bars.		·howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place; · **To ensure compliance, the DNS/Designee is responsible for thecompletion of the Resident Care Rounds CQI tool weekly times 4 weeks, monthlytimes 6 and then quarterly to encompass all shifts until continued complianceis maintained for 2 consecutive quarters. The results of these audits will bereviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an actionplan will be developed to ensure compliance.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155132		08/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(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
	On 8/20/15 at 2:22 p.m., the Director of Nursing observed Resident #33's wheelchair. 3. On 8/12/15 at 1:50 p.m., Room #203's bathroom was observed to have a dark substance around the wall baseboards, sink, and toilet. On 8/20/15 at 9:33 a.m., Room #203's bathroom was observed with the Housekeeping Supervisor. The Housekeeping Supervisor indicated the dark substance around the toilet, sink, and baseboards was a grime buildup. She indicated it was a large buildup that the housekeeping equipment was unable to clean. She indicated the former contracting cleaning company had a machine that would take the buildup off the floors, but the facility did not own one. She indicated all of the bathroom floors on the 200 hall were in need of replacement due to the grime buildup and stains. She indicated she planned on having all of the toilets recaulked soon. On 8/20/15 at 9:17 a.m., the Housekeeping Supervisor provided the cleaning forms daily expectations, daily cleaning log, and deep cleaning calendar. The daily routine cleaning forms from 8/8/15 to 8/19/15 indicated no resident rooms had been deep cleaned in the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(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
	Pathways unit. The Deep Cleaning Calendar for the Pathway unit indicated no rooms in the 200 halls had been deep cleaned in August. During an interview on 8/19/15 at 5:08 p.m., the Director of Nursing (DON) indicated there had been a change in management and the facility had switched from a contracted cleaning company to facility employee housekeeping. The DON indicated the recent switch may have caused a lapse in appropriately cleaning resident room. During an interview on 8/20/15 at 9:29 a.m., the Housekeeping Supervisor indicated the nursing staff was responsible for cleaning residents' wheelchair. She indicated the Certified Nursing Assistants (CNA) on the third shift were responsible, but the task was not getting done. She indicated she and the Administrator were scheduling a day to powerwash all of the wheelchairs. During an interview on 8/20/15 at 2:22 p.m., the DON indicated resident wheelchairs were supposed to be cleaned on night shift and there was a calendar and a checkoff list for the staff to use. She indicated when the company switched ownership she had lost her electronic record of the calendar and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/21/2015
NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122	

(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
	checkoff list. She indicated the CNAs still had paper copies of the checkoff list and calendar they used. During an interview on 8/20/15 at 3:36 p.m., the DON indicated she only found 2 resident wheelchair cleaning checkoff sheets for the month of August and neither sheet was marked that the wheelchairs were cleaned. She indicated there was no documentation that resident wheelchairs had been cleaned in August. During an interview on 8/20/15 at 8:46 a.m., the Housekeeping manager indicated she expected her staff to clean under and behind the beds. She indicated the housekeepers were originally contracted and only worked 4 hours a day. She indicated they had recently been trained and had a daily cleaning log they were to complete for each room. She indicated there currently was not a deep cleaning schedule for the rooms, but they would deep clean resident rooms when they could. On 8/20/15 at 9:29 a.m., the Housekeeping Supervisor provided the current "Daily Cleaning," "Restroom Cleaning," and "Deep Cleaning" procedures. The "Daily Cleaning" procedure indicated all surfaces in resident rooms were to be disinfected and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155132		08/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(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
	the floors were to be cleaned. The "Restroom Cleaning" procedure indicated the floor was to be cleaned. The "Deep Cleaning" procedure indicated, "...5. Dust all areas not cleaned on a daily basis..." and "...8. Clean corners and baseboards..." The procedure indicated the restroom and room floors were to be cleaned as well. On 8/21/15 at 12:00 p.m., the Nurse Consultant provided the current "Cleaning Guidelines" policy. The policy the resident's restrooms were be to cleaned and disinfected daily. The policy stated, "Each hall housekeeper should do a minimum of one resident room deep clean including disinfection's of mattresses and bed frame per day to assure that all rooms have been deep cleaned each month." The policy indicated every Tuesday staff should wipe down walls, every Thursday staff should clean baseboards, and every Friday windows should be cleaned. 3.1-19(f)			
F 0469 SS=E Bldg. 00	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. Based on observation, interview and	F 0469	·whatcorrective action(s) will be	09/20/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 08/21/2015
NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122	

