

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155511	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/05/2016
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NAME OF PROVIDER OR SUPPLIER TERRE HAUTE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 830 S 6TH ST TERRE HAUTE, IN 47807
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: March 28, 29, 30, and 31, April 1, 4, and 5, 2016</p> <p>Facility Number: 000446 Provider Number: 155511 AIM Number: 100288720</p> <p>Census bed type: SNF/NF: 30 Total: 30</p> <p>Census payor type: Medicare: 6 Medicaid: 18 Other: 6 Total: 30</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review was completed by 21662 on April 6, 2016.</p>	F 0000		
F 0241 SS=D	483.15(a) DIGNITY AND RESPECT OF			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Bldg. 00	<p>INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview, and record review, the facility failed to maintain an environment to promote dignity for 2 random observations of residents. (Resident #49 and #7).</p> <p>Findings include:</p> <p>1. On 3/29/16 at 10:00 a.m., Resident #49 was observed in a group of residents by the back door of the facility as they prepared to exit out onto the smoking area. The DON (Director of Nursing) was observed telling Resident #49 he was not able to go outside the facility with the group because he was an elopement risk. The DON's comments were able to be overheard by all staff and residents who were present. The resident became upset and stomped away from the area towards his room.</p> <p>On 3/29/16 at 2:10 p.m., RN #4, indicated she did not believe Resident #49 was an elopement risk. She indicated the resident enjoyed going outside and wanted to smoke.</p> <p>On 3/31/16 at 11:51 a.m., the DON</p>	F 0241	<p>By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective May 5th, 2016 to the annual licensure survey conducted on April 5th, 2016. We respectfully request a paper review. We will provide you with any additional information to confirm compliance per your request.</p> <p>F241</p> <p>It is the practice of this facility to assure that care is promoted for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>The correction action taken for those residents found to be affected by the deficient practice include:</p> <p>DON given a teachable moment on resident rights related to dignity and discussing treatment in a private</p>	05/05/2016
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	<p>indicated he was unable to provide an elopement assessment for Resident #49 that indicated he was an elopement risk. The DON indicated he had been told by the staff the resident was observed looking out of the windows of the exit doors and pushing buttons on the keypad at the doors. The DON indicated he had assumed the staff had completed an elopement assessment on the resident based upon the reported observation. He indicated the only elopement assessment for the resident was on the admission assessment, which had indicated the resident was not at risk for elopement.</p> <p>On 4/4/16 at 3:05 p.m., the DON indicated it was not appropriate for anyone to talk about any resident's private or medical information in an area where it could be overheard by others.</p> <p>On 3/31/16 at 9:16 a.m., review of Resident #49's medical record indicated the resident was non-verbal due to history of cancer of and removal of the larynx.</p> <p>Review of a document titled, "Admission Nursing Assessment," dated 3/16/16, indicated the resident was not an elopement risk.</p> <p>The resident's Admission Minimum Data Set (MDS) assessment dated 3/24/16,</p>		<p>area. RN #4 given a teachable moment on resident rights related todignity and assessing/treating in a private area.</p> <p>Other residents that have the potential to be affected havebeen identified by: All residents who come into public areas had the potential tobe affected and those coming to these areas have been reviewed. No additional residents were identified. The measures or systematic changes that have been put intoplace to ensure that the deficient practice does not recur include: An in-service has been conducted with all employees regardingDignity related to discussing a resident's private or medical information in anarea it could be overheard and assessing/treating residents only in privateareas. The IDT team will be monitoring public areas for discussions that shouldbe private, assessments and treatments that should be done in private andpromoting dignity as part of the QAPI process. The corrective action taken to monitor performance to assurecompliance through quality assurance is: A Performance Improvement Tool has been initiated thatrandomly observes 5 residents in public areas received care in a manner thatmaintains or enhances their</p>	

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	<p>indicated the resident had not exhibited any wandering behavior. The assessment indicated a cognitive assessment could not be completed due to the resident's non-verbal status. A Social Service progress note dated 3/16/16, indicated the resident was alert and oriented times three.</p> <p>2. On 4/1/16 at 9:02 a.m., RN (Registered Nurse) #4 was observed by the nurses' station in the hallway to apply a stethoscope to Resident #7's chest and assess the resident's heart and lungs.</p> <p>On 4/5/16 at 10:39 a.m., the DON (Director of Nursing) indicated staff should assess residents in a private room, behind closed doors. Staff should not assess any resident in a hallway or public place.</p> <p>Resident #7's record was reviewed on 3/31/16 at 9:28 a.m., Resident #7 had a diagnoses which included, but was not limited to, congestive heart failure and depression. A Minimum Data Set (MDS) assessment, dated 3/2/16, indicated Resident #7 had moderate cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 11 out of 15 and required assistance of one staff for locomotion on the unit.</p> <p>The facility policy titled, "Resident</p>		<p>dignity and respect. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, and quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations for new interventions or training as needed based on the outcome of the Pt tool.</p> <p>The date the systemic changes will be completed: May 5th, 2016</p>	

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F 0248 SS=D Bldg. 00	<p>Rights," identified as current and provided by the Social Service Director on 4/4/16 at 10:06 a.m., indicated "... (a) Dignity. The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality..."</p> <p>3.1-3(t)</p> <p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. Based on observation, interview, and record review, the facility failed to ensure residents were provided with activities designed to meet their interest and their physical, mental, and psychosocial well-being for 3 of 6 residents reviewed for activities (Residents #3, #4, and # 35). Findings Include: 1. On 3/28/16 at 10:20 a.m., two residents were observed to be sitting in</p>	F 0248	<p>F248 It is the practice of this facility to assure that an ongoing program of activities is provided in accordance with the comprehensive assessment, the interests and the physical, mental and psychosocial well-being of each resident. <i>The correction action taken for those residents found to be affected by the deficient practice include:</i> Resident #3, #4, and #35 have been interviewed for new activity</p>	05/05/2016

