

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155160	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/29/2016
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NAME OF PROVIDER OR SUPPLIER  STONEBROOKE REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 990 N 16TH ST NEW CASTLE, IN 47362
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F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: July 24, 25, 26, 27, 28, and 29, 2016</p> <p>Facility number: 000080 Provider number: 155160 AIM number: 100289330</p> <p>Census bed type: SNF: 10 SNF/NF: 90 Total: 100</p> <p>Census payor type: Medicare: 15 Medicaid: 69 Other: 16 Total: 100</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 30576 on August 5, 2016</p>	F 0000		

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

TITLE

(X6) DATE

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

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F 0246 SS=D Bldg. 00	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident's call light was in reach for 2 observations and 1 of 12 residents. (Resident #97)</p> <p>Findings include:</p> <p>During an observation, on 7/25/16 at 10:14 a.m., Resident #97 was lying on her back with the head of her bed up about 30 degrees. Her call light was on the right side of her bed where she could not reach it with her left hand. Resident #97 had right sided weakness and when asked if she could reach her call light, she attempted to reach towards the right with her left hand but could not reach the call light.</p> <p>On 7/26/2016 at 2:22 p.m., Resident #97's call light was observed on the overbed table, on the right side of her bed out of reach with her left hand.</p> <p>During an interview, on 7/26/2016 at</p>	F 0246	<p>Please find enclosed a plan of correction from our annual survey conducted July 24,2016 thru July 29,2016 We respectfully request a desk review and paper compliance in this matter Thank you for your consideration 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #97 call light was placed in reach of resident's left hand and plan of care updated to reflect call light location 2) how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents with Hemiparesis/Hemiplegia have the potential to be affected by this alleged deficient practice, CNA #7 was in-serviced on placing call light within reach of resident's left hand, audit completed to identify all residents with Hemiparesis/Hemiplegia per DNS/designee , Review residents identified with Hemiparesis/Hemiplegia and completed plan of care 3) what measures will be put into place or</p>	08/28/2016			

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	<p>2:24 p.m., CNA #7 indicated Resident #97 can use her call light to call staff when she needs something.</p> <p>Resident #97's record was reviewed on 7/28/2016, at 3:22 p.m. The record indicated Resident #97 had diagnoses that included, but were not limited to, difficulty swallowing, depression, chronic obstructive pulmonary disease, right hand and wrist contracture, hemiplegia (paralysis on one side of the body) and hemiparesis (paralysis/weakness on one side of the body) following intracranial hemorrhage affecting the right dominant side, insomnia, aphasia, (unable to speak), anxiety, type 2 diabetes mellitus, mixed hyperlipidemia (high blood fats), high blood pressure, history of transient ischemic attack and cerebral infarction, urinary retention, and chronic pain.</p> <p>An Annual Minimum Data Set assessment, dated 5/18/16, indicated Resident #97 was severely impaired in cognitive skills for daily decision making, required extensive assistance of 2 for bed mobility, transfers, toileting, and personal hygiene, did not walk, required extensive assist of 1 for eating, was totally dependent on 2 for bathing, and had impairment on one side of upper and lower extremities.</p>		<p>what systemic changes will be made to ensure that the deficient practice does not recur; All nursing staff in-service on call light placement and call light rounds to be completed by DNS/designee by 8/28/2016, Hall charge nurse will utilize audit tool (Attachment A) and complete hourly rounds to ensure correct placement of resident call light as indicated per plan of care, DNS/designee will audit daily to ensure that hourly checks are being completed 4) how the corrective action(s) will be monitored to ensure the deficient practice will not recur,ie, what quality assurance program will be put into place; CQI tool for call lights (Attachment B) will be completed weekly x4 weeks, monthly x 3 months, and quarterly thereafter until compliance is achieved, Results will be reviewed at monthly Quality Assurance Meeting which is overseen by the Executive Director, If a compliance of 100% is not achieved then an action plan will be developed to ensure compliance 5) By what date the systemic changes will be completed; Completion date 8/28/16</p>	

