| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155441 | A. BUILDING 00<br>B. WING | 08/24/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| CORYDON NURSING AND REHABILITATION CENTER | 315 COUNTRY CLUB RD<br>CORYDON, IN 47112 |

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure survey.<br><br>Survey dates: August 20, 21, 22, 23, and 24, 2018<br><br>Facility number: 000338<br>Provider Number: 155441<br>AIM number: 100287590<br><br>Census bed type:<br>SNF/NF: 26<br>Total: 26<br><br>Census payor type:<br>Medicaid: 23<br>Other: 3<br>Total: 26<br><br>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on September 4, 2018. | F 0000 | | |
| F 0550<br>SS=D<br>Bldg. 00 | 483.10(a)(1)(2)(b)(1)(2)<br>Resident Rights/Exercise of Rights<br>§483.10(a) Resident Rights.<br>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.<br><br>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, | | | |

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

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| | recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br><br>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.<br><br>§483.10(b) Exercise of Rights.<br>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.<br><br>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.<br><br>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.<br>Based on observation and interview, the facility failed to ensure residents were provided privacy during 3 of 4 observations of care (Residents 08, 10, and 23).<br><br>Findings include:<br><br>1. During an observation, on 08/22/18 at 09:13 a.m., CNA (Certified Nursing Assistant) 1 and CNA 2 performed perineal care (washing of genitals and anal area), on Resident 10, without | F 0550 | F550 Rights/Exercise of Rights<br>- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;<br>o CNAs identified were Re-educated on Rights of privacy. Resident Rights is included and will continue to be in new hire orientation. | 09/23/2018 |

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| | fully closing the privacy curtains, which were left open by three feet. The resident's roommate, Resident 6, was observed in her wheelchair from the opening of the privacy curtains. CNA 2 then observed the roommate and pulled the curtains closed. Resident 10 was severely cognitively impaired.<br><br>2. During an observation of perineal care, on 08/22/18 at 10:18 a.m., for Resident 23 by CNAs 2 and 1, the privacy curtains were left open the entire width of the resident's bed, from the junction of the tracking to the wall. The resident's roommate was present. LPN (Licensed Practical Nurse) 3 knocked and entered the resident's room. She performed wound care to the resident's coccyx, leaving the privacy curtains open. Resident 23 was severely cognitively impaired.<br><br>3. During an observation of perineal care, on 08/22/18 at 11:12 a.m., for Resident 8 by CNAs 1 and 2, the procedure was performed with the privacy curtains open at the head of the bed by three feet from the window between the residents. The curtains were left open 18 inches at the foot of the bed from the intersecting track to the wall. Resident 10 was severely cognitively impaired.<br><br>During an interview, on 08/22/18 at 11:20 a.m., CNA 1 indicated for care she would close the curtains to perform the perineal care.<br><br>On 08/22/18 at 12:47 p.m., during an interview with the DON (Director of Nursing), she indicated during care staff should knock on the door, pull the privacy curtains, and if another resident or their family member was in the room, they were asked to leave the room.<br><br>The review, on 08/22/18 at 12:52 p.m., of the | | - how other residents having the potential to be affected by the same deficient practice will be identified and corrective action(s) will be taken;<br>o All residents requiring assistance from staff have the potential to be affected by this finding. Staff observed non-compliant with this finding will be educated on the spot will be re-educated on the Non-Compliance.<br><br>- what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;<br>o All Staff In-Service on 9/19/18 Resident Rights and Privacy<br>o The DON/or Designee will complete audits of residents requiring assistance weekly x 4 and then monthly x 5 months.<br><br>- how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place;<br><br>o The results of these audits will be reviewed by the QAPI committee monthly. If compliance | |

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| | Resident Privacy Policy provided by the DON indicated "...Privacy shall be maintained during all care...Doors, curtains and privacy curtains shall be closed during Resident care activities to provide full visual privacy..."<br><br>3.1-3(t) | | is not achieved, an action plan will be developed and implemented. Monthly QAPI minutes and action plans are submitted to regional operations staff and corporate risk management team for review<br><br>- by what date the systemic changes will be completed<br>o Sept 19, 2018<br><br>- Facility requests desk review in lieu of revisit | |
| F 0689 SS=D Bldg. 00 | 483.25(d)(1)(2)<br>Free of Accident Hazards/Supervision/Devices<br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>Based on observation, record review, and interview, the facility failed to ensure appropriate interventions were in place to prevent cognitively impaired residents from entering a potentially combative resident's room for 2 of 3 residents reviewed for accident hazards. (Resident's 21, and 12).<br><br>Findings include:<br><br>1. During an observation, on 08/24/18 at 1:25 p.m., Resident 21 was observed walking out of Resident 27's room. Resident 27 yelled, "Get out of my room" as Resident 21 walked out of the resident's | F 0689 | F689 Free of Accident Hazards/Supervision/Devices<br><br>- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;<br>o Resident 27 was moved to a room that was across the Nurses Station to ensure proper monitoring.<br>o 15-minute Checks imitated x 2 weeks. | 09/23/2018 |