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	<p>the dining room, which also served as the facility activity area. There were no activities being conducted at this time. According to the March 2016 activity calendar, "Coffee /Snacks" were to be conducted at 10:15 a.m.</p> <p>On 3/30/16 at 10:30 a.m., two residents were observed to be sitting in their wheelchairs in the dining room. According to the March 2016 activity calendar, "Crafts" were to be conducted at 10:30 a.m. There were no facility staff present at this time and no craft supplies were out.</p> <p>On 3/31/16 at 10:40 a.m., Resident # 3 was observed reading a newspaper independently in the dining room. According to the March 2016 activity calendar, "Coffee/Snacks" were to be conducted at 10:30 a.m. There were no facility staff present at this time in the dining room.</p> <p>On 4/1/16 at 10:30 a.m., Resident # 3 was observed to be sitting in the dining room eating a snack at a table with one other resident. According to the April 2016 activity calendar, "Book Club" were to be conducted at 10:30 a.m. There were no facility staff conducting the activity at this time.</p> <p>On 4/4/15 at 3:22 p.m., Resident # 3 was observed to be reading her mail at the</p>		<p>preferences.</p> <p>Resident #35 was placed on 1:1's 5 x week.</p> <p>Activity Director was given a teachable moment in regards to following activity calendar, adding evening and weekend activities and monitoring activity assistants.</p> <p>Other residents that have the potential to be affected have been identified by:</p> <p>All residents attending activities had the potential to be affected, new activity preferences were obtained on all residents, but none were identified.</p> <p>The measures or systematic changes that have been put in place to ensure that the deficient practice does not recur include:</p> <p>All Activity Staff has been in-serviced related to following Activity Calendar, engaging residents and the adding of weekend and evening activities.</p> <p>The corrective action taken to monitor performance to assure compliance through quality assurance is:</p> <p>A Performance Improvement Tool has been initiated that randomly observes Evening and Weekend Activities are posted on calendar and followed, staff engaging residents during activities and that the calendar is being followed. The Administrator, Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, then</p>	

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	<p>table in the dining room. According to the April 2016 activity calendar, "Ball toss" were to be conducted at 3:00 p.m. There were no facility staff present in the dining room at this time.</p> <p>During a stage 1 interview on 3/28/16 at 1:45 p.m., Resident # 3 indicated the facility did not offer activities in the evening and very little activities on the weekends. She further indicated the activities ended around 3:00 p.m.-3:30 p.m., in the afternoon. She indicated there are no staff present to conduct the activities in the evening.</p> <p>During an interview on 4/1/16 at 9:12 a.m., the Activity Director indicated she was in charge of activities, housekeeping, and laundry. She further indicated it was hard to do all these jobs at times. The activity director indicated her activity aide was at the facility from 10:00 a.m. . -7:00 p.m.</p> <p>Resident # 3's medical record was reviewed on 3/30/16 at 11:00 a.m.</p> <p>Resident # 3 had a diagnosis which included, but was not limited to, depression. A minimum data set (MDS) assessment dated 12/11/15, indicated Resident # 3 had no cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 15 out 15 and required a one person physical assist</p>		<p>quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools.</p> <p>The date the systemic changes will be completed: May 5, 2016</p>	

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	<p>with locomotion on unit.</p> <p>A preference for customary routines and activity preferences document was dated 3/14/16 and reviewed on 4/4/16 at 9:20 a.m. The assessment indicated it was very important for Resident # 3 to have books, newspapers, and magazines to read, and also very important for her do things with groups of people.</p> <p>2. On 3/28/16 at 2:00 p.m., Resident # 4 was observed to be sleeping in his wheelchair in the hallway outside of his room.</p> <p>On 4/1/16 at 10:30 a.m., Resident # 4 was observed to be sitting in the dining room at a table eating a snack with another resident. According to the April 2016 activity calendar, "Book Club" were to be conducted at 10:30 a.m. There were no facility staff conducting the activity at this time.</p> <p>On 4/4/16 at 10:36 a.m., Resident # 4 was observed to be sitting in his wheelchair in the hallway outside of him room. The April 2016 activity calendar indicated, "Sunshine Group" were to be conducted at 10:30 a.m. There were no facility staff conducting the activity.</p> <p>On 4/4/16 at 3:22 p.m., Resident # 4 was observed to be sitting at a table in the dining room. According to the April 2016 activity calendar, "Ball toss" was to be</p>			

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	<p>conducted at 3:00 p.m. There were no facility staff present in the dining room at this time.</p> <p>During an interview on 4/4/16 at 3:20 p.m., Resident # 4 indicated there were not many activities conducted in the evening and most days the activities end at 3:00 p.m. He further indicated there were not many activities on the weekends.</p> <p>Resident # 4's medical record was reviewed on 4/4/16 at 2:30 p.m. Resident # 4 had a diagnosis which included, but were not limited to, depression. A quarterly MDS assessment dated 3/4/16, indicated Resident # 3 had moderate cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 10 out 15 and required a one person physical assist for transfers.</p> <p>An annual MDS assessment dated 1/29/16, indicated it was very important for Resident # 4 to have books, newspapers, and magazines to read, and also very important for him do things with groups of people.</p> <p>An activity calendar document for March, 2016, was reviewed on 4/4/16 at 1:37 p.m. Five to Six activities were scheduled each day starting at 10:15 a.m., 10:30 a.m., 11:30 a.m., 2:00 p.m., 3:00 p.m. 7 out of 23 days had an activity</p>			

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F 0250 SS=E Bldg. 00	<p>scheduled at 7:00 p.m. The activities at 7:00 p.m. included movies or cards. No additional activities were scheduled for evenings on weekdays. Saturday evening activities included at 6:00 p.m., "Ball Toss" and Sunday evening activities included at 7:00 p.m., "Cards or Movies." An activity calendar document for April 2016, was reviewed on 4/4/16 at 1:40 p.m., four to five activities were scheduled each day starting 10:15 a.m., 10:30 a.m., 11:00 a.m., 2:00 p.m., 3:00 p.m. 3 out of 21 days at an activity scheduled at 4:00 p.m. 9 out of 21 days had an activity scheduled at 6:00 p.m. The activities at 6:00 p.m. included puzzles, cards, movies, or trivia. Saturday evening activities included at 6:00 p.m. "Exercise, Ball Toss, and Words with Friends" for 3 out of 5 Saturdays and Sunday evening activities included at 6:00 p.m. "Connect 4 and movie" for 2 out 4 Sundays.</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on observation, interview and record, the facility failed to provide</p>	F 0250	<p>F250 It is the practice of this facility to provide medically-related</p>	05/05/2016