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	<p>A care plan, dated 5/20/16, indicated a problem for: "Resident has impaired vision R/T (related to) age. Goal: Resident will not experience negative consequences of vision loss as evidenced by: remaining physically safe, and participating in social and self-care activities. Approaches (included but were not limited to)...Keep call light in reach at all times...."</p> <p>A care plan, last revised on 5/20/16, indicated a problem for: "Resident is at risk for fall due to: debility, risks associated with multiple medications, incontinence, and right hemiparesis. Goal: Resident will be free from fall related injury. Approaches (included but were not limited to)...Call light in reach...."</p> <p>During an interview, on 7/29/2016 at 1:55 p.m., the Director of Nursing Services and Executive Director indicated they don't have a policy for placing the call light in reach, it is part of general nursing duties.</p> <p>3.1-3(v)(1)</p>			

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F 0309 SS=D Bldg. 00	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on interview and record review the facility failed to complete a neurological assessment for an unwitnessed fall and failed to assess a resident experiencing emesis for 1 of 6 residents who met the criteria for hospitalization of 3 residents reviewed for hospitalization (Resident #23).</p> <p>Finding include:</p> <p>1.) Review of the record of Resident #23 on 7/25/16 at 2:48 p.m., indicated the resident was admitted to the hospital within 30 days of admission to the facility.</p> <p>Review of the record of Resident #23 on 7/26/16 at 12:46 p.m., indicated the resident's diagnoses included, but were not limited to, rhabdomyolysis, insomnia, reflux, dysphagia, constipation, pain, acute kidney failure, enlarged prostate, urinary retention, arteriosclerotic heart</p>	F 0309	<p>Please find enclosed a plan of correction from our annual survey conducted July 24,2016 thru July 29,2016 We respectfully request a desk review and paper compliance in this matter Thank you for your consideration 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #23 no longer resides at facility 2) how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents that have an unwitnessed fall have the potential to be affected by the alleged deficient practice, All residents experiencing emesis have the potential to be affected by this alleged deficient practice, LPN #3 has been educated to complete a neurological on any resident that has an unwitnessed fall per policy, RN #23 has been educated to assess and document on all residents with a</p>	08/28/2016

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	<p>disease, Cerebrovascular accident (CVA), and dehydration.</p> <p>The Admission Minimum Data Set (MDS) assessment for Resident #23, dated 4/26/16, indicated the resident had unclear speech. He was able to understand others sometimes and was sometimes was able to be understood. The resident was severely impaired for daily decision making. The resident required extensive assistance of two people for bed mobility, transfers, personal hygiene, dressing and toilet use. The resident required extensive assistance of one person for locomotion on and off the unit. The resident had a catheter and was frequently incontinent of his bowels.</p> <p>The fax to the physician, dated 4/27/16 (no time), indicated Resident #23 had two small soft formed dark brown in color with red noted bowel movements. The resident's abdomen was soft, round and non tender. The resident vomited a large amount of brown emesis last evening and vomited thin/clear three times during the night. The resident had a decrease in appetite. The resident's blood pressure was 100/60, temperature- 97.9, respirations-18, pulse- 69 and oxygen saturation was 94 percent. The record indicated there was no assessment or</p>		<p>change in condition ie emesis , All licensed nursing staff will be in-serviced on fall policy and initiating neurological assessment on all unwitnessed falls, All licensed nursing staff will be in-serviced on completing assessment and documenting on all residents with change in condition ie emesis 3) what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; DNS/designee will in-service all licensed nursing staff by 8/28/16 on fall policy and initiating a neurological assessment on all unwitnessed falls, DNS/designee will in-service all licensed nursing staff by 8/28/16 on completing an assessment and documenting on all residents with a change in condition ie emesis, DNS/designee will review the facility activity report daily to identify residents with change in condition or falls, DNS/designee will check post fall that neurological checks have been initiated 4) how the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie, what quality assurance program will be put into place; CQI tool for Neurological/ Change in condition assessment (Attachment C) will be completed weekly x 4 weeks, monthly x 3 months and quarterly thereafter until compliance is achieved, Results will be</p>	

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	<p>documentation of the resident after he experienced emesis three times during the night.</p> <p>The progress note for Resident #23, dated 4/29/16 at 3:42 a.m., indicated the resident had been up and down during this shift. The resident was easily redirected back into a laying position. The resident's bed alarm was in place and functioning.</p> <p>The event report for Resident #23, dated 4/29/16 at 7:40 a.m., indicated the resident had an unwitnessed fall . The resident was fully clothed with gripper socks on. The resident was in his wheelchair at the nursing station. The resident was sitting on the left foot pedal of his wheelchair with his right arm between the right foot pedal and wheel of the wheelchair. The intervention implemented was therapy referral.</p> <p>The progress note for Resident #23, dated 4/29/16 at 7:45 a.m., indicated the resident was up in his wheelchair at the nursing station. The resident was restless and trying to get out of bed. The resident was moving around in his wheelchair. The resident was found sitting on the left foot pedal of his wheelchair with his right arm between the right foot pedal and the wheel of the wheelchair. The resident's</p>		<p>reviewed in monthly Quality Assurance meeting which is overseen by the Executive Director and if a threshold of 100% is not achieved an action plan will be developed to ensure compliance 5) By what date the systemic changes will be completed; Completion date 8/28/16</p>	