(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
	record review, the facility failed to ensure the kitchen was free from flies for 2 of 2 kitchen observations. Finding includes: During an initial kitchen tour with the Dietary Manager (DM) and Dietary Consultant (DC) on 08/12/2015 from 11:12 a.m. - 12:10 p.m., flies were observed in the dry food storage area and kitchen near the food serving tables. During a kitchen observation on 08/13/2015 from 11:02 a.m. -11:33 a.m., flies were observed in the area where food was being pureed. During an interview on 08/13/15 at 11:02 a.m., Dietary Aide (DA) #2 indicated flies had been a problem in the kitchen this summer. During an interview on 08/13/2015 at 1:43 p.m., the DC indicated flies in the kitchen were a recent issue. He indicated pest control identified the issue last week. The DC indicated a screen would be placed at the outside entrance door to the kitchen. A " Pest Prevention Service Report," dated 08/06/2015, indicated heavy house fly activity in the kitchen. The report		accomplished for those residents found to havebeen affected by the deficient practice; · **No residentswere found to be affected. Steri-Tech was in the building and exterminatedflying pests** ·howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken; · **All residents have the potential to beaffected. Additionalinsect light traps were placed and an air screen will be installed to reducepests from entering facility.** ·whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur; · **Additionalinsect light traps were placed and an air screen will be installed to reducepests from entering facility. Steri-TechPest Control company will make regular monthly visits TheDM will monitor for adequate pest control daily and report to the MaintenanceDirector if there is any issue with pest control. The Maintenance Director willcontact the pest control company for additional visit/intervention.** ·howthe corrective action(s) will be monitored to ensure the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/21/2015
NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122	

(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
	indicated, " ...Performed Regular, Insect Light Trap (ILT) Maintenance Prog [Program] today .... " A " Pest Prevention Service Report, " dated 08/13/2015, indicated medium house fly activity in the dish room and heavy exterior activity. The report indicated, " ...Follow Up Service for Flies today .... " A "PEST CONTROL" policy, dated 02/2012, and identified by the DC as current, indicated, " ...2. The executive director should appoint a department head (usually Maintenance or Housekeeping) to monitor the activities of the PCO [Pest Control Operator]...7. All staff should practice pest prevention, including but not limited to: a. Keep food storage and preparation areas clean...d. Screen windows in food preparation areas and areas where there is opened ventilation. E. Seal opening into buildings, especially around ducts or pipes .... " 3.1-19(f)(4)		deficient practicewill not recur, i.e., what quality assurance program will be put into place; · **To ensure compliance, the Dietary Manager/designee is responsible for thecompletion of the AM Daily Walk-thru Checklist CQItool weekly times 4 weeks, monthly times 6 and then quarterly to encompass allshifts until continued compliance is maintained for 2 consecutive quarters. Theresults of these audits will be reviewed by the CQI committee overseen by theED. If threshold of 95% is not achievedan action plan will be developed to ensure compliance.**	
F 9999 Bldg. 00	3.1-14 PERSONNEL	F 9999	·whatcorrective action(s) will be accomplished for those residents	09/20/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 08/21/2015
NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122	

(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
	(a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Specific inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. This state rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure reference verification for 1 of 5 recently hired employees . This deficiency had the potential to affect 60 of 60 residents residing in the facility. Finding includes: Employee records were reviewed on 08/20/2015 at 4:49 p.m. The record did not indicate an employee reference was obtained prior to hiring Licensed Practical Nurse (LPN) #1. The record indicated LPN #1 began employment on 06/05/2015. During an interview on 08/21/2015 at 4:49 p.m., the Business Office Manager indicated she was not able to locate documentation of references being		found to havebeen affected by the deficient practice **·LPN #1 now hasreference check** ·howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken; **Personnel files for current employees werereviewed by the Executive Director to ensure reference checks were completed . Department managers will be educatedby the ED on or before 9/18/15 on the hiring process, including checkingreferences for potential new employees.** ·whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur; **Department managers will be educated by theExecutive Director on or before 9/18/15 on the hiring process, includingchecking references for potential new employees. The Executive Director/designee willaudit the file for each new employee to ensure the file is complete, includingreferences.** ·howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place;	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/21/2015
NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122	

(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
	verified prior to LPN #1 beginning employment on 06/05/2015.		· **To ensure compliance, the ExecutiveDirector is responsible for the completion of the Employee Files CQI toolweekly times 4 weeks, monthly times 6 and then quarterly to encompass allshifts until continued compliance is maintained for 2 consecutive quarters. Theresults of these audits will be reviewed by the CQI committee overseen by theED. If threshold of 95% is not achievedan action plan will be developed to ensure compliance.**	