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	<p>services to address maladaptive behaviors for 2 of 3 residents reviewed for behavior management. (Residents #25 and 29) and impacted two additional residents who were affected by the behaviors. (Resident # 8 and 7)</p> <p>Findings include:</p> <p>1. On 3/29/26 at 2:36 p.m., Resident #25 was observed sitting in a wheelchair in the activity room by the front door, yelling "hey" or "help." When questioned, Resident #25 stopped yelling, denied any pain and indicated he was "okay." Resident #25 continued to yell "hey" or "help" until he fell asleep at 3:08 p.m.</p> <p>On 3/30/16 at 9:09 a.m., Resident #25 was observed sitting in a wheelchair in his room with the television on, yelling "hey" or "help." Staff were not observed to interact or redirect the resident from yelling.</p> <p>On 3/30/26 at 2:05 p.m., Resident #25 was observed sitting in a wheelchair in the activity room by the front door, yelling "hey" or "help." Staff were not observed to interact or redirect the resident from yelling.</p> <p>On 3/31/2016 at 9:45 a.m., Resident #25</p>		<p>socialservices to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p><i>The correction action taken for those residents found to be affected by the deficient practice include:</i></p> <p>LPN #5, CNA #11, SSD, Act Director#13 were all given teachable moments for not attempting to engage residents in any sort of activity or re-direction during episodes.</p> <p>SSD was given teachable moment for not addressing wandering behavior on care plan and for not following Behavior Management Policy addressing outside assistance.</p> <p><i>Other residents that have the potential to be affected have been identified by:</i></p> <p>All residents with behaviors have been reviewed for behavior plans that include interventions. No other residents were noted to be affected.</p> <p><i>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</i></p> <p>All staff has been in-serviced related to behavior plans/interventions and engaging resident during episodes of behaviors.</p> <p>SSD has been in-serviced on reviewing behaviors daily in morning meeting. including review of the clinical record, the behavior tracksheet, the care plan and the c.n.a. assignment sheet for proper intervention.</p>	

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	<p>was observed in bed with the television on, yelling "hey" or "help." The resident continued to yell "hey" or "help" until 10:20 a.m., when staff assisted the resident to the dining room.</p> <p>On 3/31/2016 at 11:15 a.m., Resident #25 was observed sitting in a wheelchair in the activity room at a table, yelling "hey" or "help." Staff were not observed to interact or redirect the resident from yelling.</p> <p>On 3/31/26 at 2:30 p.m., Resident #25 was observed sitting in a wheelchair in the activity room by the front door, yelling "hey" or "help." Staff were not observed to interact or redirect the resident from yelling.</p> <p>On 4/1/16 at 10:10 a.m., Resident #25 was observed sitting in a wheelchair in the in the hallway outside of his room, yelling "hey" or "help." Staff were not observed to interact or redirect the resident from yelling.</p> <p>On 4/4/16 at 9:15 a.m., Resident #25 was observed in bed with the television on, yelling "hey" or "help." Staff were not observed to interact or redirect the resident from yelling. The resident continued to yell "hey" or "help" until 10:45 a.m., when staff assisted the</p>		<p>The corrective action taken to monitor performance to assure compliance through quality assurance is:</p> <p>A Performance Improvement Tool has been initiated that randomly reviews 5 residents with behaviors related to any new or worsening behaviors interventions implemented, care planned, brought to morning meeting. The SSD, or designee, will complete this tool weekly x3, monthly x3, and quarterly x3. Any issues identified will be immediately corrected. Any identified issues will be immediately addressed. The Quality Assurance Committee will review the tool at the scheduled meetings with recommendations for additional interventions as needed based on review of the outcomes of the PI tool. The Quality Assurance committee will also review any negative findings identified related to any nonqualified personnel identified to provide care to a resident with additional recommendations if needed.</p> <p>The date the systemic changes will be completed: May 5, 2016</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155511	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/05/2016
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NAME OF PROVIDER OR SUPPLIER TERRE HAUTE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 830 S 6TH ST TERRE HAUTE, IN 47807
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	<p>resident to the activity room to sit by the front door.</p> <p>On 4/4/16 at 1:10 p.m., Resident #25 was observed sitting in a wheelchair in his room and yelling "Hey or Help." Staff were not observed to interact or redirect the resident from yelling.</p> <p>On 3/28/16 at 10:40 a.m., LPN (Licensed Practical Nurse) #2 indicated Resident #25 yelled out often throughout the day and night. LPN # 2 indicated they had tried everything and the resident was on routine pain medication. The doctors had indicated to the staff, the resident was going to yell, because he has bipolar disorder.</p> <p>On 3/30/16 at 9:37 a.m., CNA (Certified Nursing Assistant) #11 indicated Resident #25 often yelled out. The staff had tried different interventions, incontinence care, television, or take resident to a different location such as the hallway or activity room, but nothing seemed to work and the resident continued to yell.</p> <p>On 3/30/16 at 12:34 p.m., in an interview with psych services, the psychologist indicated, when the facility agreed to take Resident #25, he was on an antipsychotic medication, which cost for the monthly</p>			

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	<p>shot 2000 dollars and an additional 2000 dollars for the monthly pills. The facility could not get the medication for him. The resident started yelling. (Name of Hospital), the psychiatric hospital, admitted the resident to see how bad he was and if they could get the resident to stop yelling. Resident #25's medical doctor had been generous with the amount of interventions and medications tried, but nothing seemed to work and Resident #25 continued to yell out.</p> <p>On 3/31/16 at 11:56 a.m., the ADM (Regional Administrator Consultant) indicated, she had noticed how loud it was in the facility when she had entered the building. The ADM indicated this was not the appropriate facility for resident. Resident #25 liked to talk and needed assistance with activities, but then he would start to yell again. Resident #25 would be better placed on a closed unit for residents with behaviors, which had activities geared more for behavioral residents.</p> <p>On 4/4/16 at 2:35 p.m., the SSD (Social Service Director) indicated staff had tried a multitude of interventions for Resident #25, but he continued to yell. Resident #25 is now being sent to another facility which has a closed unit.</p>			