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	<p>range of motion was as usual and there were no apparent injuries. The resident was assisted back into his wheelchair.</p> <p>The progress note for Resident #23, dated 4/29/16 at 10:15 a.m., indicated the Nurse Practitioner (N.P.) was at the facility and made aware of the resident's fall and the resident was not acting his usual self. The N.P. gave new orders for a STAT (immediately) CT (computed tomography) of abdomen and pelvis and CBC (complete blood count) and CMP (comprehensive metabolic panel).</p> <p>The progress note for Resident #23, dated 4/29/16 at 1:05 p.m., indicated the resident left to go to the hospital by ambulance for the CT scan, CBC and CMP.</p> <p>The progress note for Resident #23, dated 4/29/16 at 2:00 p.m., indicated the resident returned to the facility. The facility was awaiting the test results.</p> <p>The progress note for Resident #23, dated 4/29/16 at 2:10 p.m., indicated the N.P. ordered the resident to be sent back to the hospital due to the lab results and CT scan. The local hospital was called and given report.</p> <p>The Emergency Department (ED)</p>			

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	<p>provider note for Resident #23, dated 4/29/16 at 3:10 p.m., indicated the resident primary complaint was altered mental status. The resident was drowsy and disoriented to person. The resident had deteriorated with abdominal pain and not eating. The resident WBC was 34.28 (high) and his renal function had worsened. The CT scan of the abdomen showed diffuse inflammatory changes to the duodenum and possible pancreas. The diagnostic impression was multisystem organ failure, sepsis and duodenitis. The resident would be admitted for antibiotic therapy and intravenous therapy fluids.</p> <p>The local hospital history and physical for Resident #23, dated 4/29/16, indicated the resident was experiencing generalized weakness for approximately 3 days. The resident was a poor historian as he had a recent CVA and minimally verbal. The resident began having episodes of vomiting 3 days ago. The resident had poor oral intake, generalized edema and decreased activity. The resident came to the emergency room and was found to have dehydration, elevated WBC and an abnormal CT of the abdomen and pelvis. The "assessment/plan" indicated the resident had a urinary tract infection with sepsis, acute renal failure, duodentis ("this was likely the resident's cause of vomiting</p>			

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	<p>and poor oral intake in the last three days") and dementia.</p> <p>The progress note for Resident #23, dated 5/2/16 at 2:40 p.m., indicated the resident returned from the hospital. The resident was lethargic and non responsive. The resident had rhonchi breath sounds.</p> <p>Interview with the LPN #3 on 7/27/16 at 2:28 p.m., indicated she was the nurse for Resident #23 when he fell on 4/29/16 and did not complete a neurological assessment on the resident after he fell. LPN #3 indicated when she found the resident he had slid out of his wheelchair and the position he was in she did not think he had hit his head.</p> <p>Interview with LPN #3 on 7/27/16 at 2:42 p.m., indicated she was unsure how long it had been between the last time she seen Resident #23 and when he fell on 4/29/16. LPN #3 indicated she did not think it had been a long time. LPN #3 indicated she did give report to the hospital when he was admitted on 4/29/16 and could not remember if she told the hospital in report that the resident had experienced a fall prior to hospitalization.</p> <p>Interview with the Director of Nursing Services (DNS) on 7/29/16 at 10:25 a.m.,</p>			

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	<p>indicated there was no assessment of Resident #23 after he vomited three times on 4/27/16 during the night.</p> <p>Interview with RN #4 on 7/29/16 at 10:34 a.m., indicated she was the nurse that sent the fax on 4/27/16 to the physician related to Resident #23 experiencing emesis. RN #4 indicated she was not the nurse caring for him during the night when he vomited three times. RN #4 indicated she knew the resident had vomited three times during the night because she was told about it in report.</p> <p>During interview with the DNS on 7/29/16 at 2:31 p.m., indicated when a resident experienced vomiting a respiratory assessment, abdominal assessment, vital signs, description and amount of the emesis should be completed.</p> <p>The fall management program provided by DNS on 7/27/16 at 2:30 p.m., indicated "A neurological assessment will be initiated on all un-witnessed falls".</p> <p>3.1-37(a)</p>			