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| | room.<br><br>The clinical record reviewed, on 08/24/18 at 11:14 a.m., indicated Resident 21's diagnoses included, but were not limited to, dementia, legal blindness, psychosis, and cognitive communication deficit. The Quarterly MDS (Minimum Data Set) assessment, dated 07/23/18, indicated Resident 21 was severely cognitively impaired. The resident required supervision, over sight, encouragement, or cueing with locomotion on the unit.<br><br>The clinical record reviewed, on 08/24/18 at 10:24 a.m., indicated Resident 27's diagnoses, included but were not limited to, Huntington's Disease, dysphagia, anxiety disorder, dementia, major depressive disorder.<br><br>The review of the progress notes, on 08/24/18 at 12:49 p.m., indicated Resident 27 had been sent to the Emergency Room 08/08/18, for being combative with staff.<br><br>During an interview, on 08/24/18 at 9:18 a.m.,The Behavior Care Coordinator indicated the resident needed forewarning of what was going to happen. His behaviors occurred when something happened and he was not forewarned.<br><br>2. During an interview, on 08/24/18 at 10 a.m., Resident 12 indicated she hugged the new people to let them know how much she liked it at the facility.<br><br>The clinical record reviewed, on 08/24/18 at 11:17 a.m., indicated Resident 12's diagnoses included, but were not limited to, Huntington's Disease, cognitive communication deficit, dementia, and obsessive-compulsive disorder. The Admission MDS Assessment, dated 06/18/18, indicated | | - how other residents having the potential to be affected by the same deficient practice will be identified and corrective action(s) will be taken;<br>o SSD to review Behavior Tracker Logs.<br><br>- what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;<br>o Magnetic Stop Sign placed in front of resident 27's door<br>o 1-hour checks in place for 30 days<br><br>- how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;<br>o The results of these audits will be reviewed by the QAPI committee monthly. If compliance is not achieved, an action plan will be developed and implemented. Monthly QAPI minutes and action plans are submitted to regional operations staff and corporate risk management team for review<br><br>- by what date the systemic changes will be completed.<br>o Sept 19, 2018 | |

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| | Resident 12 was moderately cognitively impaired. The resident was independent for locomotion on the unit.<br><br>During an interview, on 08/24/18 at 10:52 a.m., the ED (Executive Director) indicated that no interventions were in place to prevent danger to other residents who may wander into Resident 27's room. He did not know what to do aside from having Resident 21 walk back to his room, from dinner and meals by another route. He did not want to shut Resident 27's door without his consent and did not have enough staff for one on one care.<br><br>3.1-37(a) | | - Facility requests desk review in lieu of revisit | |
| F 0912 SS=B Bldg. 00 | 483.90(e)(1)(ii)<br>Bedrooms Measure at Least 80 Sq Ft/Resident<br>§483.90(e)(1)(ii) Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms;<br>Based on observation, record review, and interview, the facility failed to ensure a room with more than two residents had at least 80 square feet per resident for 2 of 2 rooms capable of holding more than two residents. This had the potential to affect 6 of 26 residents residing in the facility. (Rooms 7 and 11)<br><br>Findings include:<br><br>On 8/20/18 at 10:05 a.m., the Executive Director provided a copy of a letter, dated August 29, 2017 which indicated, "...All beds in this room are dually certified. Each room measures 234 square feet, which allows for 78 square feet per resident when three residents are present. The health and | F 0912 | F912 Bedrooms Measures at Least 80 Sq. Ft/resident<br>- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;<br>o Only rooms 7 and 11 are affected<br><br>- 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;<br>o The Square footage of the room will not pose a threat to the | 09/23/2018 |