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NAME OF PROVIDER OR SUPPLIER TERRE HAUTE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 830 S 6TH ST TERRE HAUTE, IN 47807
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	<p>On 4/5/16 at 9:25 a.m., the DON (Director of Nursing) indicated the staff had tried all the standard interventions with Resident #25, but nothing seemed to work.</p> <p>Resident #25's record was reviewed on 3/30/16 at 10:27 a.m. Resident #25 had diagnoses which included, but were not limited to, Parkinson's disease, schizoaffective disorder, and dementia. A Minimum Data Set (MDS) assessment, dated 2/26/16, indicated Resident #25 had moderate cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 8 out of 15 and required total dependence of staff for locomotion on the unit. The assessment coded the resident with verbal behaviors.</p> <p>An IPOC (Intermediated Plan of Care), dated 3/24/16, addressed the behavior of yelling. The note indicated staff were to address the resident's needs, and offer foods, fluids, and toileting as needed.</p> <p>2. On 3/28/16 at 10:54 a.m., Resident #29 was observed to walk into the kitchen. The dietary aid attempted to redirect the resident out of the kitchen into the hallway. The resident resumed wandering in the hallway and into two other resident rooms. No attempt to engage the resident in any sort of activity</p>			
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	<p>was observed.</p> <p>On 3/28/16 at 11:45 a.m., there were observed eight stop signs on residents' doors throughout the facility.</p> <p>On 3/28/16 at 12:09 p.m., Resident #29 was observed to take a dinner roll from Resident #7's plate during the dining observation. Resident #7 took the dinner roll back from Resident #29. Resident #7 told Resident #29 that the roll was hers.</p> <p>On 3/28/16 at 2:04 p.m., Resident #29 was observed wandering the hallway, attempted to take the fire extinguisher off of the wall, and then wandered in and out of the shower room. No attempt to engage the resident in any sort of activity was observed.</p> <p>On 3/29/16 at 1:39 p.m., Resident #29 was observed in the dining room, aimlessly wandering around touching different objects, while other residents played tic tac toe and had manicures. Activity assistant #12 asked Resident #29 to go with her and invite other residents to get a manicure. The activity assistant walked Resident #29 to the nurses' station and asked if there was anyone available to walk with the resident.</p> <p>On 3/30/16 at 9:37 a.m., the resident was</p>			

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	<p>observed aimlessly wandering and entered three resident rooms that were not hers. The resident would enter another resident's room, look around the room, and then exited the room on her own and continued to wander the hallway. No attempts were made to engage the resident in any sort of activity.</p> <p>On 3/30/16 at 10:03 a.m., Resident #29 entered room number 6, folded the blanket that was on the bed, and then proceeded to enter room number 8. LPN #2 came into room 8 and asked the resident to come with her. LPN #2 indicated if Resident #29 stayed in the room, she would get into the paperwork. LPN #2 took the resident by the hand and led her to the nurses' station.</p> <p>On 3/28/16 at 11:12 a.m., Resident #8 indicated Resident #29 came into his room and took things. The staff would soon find the misplaced items and return the items to him. The staff have put a stop sign at my door, but Resident #29 went underneath the stop sign and wandered into his room.</p> <p>On 3/28/16 at 1:40 p.m., Resident #7 indicated Resident #29 was her roommate and would sometimes get into her personal belongings. Resident #7 indicated she would put back whatever</p>			

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	<p>Resident #29 had taken, because Resident #29 did not know any better.</p> <p>On 3/29/16 at 3:06 p.m., LPN #5 indicated Resident #29 wandered around the facility. We have a staff member who walked with her until the resident got tired, wanted a snack, or was ready to lie down for a nap.</p> <p>On 3/30/16 at 12:49 p.m., during an interview with psychiatric services, the psychologist indicated, the resident echoes and has had a life long use of benzodiazepines, which had made it difficult to find a medication to help with the resident's behaviors now.</p> <p>On 3/31/16 at 11:34 a.m., the SSD (Social Service Director) indicated Resident #29 had wandering behaviors. She indicated a staff member would walk with the resident for one on one time. The SSD indicated she had tracked the resident's wandering behaviors and the resident wandered every day. The SSD further indicated she had spoken to Resident #29's daughter, concerning sending Resident #29 to a closed dementia unit, but the daughter did not want the resident to go to a closed dementia unit. The SSD indicated Resident #7 (# 29's roommate) tried to help Resident #29. She SSD indicated</p>			

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NAME OF PROVIDER OR SUPPLIER TERRE HAUTE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 830 S 6TH ST TERRE HAUTE, IN 47807
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	<p>the staff had adjusted Resident #29's medications, provided one on one, walked with her, and "what else are we suppose to do for her?"</p> <p>On 3/31/16 at 11:52 a.m., the Activity Director #13 indicated the staff would walk Resident #29 around the facility, because the resident would grab the staff's hand and say "let's go." The staff did not walk Resident #29 around constantly, sometimes the resident would sit in the activity room. She indicated activity staff would sit down with Resident #29 and tried to read the paper or give her a busy bag, but she did not want anything to do with the activity after about 20 to 25 minutes. Activity Director # 13 indicated the staff could get her to sit for a little while, but the resident loved to walk and wandered around the facility.</p> <p>On 4/1/16 at 1:27 p.m., the ADM indicated she knew the facility had behavior problems of wandering when she saw all the stop signs on the residents' doors throughout the facility during her tour of the building. The ADM indicated this was not the appropriate facility for Resident #29. Resident #29 would be better placed on a closed or locked unit for wandering residents, which had activities geared more for behavior residents.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155511	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/05/2016
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	<p>On 4/4/16 at 2:57 p.m., the SSD indicated she got Resident #29 place in a closed dementia unit in another facility and the family and doctor had been notified the resident would be moving on 4/5/16.</p> <p>On 4/5/16 at 9:25 a.m., the DON indicated staff would go through all of Resident #29's interventions, let the resident get tired, and take a nap.</p> <p>Resident #29's record was reviewed on 3/29/16 at 1:39 p.m. The resident's annual MDS assessment, dated 2/29/16, coded the resident's cognition as severely impaired. The assessment coded the resident with daily behaviors of wandering.</p> <p>A Behavior Log Report for March, 2016, indicated daily the resident wandered about the facility, was brought to the nurses' station and a snack or drink had been given.</p> <p>An interdisciplinary plan of care, dated 2/29/16, addressed the behavior of aimlessly wandering. The goal was to keep the resident free from falls related to the accelerated walking and to provide rest periods. No interventions were noted on the plan to address the wandering</p>			