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F 0323 SS=D Bldg. 00	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to follow the resident's plan of care and physician's order to keep the bed in low position to prevent accidents, for 2 of 3 residents reviewed for accidents. (Resident #19 and #10).</p> <p>Findings include:</p> <p>1. Resident #19's record was reviewed on 7/26/16 at 12:41 p.m. Her quarterly Minimum Data Set (MDS) assessment dated 6/9/16, indicated she was understood and had the ability to understand others. She was moderately impaired in her cognitive daily decision making skills. She required extensive assistance of 2 person for bed mobility, transfers, and toileting. She required supervision with set-up help only to walk in her room and limited assistance of 1 person to walk in the corridor and on the unit. She utilized a walker for mobility.</p>	F 0323	<p>Please find enclosed a plan of correction from our annual survey conducted on July 24,2016 thru July 29,2016 We respectfully request a desk review and paper compliance in this matter Thank you for your consideration 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Residents #10 and #19 beds were placed in lowest position 2) how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; LPN #8 and RN #9 were in-serviced on bed in lowest position, all residents with an order for bed in lowest position as a fall intervention have the potential to be affected by this alleged deficient practice, DNS completed and audit and identified all residents with an order for bed in lowest position, review of all residents identified with order for bed in lowest position to ensure that this</p>	08/28/2016

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	<p>She was not steady and only able to with human assistance when moving from a seated to standing position, surface to surface transfer, and moving on and off the toilet. She was not steady but able to stabilize without human assistance when turning around and facing the opposite direction while walking. She had 1 fall with minor injury since her prior assessment.</p> <p>Resident #19's diagnoses documented on her July 2016 physician's recapitulation orders included but were not limited to, vascular dementia without behavioral disturbances, anemia, insomnia, cataracts, gout, osteoarthritis, hypertension, type 2 diabetes, and a history of falls.</p> <p>An "Event Report" for Resident #19 dated 7/19/16 at 10:10 p.m., indicated she had an unwitnessed fall. She had been hollering out and found supine on the floor next to her bed. No injuries were noted. The immediate intervention put into place to prevent another fall was her bed would be in the lowest position.</p> <p>A "Progress Note" for Resident #19 dated 7/20/16 at 8:04 p.m., indicated the Interdisciplinary Team (IDT) had met to review a fall that had occurred with Resident #19 on 7/18/16. Resident #19</p>		<p>intervention is reflected on residents individualized plan of care 3) what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; All nursing staff will be in-serviced by 8/28/16 on bed in lowest position and hourly rounds by the DNS/designee, Hall charge nurse will complete hourly rounds to ensure that beds are in lowest position per plan of care and document on audit tool (Attachment D), DNS/designee will audit daily to ensure that hourly checks of beds in lowest position are being completed by hall charge nurse 4) how the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie, what quality assurance program will be put into place; CQI tool (Attachment E) for hourly checks will be completed weekly x 4 weeks, monthly x 3 months and quarterly thereafter until compliance is achieved, Results of the audit will be reviewed at monthly Quality Assurance meeting which is overseen by the Executive Director and if a threshold of 100% is not achieved then an action plan will be developed to ensure compliance 5) by what date the systemic changes will be completed; Completion date 8/28/16</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155160	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/29/2016
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	<p>had appeared to have rolled out of bed. Resident #19 had been assisted back to bed. The IDT had agreed the approach to prevent a reoccurrence would be to keep Resident #19's bed in the lowest position.</p> <p>A physician's order for Resident #19 documented on her July 2016 physician's recapitulation orders initiated 7/20/16, indicated her bed would be in the lowest position when she was in bed.</p> <p>A plan of care for Resident #19 initiated 8/12/15, indicated she was at risk for falls due to a history of falls, poor safety awareness, weakness, incontinence, and multiple medications. Her goal indicated her fall risk factors would be reduced in an attempt to avoid significant fall related injuries. An approach initiated 7/20/16, indicated her bed would be in the lowest position.</p> <p>A "Progress Note" for Resident #19 dated 7/21/16 at 11:07 a.m., indicated she had a light blue bruise to her forehead that measured 5.2 centimeters (cm) by 5.4 cm, a blue bruise on her left elbow that measured 2.0 cm by 1.2 cm, and a blue bruise laterally to her left elbow that measured 4.5 cm by 4.0 cm. Resident #19 had reported the areas had been tender to touch since her fall on 7/19/16.</p>			