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| | safety of the residents are not jeopardized and there it does not pose a threat to the resident's quality of care and quality of life when three are placed in this room." He presented a floor plan with measurements of Rooms 7 and 11.<br>The following diagrams were presented:<br><br>Room 7, SNF/NF (Skilled Nursing Facility/ Nursing Facility), had the capacity of three resident beds and was a total of 234 square feet, equaling 78 square feet per resident.<br><br>Room 11, SNF/NF had the capacity of three resident beds and was a total of 234 square feet, equaling 78 square feet per resident.<br><br>On 8/21/18 at 11:59 a.m. during an interview with the Executive Director, he indicated he would like to continue the room waiver for Room 11 and Room 7. He would continue to use Room 11 as a television room for now, unless the facility filled up and the room was needed.<br><br>3.1-19(l)(2)(A)<br>3.1-19(l)(3)<br>3.1-19(l)(8) | | resident's Health and Safety, Quality of Life, and Quality of Care<br>o Currently room 7 has only 2 residents and room 11 does not have any residents residing in room<br><br>- what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;<br>o 3 residents would reside in rooms 7 and 11 as a last resort<br>o Facility would take into account if any resident had any specialty items such as a bed side toilet or oxygen<br>o Residents will have access to Restrooms and Showers<br>o Resident will access to Personal Items, and Personal Storage Space<br><br>- how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;<br>o Social Services Director/Designee will monitor rooms when there are 3 in a room weekly.<br><br>- by what date the systemic changes will be completed.<br>o Sept 19, 2018 | |

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| | | | - Facility requests desk review in lieu of revisit | |
| F 0914 SS=E Bldg. 00 | 483.90(e)(1)(iv)(v)<br>Bedrooms Assure Full Visual Privacy<br>§483.90(e)(1)(iv) Be designed or equipped to assure full visual privacy for each resident;<br><br>§483.90(e)(1)(v) In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains.<br>Based on observation and interview, the facility failed to ensure the tracking and privacy curtains were maintained for proper fit and repair for 7 of 18 resident rooms. (Room 1, 2, 6, 7, 9, 10, and 14)<br><br>Findings include:<br><br>During the initial tour, on 08/22/18 at 01:46 p.m., with the Maintenance Director the following was observed:<br><br>Room 14, the center track didn't meet the window for full closure of the privacy curtains.<br>Room 10, the privacy curtain hooks were on two eyelets, preventing full closure.<br>Room 9, the privacy curtain hooks were on two eyelets, preventing full closure.<br>Room 7, the privacy curtains were off hooks and hanging.<br>Room 6, the privacy curtains were too short to intersect at the center track and the front tack was missing a curtain. The tracking was hanging loose by one foot, at the foot of the bed.<br>Room 2, the privacy curtains were off of the hook on the center tracking, preventing full closure. | F 0914 | F914 Bedrooms Assure Full Visual Privacy<br><br>- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;<br>o Rooms being evaluating for need of new curtains and full visual privacy.<br>o Room Audit for full visual privacy has been completed and those curtains not meeting visual privacy will be repaired or replaced.<br><br>- 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;<br>o All residents residing in facility have potential to be affected by deficient practice. Curtains in resident's rooms checked for | 09/23/2018 |

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| | Room 1, the privacy curtains on the intersecting track, between the beds, were to short to intersect, preventing full closure.<br><br>During an interview, on 08/22/18 at 01:51 p.m., the Executive Director indicated the curtains were old and needed to be replaced.<br><br>During an interview, on 08/22/18 at 01:52 p.m., the Maintenance Director indicated the wrong privacy curtains were on the track or they were too short. He relied on the housekeeping staff to let him know what needed to be repaired.<br><br>During an interview, on 08/22/18 at 01:56 p.m., the Housekeeping Manager indicated some of the tracks are old and the curtains catch. The wrong curtains were probably placed on the tracks and the rooms each had a different sized curtain. She monitored the cleanliness and would ask maintenance to repair the curtains when she saw an issue. She did not have a written procedure for monitoring of the privacy curtains, but indicated she checked them once or twice a week herself.<br><br>3.1-19(l)(6)<br>3.1-19(l)(7) | | proper fit and functioning. Curtains not meeting the requirement will be repaired or replaced.<br><br>- what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;<br>o Housekeeping/Maintenance Dept to audit 1x weekly for 4 weeks and monthly for 5 months for privacy curtains in every room to ensure proper fit. Will be included in monthly preventative maintenance or housekeeping logs<br>o ---Housekeeping/Maintenance Dept to audit 1 x weekly for 4 weeks and monthly for 5 months for privacy curtains in every room to ensure proper functioning. Will be included in monthly preventative maintenance or housekeeping logs.<br><br>- how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;<br>o The results of these audits will be reviewed by the QAPI committee monthly. If compliance is not achieved, an action plan will | |

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| | | | be developed and implemented. Monthly QAPI minutes and action plans are submitted to regional operations staff and corporate risk management team for review<br><br>- by what date the systemic changes will be completed.<br>o September 19, 2018.<br><br>- Facility requests desk review in lieu of revisit | |