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	<p>behavior.</p> <p>A care plan, provided by LPN #5 on 3/29/16 at 3:25 p.m., with the most recent update of 2/29/16, addressed the resident's preferences for news, reading, magazines, listening to music, being around pets, crafts, walking, going outside when the weather permitted, and religious/spiritual services.</p> <p>A facility policy, titled "Behavior Management," dated December, 2015, was provided by the SSD on 3/31/16 at 12:25 p.m., included but was not limited to, "...Residents in long term care facilities may exhibit puzzling and troublesome behaviors. The behaviors may become difficult to handle for staff and may involve other residents. Sometimes, a resident becomes dangerous to himself or abusive to others and may keep others from enjoying a quiet and peaceful place. The staff should assess the behaviors and document in a quantitative manner, to assist in determining whether the behaviors can be addressed in the facility or whether outside assistance may be needed...."</p> <p>3.1-34(a)(1) 3.1-34(a)(2)</p>			

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NAME OF PROVIDER OR SUPPLIER TERRE HAUTE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 830 S 6TH ST TERRE HAUTE, IN 47807
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F 0278 SS=E Bldg. 00	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on interview and record review, the facility failed to ensure the accuracy of the functional status used for the coding for the Quarterly Minimum Data Set for 5 of 5 residents reviewed for a</p>	F 0278	<p>F278 It is the practice of this facility that the assessment must accurately reflect the resident's status. <i>The correction action taken for</i></p>	05/05/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155511	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/05/2016
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	<p>decline in Activities of Daily Living (ADL's) or a decline in urinary continence. (Resident # 10, 30, 12, 2, and 7)</p> <p>Findings Include:</p> <p>1. On 3/29/16 at 1:45 p.m., review of Resident # 10's Quarterly Minimum Data Set (MDS) assessment dated 01/18/16, Section G (G0110) titles "Activities of Daily Living (ADL) Assistance," indicated a code 4-for transfers and 1-for locomotion on unit.</p> <p>A Certified nurses aid (CNA) ADL tracking grid was provided by the Regional MDS Consultant on 3/19/16 at 3:22 p.m., the grid indicated Resident # 10 had a score of 3 for transfers and 2 for locomotion on unit. The ADL grid was from the time frame of 01/12/16-01/18/16.</p> <p>On 3/29/16 at 1:53 p.m., a review of Resident # 10's Quarterly Minimum Data Set (MDS) dated 03/01/16, Section G (G0110) titled "Activities of Daily Living (ADL) Assistance," indicated a code 4-for bed mobility.</p> <p>A CNA activities of daily living tracking grid was provided by the Regional MDS Coordinator consultant on 3/29/16 at 3:22</p>		<p>thoseresidents found to be affected by the deficient practice include: Residents # 10, 30, 12, 2 and 7 were re-assessed for accuracy of ADL coding. MDS Nurse was given a teachable moment regarding inappropriate coding.</p> <p>Other residents that have the potential to be affected have been identified by: All residents ADL codes were assessed for accuracy and corrections made.</p> <p>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include: The MDS Coordinator has been in-serviced on accuracy of coding ADLS</p> <p>The corrective action taken to monitor performance to assure compliance through quality assurance is: A Performance Improvement Tool has been initiated that randomly reviews 5 Residents Comprehensive assessments for proper coding. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, and quarterly x3. Any issues identified will be immediately corrected. Any identified issues will be immediately addressed. The Quality Assurance Committee will review the tool at the scheduled meetings with recommendations for additional interventions as needed based on</p>	

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	<p>p.m., the grid indicated Resident # 10 had a score of 3 for bed mobility. The ADL grid was from the time frame of 02/24/16-03/01/16.</p> <p>During an interview on 3/29/16 at 2:20 p.m., the Regional MDS Consultant indicated, Resident # 10's quarterly MDS assessment had not been coded correctly for this resident. She indicated on the quarterly assessment completed 01/18/16, Resident # 10 should have been coded a 3 (extensive assist) for transfers and a 2 (limited assist) for locomotion on unit. She further indicated on his quarterly assessment completed 03/01/16, Resident # 10 should have been coded a 3 (extensive assist) for bed mobility.</p> <p>2. On 3/30/16 at 9:20 a.m., review of Resident 30's Quarterly Minimum Data Set assessment dated 10/29/15, Section G (G0110) titled "Activities of Daily Living Assistance, " indicated a code 2-for transfers.</p> <p>An ADL flow sheet was provided by the Regional MDS Consultant on 3/30/16 at 2:56 p.m. The flow sheet indicated Resident # 30 had a score of 3 for transfers. The ADL flow sheet was from the time frame of 10/23/15-10/29/15.</p> <p>During an interview on 3/30/16 at 2:36</p>		<p>review of the outcomes of thePI tool.</p> <p>The date the systemic changes will becompleted:</p> <p>May 5, 2016</p>	