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	<p>An interview with LPN #8 on 7/25/16 at 10:15 a.m., indicated Resident #19 had fell on 7/19/16, and 2 days later staff had discovered Resident #19 had some bruising.</p> <p>On 7/26/16 at 1:18 p.m., Resident #19 was observed lying in bed covered with a blanket. Her bed was raised approximately 2 foot from the floor. She indicated she had fell a few minutes ago and had not hurt herself. She indicated she thought she had fell in her room.</p> <p>On 7/26/16 at 1:19 p.m., RN #9 brought Resident #19 some Tylenol. RN #9 indicated Resident #19 had fell in her bathroom and was found lying on her back at 12:40 p.m. RN #9 indicated Resident #19 had ambulated from the dining room to her bathroom indecently with a walker and had fell. RN #9 indicated no injuries were noted from the fall.</p> <p>On 7/28/16 at 1:38 p.m., Resident #19 was observed lying in bed on her left side covered with a blanket with her eyes closed. Her bed was approximately 2 foot from the floor. LPN #10 entered Resident #19's bedroom and indicated Resident #19's bed was in the low position.</p>			

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	<p>On 7/28/16 at 2:35 p.m., LPN #8 assessed Resident #19 for some discoloration on her right shin. Resident #19's bed had been placed in the lowest position and was near the floor.</p> <p>2. Resident #10's record was reviewed on 7/27/16 at 3:55 p.m. His quarterly MDS assessment dated 4/23/16, indicated he was sometimes understood and he sometimes understood others. He was severely impaired in his cognitive daily decision making skills. He required extensive assistance of 2 persons for bed mobility. He required extensive assistance of 1 person to transfer and toilet. He walked in his room, the corridor, and unit with limited assistance of 1 person. He was not steady and only able to stabilize with human assistance moving from a seated to standing position. He was not steady but able to stabilize without human assistance for surface to surface transfers, turning and facing the opposite direction while walking, and moving on and off the toilet. He had no falls since his prior assessment.</p> <p>Resident #10's diagnoses documented on his July 2106 physician's recapitulation orders included but were not limited to, dementia with behavioral disturbance, anxiety disorder, insomnia, chronic pain,</p>				

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	<p>osteoporosis, vitamin B-12 deficiency anemia, type 2 diabetes, and hypertension.</p> <p>A "Fall Event" for Resident #10 dated 6/29/16 at 11:11 a.m., indicated he had an unwitnessed fall and was found sitting on his buttock next to his bed after attempting to get up. No injuries were noted. The intervention put in place to prevent another fall was his bed would be in the lowest position when he was in bed. A "Fall Event" documented for Resident #10 indicated he had also suffered a fall on 4/30/16, 7/2/16, and /22/16, while ambulating.</p> <p>A "Progress Note" for Resident #10 dated 6/30/16 at 12:07 p.m., indicated IDT met to review a fall that occurred with Resident #10 on 6/2/16 at 11:11 a.m. Staff had entered Resident #10's bedroom and found sitting on his buttock next to his bed. No injuries were noted. The immediate intervention was for staff to toilet resident prior to bed and check him every 2 hours and as needed. His bed would be placed in the lowest position.</p> <p>A physician's order on Resident #10 documented on his July 2016 physician's recapitulation orders initiated 6/30/16, indicated his bed would be in the lowest position when he was in bed.</p>			

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	<p>A plan of care for Resident #10 initiated 3/19/12, indicated he was at risk for falls related to a history of falls, decreased mobility, transfer ischemic attack, dementia, incontinent at times, prostate cancer, anemia, unsteady gait at times, unable to learn assistive device safety, impulsivity, poor safety awareness, and risk associated with multiple medications. He was noted to unplug alarms and get down on the floor to look for different items. His goal would be to have no injury related to falls. An approach initiated 6/30/16, indicated his bed would be in the lowest position at all times.</p> <p>On 7/29/16 at 10:34 a.m., Resident #10 was observed lying in bed on his right side covered with a blanket. He indicated he thought he would get some sleep. His call light was under his bed. His bed was approximately 2 foot off the floor. He indicated he was thirsty and started to get out of bed. He was encouraged to stay in bed and CNA #11 was informed Resident #10 complained of thirst.</p> <p>On 7/29/16 at 10:38 a.m., CNA #11 encouraged Resident #10 to stay in bed and informed him she would bring him something to drink. CNA #11 provided Resident #10 with his call light. CNA</p>			

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	<p>#11 pushed a button on Resident #10's bed footboard and lowered his bed next to the floor. CNA #11 indicated if a resident had an intervention to have the bed in low position it meant to lower the bed as low as it would go. CNA #11 indicated the information related to a resident's interventions was posted in the Kiosk.</p> <p>The "Fall Management Program" procedure provided by the Director of Nursing Services on 7/29/16 at 1:00 p.m., indicated the following: "Policy: ...To ensure residents residing within the facility will maintain maximum physical functioning through the establishment of physical, environmental, and psychosocial guidelines to prevent injury related to falls. Procedure: ...5. Residents who are categorized as moderate to high risk should have fall interventions implemented based on resident specific risk factors. 6. The resident specific care requirements will be communicated to the assigned caregiver utilizing resident profile or CNA assignment sheet...."</p> <p>3.1-45(a)(2)</p>			

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F 0371 SS=E Bldg. 00	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation and interview, the facility failed to educate staff on the correct procedure to monitor the dish machine water temperature, document food temperatures every meal, and document sanitation bucket solution in the kitchen 3 times daily. This practice had the potential to affect 100 resident who received meals from the kitchen.</p> <p>Findings include:</p> <p>During initial tour of the kitchen on 7/24/16 at 4:11 p.m., the chemical dish machine had recommendations posted on the outside of the machine to wash dishes at a minimum of 120 degrees and rinse dishes at a minimum of 120 degrees.</p> <p>The "Low Temp Dishmachine Temperature/Sanitizer Log" posted on the wall near the dish machine indicated the supper wash and rinse temperature had</p>	F 0371	<p>Please find enclosed a plan of correction from our annual survey conducted July 24,2016 thru July 29,2016 We respectfully request a desk review and paper compliance in this matter Thank you for your consideration 1) what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;- No residents were affected by this alleged deficient practice,- All dietary staff have been in-serviced on the correct procedures to monitor dish machine water temperature, documenting food temperatures every meal and documenting sanitation bucket solution in the kitchen 3 times daily -Water temperature gauge on wash machine was replaced to ensure accuracy 2) how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; - All residents have the potential to be</p>	08/28/2016

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NAME OF PROVIDER OR SUPPLIER  STONEBROOKE REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 990 N 16TH ST NEW CASTLE, IN 47362
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	<p>been posted for 7/24/16. The wash temperature indicated 120 degrees and the rinse temperature indicated 130 degrees. Dietary Cook #12 indicated she had posted the supper temperatures for 7/24/16 by mistake. She marked the temperatures out on the log she had posted for supper on 7/24/16. She indicated she didn't really know but she believed the temperature gauge on the dish machine was broken. She indicated she was going to test the dish machine water temperature and placed a glass faced thermometer in the well of water attached to the dish machine during the wash cycle. She pulled the thermometer out and indicated that procedure wasn't working. She placed the same thermometer in the dish machine and checked the thermometer during the wash and rinse cycle. The thermometer read 95 degrees on the wash cycle and 100 degrees on the rinse cycle. She indicated she didn't normally test the dish machine water temperature but when she did she used the glass faced thermometer. She indicated she was supposed to use a blue thermometer that she provided for observation but she didn't know how to use it. Dietary Aide #13 indicated she worked different shifts but hadn't tested the dish machine water temperature but had observed other staff test it.</p>		<p>affected by this alleged deficient practice, - Executive Director/designee will conduct daily rounds in kitchen to check that logs on dish machine water temperature, food temperatures at every meal and sanitation bucket concentration are kept current per policy - In-service completed by the Executive Director/designee to all dietary staff on policy and procedures for documenting dish machine water temperature, documenting food temperatures every meal and documenting sanitation bucket solution 3) what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; In-service completed by the Executive Director/designee by 8/28/16 on policy and procedures for documenting dish machine temperature, documenting food temperatures every meal and documenting sanitation bucket solution - Executive Director/designee to make daily rounds and check that logs on dish machine water temperature, food temperatures and documenting sanitation bucket solution are current per policy 4) how the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie, what quality assurance program will be put into place; - CQI tool (Attachment F) for Dietary will be completed weekly x 4 weeks, monthly x 3</p>	