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	<p>p.m., the Regional MDS Consultant indicated, Resident # 30's quarterly MDS assessment had not been coded correctly. She indicated the resident should have been coded a 3 (extensive assist) for transfers.</p> <p>3. On 4/1/16 at 2:54 p.m., review of Resident #12's Admission Minimum Data Set (MDS) assessment dated 2/19/16, Section G (G0110) titled "Activities of Daily Living (ADL) Assistance," indicated a code of 2-limited assistance with one person physical assist with toileting.</p> <p>A document titled, "Case Mix ADL Data Tracking Tool by Shift (Month)," dated February 2016, was provided by the Regional MDS Consultant on 4/1/16 at 3:50 p.m. The document indicated the resident was an extensive assist with ADL's 20 times on all shifts during the 7-day assessment period.</p> <p>During an interview on 4/1/16 at 3:39 p.m., the Regional MDS Consultant indicated Resident #12's ADL's had not been coded correctly on her Admission MDS assessment completed on 2/19/16.</p> <p>The CMS (Centers for Medicare and Medicaid Services) RAI (Resident Assessment Instrument) Version 3.0 Manual, G0110: "Activities of Daily</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155511	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/05/2016
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NAME OF PROVIDER OR SUPPLIER TERRE HAUTE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 830 S 6TH ST TERRE HAUTE, IN 47807
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	<p>Living (ADL)," Coding Instructions for G0110, indicated "Code 0, independent: if resident completed activity with no help or oversight every time during the 7-day look-back period and the activity occurred at least three times. Code 1, supervision: if oversight, encouragement, or cueing was provided three or more times during the last 7 days. Code 2, limited assistance: if resident was highly involved in activity and received physical help in guided maneuvering of limb(s) or other non-weight-bearing assistance on three or more times during the last 7 days. Code 3, extensive assistance: if resident performed part of the activity over the last 7 days and help of the following type(s) was provided three or more times: Weight-bearing support provided three or more times, Or Full staff performance of activity three or more times during part but not all of the last 7 days. Code 4, total dependence: if there was full staff performance of an activity with no participation by the resident for an aspect of the ADL activity and the activity occurred more than three or more times. The resident must be unwilling or unable to perform any part of the activity over the entire 7-day look-back period...."</p> <p>4. On 3/30/16 at 2:25 p.m., review of Resident #2's Quarterly Minimum Data</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155511	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/05/2016
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NAME OF PROVIDER OR SUPPLIER TERRE HAUTE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 830 S 6TH ST TERRE HAUTE, IN 47807
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	<p>Set (MDS) assessment dated 1/27/16, Section H (H0300) titled "Urinary Continence," indicated a code 0-for always continent.</p> <p>Review of a document titled, "CNA-ADL Tracking Form," dated January 2016, was provided by the DON (Director of Nursing) on 3/30/16 at 2:30 p.m. The document indicated the resident was incontinent of urine 23 times during the 7-day assessment period.</p> <p>During an interview on 3/30/16 at 2:36 p.m., the DON indicated the ADL tracking grid for urinary continence had identified Resident #2 as incontinent of urine each day during the assessment period.</p> <p>During an interview on 3/30/16 at 2:57 p.m., the Regional MDS Consultant indicated Resident #2's urinary continence had no been coded correctly on his Quarterly MDS assessment completed on 1/27/16.</p> <p>5. Resident #7's record was reviewed on 3/31/16 at 9:28 a.m., Resident #7 had diagnoses which included, but were not limited to, congestive heart failure and depression. A Minimum Data Set (MDS) assessment, dated 11/26/15, indicated Resident #7 had moderate cognitive impairment with a Brief Interview for</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155511	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/05/2016
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NAME OF PROVIDER OR SUPPLIER TERRE HAUTE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 830 S 6TH ST TERRE HAUTE, IN 47807
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	<p>Mental Status (BIMS) score of 11 out of 15 and was always continent of bowel and bladder. A 90 day scheduled assessment, dated 2/13/16, indicated the resident was always incontinent and required assistance of one staff for locomotion on the unit and toileting.</p> <p>Bowel and Bladder Continence sheets, dated November, 2015 through March, 2016 were provided by the Regional MDS Consultant on 3/30/16 at 12:10 p.m. The sheets indicated Resident #7 was continent at times, but was frequently incontinent of bowel and bladder throughout the time period.</p> <p>During an interview on 3/30/16 at 12:05 p.m., the MDS Consultant indicated the resident was incontinent at times upon admission to the facility and remained frequently incontinent throughout the time period. The MDS Consultant indicated both MDS assessments for 11/26/15 and 2/13/16 were coded incorrectly and should have been coded "frequently incontinent."</p> <p>The CMS (Centers for Medicare and Medicaid Services) RAI (Resident Assessment Instrument) Version 3.0 Manual, H0300: "Urinary Continence," Coding Instructions for H0300, indicated "...Code 0, always continent if throughout</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155511	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/05/2016
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NAME OF PROVIDER OR SUPPLIER TERRE HAUTE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 830 S 6TH ST TERRE HAUTE, IN 47807
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F 0315 SS=D Bldg. 00	<p>the 7 day look back period the resident has been continent of urine, without any episodes of incontinence. Code 1, occasionally incontinent if during the 7 day look back period the resident was incontinent less that 7 episodes. This includes incontinence of any amount of urine sufficient to dampen undergarments, briefs, or pads during daytime or nighttime. Code 2, frequently incontinent if during the 7 day look back period, the resident was incontinent of urine during seven or more episodes but had as least on continent void. This includes incontinence of any amount of urine, daytime, and nighttime. Code 3, always incontinent if during the 7 day look back period, the resident had no continent voids...."</p> <p>3.1-31(d)</p> <p>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</p>			