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	<p>The "Sanitizing Bucket Concentration" documentation hanging on the wall indicated no sanitation concentration had been taken on the 2 buckets near the steam table for breakfast on 7/22/16, 7/23/16, and 7/24/16. No sanitation concentration had been taken during lunch from 7/18/16 through 7/24/16. No sanitation concentration had been taken during supper from 7/16/16 through 7/23/16. The "Weekly Temperature Record" documentation hanging on the wall indicated no food temperatures had been taken for breakfast and lunch from 7/20/16 through 7/24/16. Dietary Cook #12 indicated the bucket sanitation concentration log and weekly food temperature log were not completed. She indicated the bucket sanitation concentration should be tested and documented every shift and the meal temperatures should be taken every meal and documented on the meal log.</p> <p>An interview with the Maintenance Director on 7/24/16 at 5:37 p.m., indicated the water temperature gauge on the dish machine had been broken approximately 5 years. He indicated the temperatures on his thermometer and the dish machine gauge didn't match and that was how he knew the dish machine gauge didn't work. He ran the dish machine and tested the wash and rinse water</p>		<p>months and quarterly thereafter until compliance is achieved, - Results will reviewed at the monthly Quality assurance meeting which is overseen by the Executive Director and if a threshold of 100% is not achieved then an action plan will be developed to ensure compliance</p> <p>5) By what date the systemic changes will be completed; Completion date 8/28/16</p>	

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	<p>temperature from the well of water attached to the dish machine with an Extech Pocket fold up thermometer. His thermometer indicated the wash cycle water temperature was 151 and the rinse cycle water temperature was 145.6. The dish machine gauge needle moved from 120 degrees to 130 degrees during the wash and rinse cycle. He indicated he was going to have the temperature gauge replaced on the dish machine.</p> <p>An interview with the Dietary Manager on 7/27/16 at 11:24 a.m., indicated a new water temperature gauge had been put on the dish machine. The company who replaced the original gauge had informed her the original temperature gauge was temping fine but replaced it per the facility's request. She indicated the staff normally read the water temperature gauge on the dish machine for posting their water temperatures. She indicated she monitored staff were posting the dish machine water temperatures. Staff always checked the food temperatures at every meal and a staff had wrote down the food temperature that were missing on the log on another piece of paper and forgot to post them. The staff were checking the sanitation bucket concentration twice daily except for the the holes on the sanitation log.</p>			

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	<p>On 7/27/16 at 11:28 .am., the Maintenance Director indicated the company that replaced the water temperature gauge on the dish machine informed him there was nothing wrong with the original temperature gauge.</p> <p>On 7/27/16 at 11:36 a.m., the Dietary Manager tested the water temperature gauge on the dish machine. The wash cycle temperature on the dish machine gauge read 124 degrees and the rinse temperature read 140 degrees.</p> <p>On 7/29/16 at 11:33 a.m., the Dietary Manager indicated the dish machine was serviced monthly and all the gauges were checked when serviced. They served 100 residents from the kitchen.</p> <p>On 7/29/16 at 12:49 p.m., the Clinical Education Coordinator indicated there had been no food borne illnesses's in the facility. Primarily it would be the Dietary Manager's responsibility to educate the kitchen staff on how to read the dish machine water temperature gauge, take and post the food temperatures, and test and post the sanitation bucket concentration.</p> <p>The "Recording Dish Machine Temperature/Sanitizer" procedure provided by the Administrator on 7/29/16</p>			

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	<p>at 1:13 p.m., indicated the following: "Policy: Dishwashing staff will monitor and record dish machine temperatures and/or sanitizer concentration to assure proper sanitizing of dishes. Procedure: 1. The Dietary Services Manager will provide a log to be posted near the dish machine. 2. The Dietary Services Manager will train the staff to monitor the dish machine temperatures throughout the dishwashing process. 3. Staff will be trained to record dish machine temperatures for the wash and rinse cycles and the sanitizer concentration (if appropriate) at each meal. 4. The Dietary Services Manager will spot check these logs to assure the temperatures/sanitizer concentrations are appropriate, and staff are monitoring dish machine temperatures. 5. Dishwashing staff will be trained to report any problems with the dish machine to the Dietary Services Manager as soon as they occur. 6. The Dietary Services Manager will promptly assess any dish machine problems and take corrective action to assure appropriate sanitization of dishes."</p> <p>The "Food Temperatures" procedure provided by the Administrator on 7/29/16 at 12:56 p.m., indicated the following: "Policy: The Facility will prepare and serve food at the proper temperature to prevent food borne illness. Procedure:</p>			