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NAME OF PROVIDER OR SUPPLIER TERRE HAUTE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 830 S 6TH ST TERRE HAUTE, IN 47807
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	<p>resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, interview, and record review, the facility failed to ensure services were provided to prevent possible urinary tract infections and medical justification for an urinary catheter for 2 of 2 residents reviewed with a urinary catheter. (Resident #31 and 30)</p> <p>Findings include:</p> <p>1. On 3/30/16 at 11:47 a.m., Resident #31 was observed sitting in a reclining high back wheelchair in the dining room. The drainage tube from the resident's indwelling urinary catheter was on the floor under his wheelchair.</p> <p>On 3/30/16 at 11:53 a.m., Resident # 31 was observed sitting in a reclining high back wheelchair. The resident was being assisted by a certified nurses assistant (CNA) from the dining room to his room. The drainage tube from the resident's indwelling urinary catheter was dragging the floor under his wheelchair while he was being pushed down the hallway.</p> <p>The resident's medical record was reviewed on 3/31/16 at 10:42 a.m.,</p>	F 0315	<p>F315</p> <p>It is the practice of Terre Haute Nursing and Rehabilitation to assure that residents who are incontinent of bladder receive appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>The correction action taken for those residents found to be affected by the deficient practice include:</p> <p>Resident #33 and 31 re-assessed for need for catheter and care planned accordingly.</p> <p>CNA #8 given a teachable moment related to catheters being correctly positioned to not drag the floor.</p> <p>Other residents that have the potential to be affected have been identified by:</p> <p>All residents with Catheters have been reviewed to assure the catheter tubing nor the drain bags were on the floor and had a care plan in place. No other residents were identified.</p> <p>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</p> <p>All Nursing staff In-serviced on Urinary Catheter Care to prevent infection of the resident's urinary</p>	05/05/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155511	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/05/2016
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NAME OF PROVIDER OR SUPPLIER TERRE HAUTE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 830 S 6TH ST TERRE HAUTE, IN 47807
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	<p>Diagnosis included but not limited to, quadriparesis. The most recent Minimum Data Set (MDS) assessment was completed on 12/16/15. The assessment identified the resident as being severely impaired in cognitive decision making skills.</p> <p>During an interview on 3/31/16 at 12:19 p.m., the Regional MDS Consultant indicated, Resident # 31 did not have a care plan for his indwelling Foley catheter.</p> <p>During an interview on 4/4/16 at 2:59 p.m., CNA # 8 indicated an indwelling Foley catheter tubing should never touch the floor.</p> <p>A policy, dated 12/2007 , identified as a current, titled, "Catheter Care,Urinary", provided by the Director of Nursing on 4/5/16 at 10:35 a.m., included but not limited to. "...11. Be sure the catheter tubing and drainage bag are kept off the floor....</p> <p>2. On 3/28/16 at 2:26 p.m., Resident # 30 was observed lying in bed watching TV. The resident had indwelling Foley catheter.</p> <p>During an interview on 3/28/16 at 11:28 a.m., RN # 4 indicated Resident # 30 had</p>		<p>tract specifically related to preventingthe tubing and drain bag from touching the floor. MDS staff in-serviced on making sure all those with anindwelling catheter have a care plan in place.</p> <p>The corrective actiontaken to monitor performance to assure compliance through quality assurance is: A Performance Improvement Tool has been initiated thatrandomly reviews 5 residents with catheters for proper positioning of tubingand drain bag and care plan in place. The Director of Nursing, or designee, willcomplete this tool weekly x3, monthly x3, then quarterly x3. Any issues identified will be immediatelycorrected. The Quality AssuranceCommittee will review the tools at the scheduled meetings with recommendationsas needed.</p> <p>The date the systemic changes will be completed: May 5, 2016</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155511	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/05/2016
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NAME OF PROVIDER OR SUPPLIER TERRE HAUTE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 830 S 6TH ST TERRE HAUTE, IN 47807
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	<p>an indwelling Foley catheter due to urinary retention.</p> <p>During an interview on 3/30/16 at 9:58 a.m., LPN # 5 indicated Resident # 30 had an indwelling Foley catheter due to urinary retention.</p> <p>During an interview on 3/31/16 at 2:35 p.m., DON (director of nursing) indicated the facility did not have a bladder scan to check for post void residual.</p> <p>During an interview on 4/1/16 at 10:04 a.m., Regional MDS Consultant indicated there was no documentation available to show where facility had check for post void residual or documentation to show urine output for Resident #30.</p> <p>Resident #30's medical record was reviewed on 3/30/16 at 10:46 a.m. Resident # 30 had a diagnoses which included, but were not limited to, congestive heart failure, diabetes mellitus, and coronary artery disease. A Quarterly MDS assessment completed on 1/29/16 and indicated Resident # 30 had an indwelling Foley catheter.</p> <p>A care plan dated 5/25/15 indicated Resident # 30 had an indwelling Foley catheter related to urinary retention.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155511	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/05/2016
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NAME OF PROVIDER OR SUPPLIER TERRE HAUTE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 830 S 6TH ST TERRE HAUTE, IN 47807
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F 0318 SS=D Bldg. 00	<p>A physician order dated 9/14/15 to discontinue indwelling Foley catheter.</p> <p>A physician order dated 9/26/15 to anchor a 16 FR (french) Foley catheter due to Resident # 30 retaining urine.</p> <p>Nurses notes were reviewed from 9/14/15-9/25/15 and lacked documentation of Resident # 30 having difficulty urinating.</p> <p>A policy, dated 8/2006 , identified as a current, titled, "Urinary Continence and Incontinence- Assessment and Management", provided by the Director of Nursing on 4/5/16 at 10:35 a.m., included but not limited to. "... 23. The physician will identify situations in which an indwelling urethral or suprapubic catheter are indicated and will document why other alternatives are not feasible...."</p> <p>3.1-41(a)(2) 3.1-41(a)(1)</p> <p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155511	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/05/2016
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NAME OF PROVIDER OR SUPPLIER TERRE HAUTE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 830 S 6TH ST TERRE HAUTE, IN 47807
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	<p>receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Based on observation, interview, and record review, the facility failed to provide range of motion services for 1 of 1 residents reviewed with limitations (contracture). (Resident #31)</p> <p>Finding Includes:</p> <p>On 3/28/16 at 11:45 a.m., Resident # 31 was observed to be lying in bed. The resident's right hand was observed with a contracture (constrictor of muscle/joints). No splints were observed in place.</p> <p>On 3/31/16 at 12:00 p.m., Resident # 31 was observed lying in bed. No splints were observed in place on his right hand.</p> <p>On 4/4/16 at 9:20 a.m., Resident # 31 was observed lying in bed. No splints were observed in place on his right hand.</p> <p>During an interview on 3/28/16 at 11:25 a.m., RN # 4 indicated Resident # 31 had a contracture to the right hand. She further indicated the resident had no splint device and was not receiving range of motion services.</p> <p>During an interview on 3/31/16 at 12:19 p.m., the Regional MDS (minimum data</p>	F 0318	<p>F318</p> <p>It is the practice of this facility to ensure that a resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>The correction action taken for those residents found to be affected by the deficient practice include:</p> <p>Resident #31 re-assessed by Therapy Department to establish a restorative program and a care plan has been put in place regarding contracture. MDS nurse was given a teachable moment for not having a care plan in place for a resident with a contracture.</p> <p>Other residents that have the potential to be affected have been identified by:</p> <p>All residents with contractures could potentially be affected. All residents were assessed for appropriate interventions.</p> <p>The measures or systematic changes that have been put in place to ensure that the deficient practice does not recur include:</p> <p>An in-service has been conducted for therapy and nursing staff related to Restorative policy, communicating and care planning of contractures.</p> <p>The corrective action taken to</p>	05/05/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155511	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/05/2016