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F 0514 SS=D Bldg. 00	<p>...8. Temperatures should be recorded at the beginning of meal service to ensure hot food is served at or above 135 F (Fahrenheit) and cold food is served at or below 41 F...."</p> <p>3.1-21(i)(2)</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on interview and record review, the facility failed to document a clinical assessment for a resident who had passed away for 1 of 1 resident who met the criteria for death (Resident #23).</p>	F 0514	Please find enclosed a plan of correction from our annual survey conducted July 24,2016 thru July 29,2016 - We respectfully request a desk review and paper compliance in this matter - Thank you for your consideration 1) what	08/28/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155160	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  07/29/2016
NAME OF PROVIDER OR SUPPLIER  STONEBROOKE REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 990 N 16TH ST NEW CASTLE, IN 47362		
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	<p>Finding include:</p> <p>1.) Review of the record of Resident #23 on 7/25/16 at 2:36 p.m., indicated the resident died within 30 days of admission to the facility.</p> <p>Review of the record of Resident #23 on 7/26/16 at 12:46 p.m., indicated the resident's diagnoses included, but were not limited to, insomnia, pain, acute kidney failure, dehydration, urinary retention, dysphagia and Cererbrovascular accident (CVA).</p> <p>The progress note for Resident #23, dated 5/3/16 at 4:15 a.m., indicated the resident passed away and notification to the physician and family were made. There were no other clinical findings documented.</p> <p>Interview with the Director of Nursing Services (DNS) on 7/28/16 at 1:28 p.m., indicated the facility did not have a policy related to a procedure for when a resident passed away.</p> <p>Interview with LPN #1 on 7/28/16 at 1:35 p.m., indicated she had assisted LPN #2 when Resident #23 passed away on 5/3/16. LPN #1 indicated she assessed Resident #23 by checking for a heart beat and pulse, listened to his chest and there</p>		<p>corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; - Resident #23 passed away at the facility 2) how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; - All residents have the potential to be affected by this alleged deficient practice, - LPN #1 and LPN #2 were in-serviced on documenting completed assessment of an expired resident, - Executive Director and DNS will be notified of residents that expire while at facility , - DNS/designee will review all documentation of an expired resident to ensure 2 licensed staff have assessed resident to verify no signs of life and documented properly 3) what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; - All licensed nurses will be in-serviced by the DNS/designee by 8/28/16 on documentation expectations in the event of a resident expiring at the facility, - DNS/designee will review all documentation of an expired resident to ensure that 2 licensed staff have assessed resident to verify no signs of life and documented assessment appropriately, - All new hired licensed nursing staff will be in-serviced by the Clinical</p>		

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	<p>were no signs of life.</p> <p>Interview with LPN #2 on 7/28/16 at 2:30 p.m., indicated she was the nurse caring for Resident #23 on 5/3/16 when he passed away. LPN #2 indicated she had monitored the resident all evening. LPN #2 indicated she had LPN #1 come and assist her to verify the resident had passed away. LPN #2 indicated they both listened for lung sounds and heart beat and felt for a pulse. LPN #2 indicated she had not documented her assessment because she had thought LPN #1 had documented it.</p> <p>3.1-50(j)(3)</p>		<p>Education Coordinator at the time of hire on documentation expectations in the event of a resident expiring at the facility, - The Executive Director and DNS will be notified of a resident expiring while at the facility 4) how the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie, what quality assurance program will be put into place; - CQI tool (Attachment G) for documentation of an expired resident will be completed by the DNS/designee weekly x 4 weeks, monthly x 3 months and quarterly thereafter until compliance is achieved,- The results will be reviewed at the monthly Quality Assurance meeting which is overseen by the Executive Director and if a threshold of 100% is not achieved then an action plan will be developed to ensure compliance 5) by what date the systemic changes will be completed; Completion date 8/28/16</p>		