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NAME OF PROVIDER OR SUPPLIER TERRE HAUTE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 830 S 6TH ST TERRE HAUTE, IN 47807
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>set) Consultant indicated Resident # 31 had no care plan in place for his contracture. She further indicated he was not on range of motion services.</p> <p>During an interview on 4/1/16 at 2:35 p.m., the Occupational Therapist indicated Resident # 31 has a palm protector and should be placed on resident's right hand daily. She further indicated the resident was recommended to be placed on range of motion services.</p> <p>During an interview on 4/1/16 at 2:44 p.m., CNA # 6 indicated Resident # 31 had a palm protector and it should be placed on the resident's right hand during the day and off at night. She indicated the resident should have been placed on passive range of motion when he returned from his most recent hospital stay, but "he fell through the cracks".</p> <p>The resident's medical record was reviewed on 3/28/16 at 11:00 a.m. The record indicated the resident's diagnoses included, but was not limited to, right hand contracture.</p> <p>A physician's order, dated 2/19/16, for the resident to wear right hand palm protector with finger separator during the day and off at night.</p>		<p>monitor performance to assure compliance through quality assurance is:</p> <p>A Performance Improvement Tool has been initiated on the following: DON to randomly observe 5 residents with contractures for proper placement of adaptive equipment, careplan and restorative programs. The Director of Nursing, or designee, will complete these tools weekly x3, monthly x3, then quarterly x3. Any issues identified will be immediately corrected and additional training will immediately occur. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations for new interventions as needed based on the outcomes of the tools.</p> <p>The date the systemic changes will be completed: May 5, 2016.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155511	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/05/2016
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NAME OF PROVIDER OR SUPPLIER TERRE HAUTE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 830 S 6TH ST TERRE HAUTE, IN 47807
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F 0325 SS=D Bldg. 00	<p>The quarterly MDS assessment, dated 12/16/15, coded the resident as having an impairment on one side for upper extremity.</p> <p>A undated policy, identified as current, titled. "Restorative Nursing Policy and Procedure", was provided by the Regional MDS Consultant on 4/5/16 at 11:11 a.m. The policy indicated " ... 2. Develop the Care Plan (restorative). The care plan must have measurable objective and the interventions must be documented in the care plan. The care plan is designed on an individual basis...4. Minutes of restorative nursing must be traced and documented daily..."</p> <p>3.1-42(a)(2)</p> <p>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</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155511	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/05/2016
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NAME OF PROVIDER OR SUPPLIER TERRE HAUTE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 830 S 6TH ST TERRE HAUTE, IN 47807
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	<p>condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on interview and record review, the facility failed to ensure the nutritional status of a resident by not providing an sack meal to the resident when she out the facility for her dialysis treatments. (Resident #45).</p> <p>Finding includes:</p> <p>On 3/30/16 at 9:45 a.m., during an interview, Resident #45 indicated she received dialysis treatment 3 times per week at the dialysis center. She indicated she would leave the facility around 3:15 p.m., and return between 7:00 p.m., and 8:00 p.m. She indicated she would not be present in the facility for the evening meal. The resident indicated the facility did not send a sack meal with her. She indicated the facility would provide her a meal tray when she returned to the facility, but only if she requested one.</p> <p>During an interview on 3/30/15 at 9:52 a.m., the Dietary Manager indicated the resident left the facility around 3:00 p.m., on her dialysis days. She indicated there would be no need to send a sack meal with the resident because she was usually back in the facility in time for the evening meal.</p>	F 0325	<p>F325</p> <p>It is the practice of Terre Haute Healthcare and Rehab to assure that residents' maintain acceptable parameters of nutritional status, such as bodyweight and protein levels, unless the resident clinical condition demonstrate that this is not possible and that they receive a therapeutic diet when there is a nutritional problem.</p> <p>The correction action taken for those residents found to be affected by the deficient practice include:</p> <p>Resident # 45 will be provided a sackmeal upon leaving for dialysis. DSM was given a teachable moment in regards to providing sack meals for residents LOA.</p> <p>Other residents that have the potential to be affected have been identified by:</p> <p>Any resident on LOA had the potential to be affected but none were identified.</p> <p>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</p> <p>All Dietary staff in-serviced on providing a sack meal to any resident on LOA during meals.</p> <p>The corrective action taken to monitor performance to assure compliance through quality</p>	05/05/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155511	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/05/2016
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NAME OF PROVIDER OR SUPPLIER TERRE HAUTE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 830 S 6TH ST TERRE HAUTE, IN 47807
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>On 3/30/16 at 11:23 a.m., LPN #2, indicated the facility would provide a sack meal for the resident on her dialysis, if the resident requested it.</p> <p>During a telephone interview with the dialysis center nurse on 3/30/16 at 12:22 p.m., the nurse indicated the dialysis staff complete a post treatment form that is sent back to the facility with each nursing facility resident. She indicated one section on the form indicated if a lunch meal was eaten during the treatment. The dialysis nurse indicated if the form was marked "no meal eaten," then no meal would have been sent with the resident.</p> <p>Review of Resident #45's medical record on 3/30/16 at 8:40 a.m., indicated the resident's diagnoses included, but were not limited to, end-stage renal disease with hemodialysis.</p> <p>The resident's Admission Minimum Data Set (MDS) assessment dated 2/5/15, indicated the resident had no cognitive deficit, had an active diagnosis of end-stage renal disease and received dialysis.</p> <p>A care plan dated 2/5/16, indicated the resident was a nutritional risk related to her diagnoses including, but not limited</p>		<p>assurance is:</p> <p>A Performance Improvement Tool has been initiated that will be utilized to randomly review 5 residents on LOA during meal time, to assure a sack meal was provided. The Administrator, DSM or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any areas identified via the audit will be immediately corrected. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed.</p> <p>The date the systemic changes will be completed:</p> <p>May 5, 2016</p>	

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	<p>to, kidney disease. Interventions included, but were not limited to, administer nutritional support.</p> <p>Review of documents titled, "Post Treatment Report," dated 2/1/16 through 4/30/16, indicated no lunch had been consumed by the resident. Documents dated 2/1/16 and 2/10/16, each had a note that indicated no lunch had been sent with the resident.</p> <p>A verbal policy, provided by the Dietary Manager on 4/5/16 at 10:53 a.m., indicated the facility would provide a sack lunch to any resident going on a LOA (leave of absence) from the facility, if it was requested.</p> <p>3.1-46(a)(1)</p>			