STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15A011	A. BUILDING 00 B. WING	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ESPECIALLY KIDZ HEALTH & REHAB	2325 S MILLER ST SHELBYVILLE, IN 46176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00426724. Complaint IN00426724 - Federal/State deficiencies related to the allegations are cited at F584. Survey dates: February 20, 21, 22, and 23, 2024 Facility number: 000273 Provider number: 15A011 AIM number: 100267870 Census Bed Type: NF: 116 Total: 116 Census Payor Type: Medicaid: 115 Other: 1 Total: 116 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 4, 2024	F 0000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under and state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey. Due to the low scope and severity of the survey finding, please find the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance, feel free to contact me.	
F 0584 SS=D Bldg. 00	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kayla Hountz	HFA	03/14/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15A011	A. BUILDING 00 B. WING	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ESPECIALLY KIDZ HEALTH & REHAB	2325 S MILLER ST SHELBYVILLE, IN 46176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. Based on observation, interview, and record review, the facility failed to ensure residents' heating/cooling unit in their room was properly affixed to the wall and that temperatures were set	F 0584	F584 Requires the facility to ensure residents' heating/cooling unit in their room was properly affixed to the wall and that	03/15/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15A011	A. BUILDING 00 B. WING	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ESPECIALLY KIDZ HEALTH & REHAB	2325 S MILLER ST SHELBYVILLE, IN 46176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	and maintained between 71 and 81 degrees Fahrenheit for 2 of 116 residents in the facility. (Residents E and CC) Findings include: An observation of Resident E's and CC's room was made on 2/20/24 at 2:58 p.m. The cover to the room's heating/cooling unit was resting on the floor not affixed to the wall. The small door to access the temperature controls on the cover had a lock on it. The unit was set to 65 degrees. An environmental tour of the facility was conducted with the AED (Assistant Executive Director,) Environmental Manager, and Maintenance Director on 2/23/24 at 11:35 a.m. During the tour an observation of Resident E's and CC's heating/cooling unit was made in their room. The unit cover remained on the floor, not affixed to the wall. The Maintenance Director picked up the cover and snapped it back into place. An interview was conducted with the Maintenance Director during the above observation. He indicated the cover was likely not on the wall, because someone wanted to change the temperature, but only he had a key to the lock on the unit to change the temperature. He wanted staff to contact him to change the temperature. He placed locks on the units approximately a year ago. An interview was conducted with CNA (Certified Nursing Assistant) 10 on 2/23/24 at 2:12 p.m. She indicated she was unsure why the heating/cooling units in residents' rooms had locks on them. An interview was conducted with LPN (Licensed		temperatures are set and maintained between 71 and 81 degrees Fahrenheit. 1. Resident E and CC heating/cooling unit was repaired and the unit affixed to the wall. The temperature was set to 71 degrees Fahrenheit. 2. All residents have the potential to be affected. A complete audit was conducted of all rooms to ensure heating/cooling units were properly affixed to the wall and room temperatures were between 71 to 81 Fahrenheit. No concerns were noted. See below for corrective measures. 3. The regulatory guidance was reviewed regarding proper temperature settings for resident rooms and heating/cooling units being properly affixed to the wall. The staff was inserviced on the above procedure. 4. The administrator will conduct 10 room observations daily ensuring that heating/cooling units are properly affixed to the wall and temperatures are maintained between 71 and 81 Fahrenheit. The administrator or her designee will utilize the monitoring tool daily times for weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100 percent compliance is obtained and maintained. (See attachment A) The audits will be reviewed during the facility's quarterly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15A011	A. BUILDING 00 B. WING	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ESPECIALLY KIDZ HEALTH & REHAB	2325 S MILLER ST SHELBYVILLE, IN 46176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Practical Nurse) 7 on 2/23/24 at 2:13 p.m. She indicated she'd worked at the facility since September, 2023, was the unit manager, and didn't know why the locks were on the heating/cooling units. An interview was conducted with the ED (Executive Director) on 2/23/24 at 2:20 p.m. She indicated during rounds, they identified that some of the residents' room temperatures were not within a certain range. The staff was changing the temperatures to make the room more comfortable for themselves, not the resident. The unit managers had keys to the heating/cooling units on their key rings. Observations of the heating/cooling units on the New Unit wing of the facility, built in 2009, where Residents E and CC resided were made on 2/23/24 between 3:00 p.m. and 3:10 p.m. The following residents rooms were observed with a secure lock on their heating/cooling units: Residents Z, MM, LL, KK, JJ, HH, GG, FF, EE, DD, BB, AA, X, Y, V, W, NN, PP, QQ, RR, SS, and TT. On 2/23/24 at 1:45 p.m. AED provided a monthly room checklist for maintenance staff that included room temperatures. This Federal tag relates to Complaint IN00426724. 3.1-19(h) 3.1-19(j)		quality assurance meetings and the plan of correction will be adjusted accordingly. If noncompliance continues, the staff member who does not follow the regulatory guidance will be inserviced 1:1 and a complete audit of all resident's room will be completed daily ensuring temperature control of 71 to 81 Fahrenheit is maintained and the heating/cooling units are affixed to the wall. 5. The above corrective measures will be completed on or before March 15, 2024.	
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15A011	A. BUILDING 00 B. WING	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ESPECIALLY KIDZ HEALTH & REHAB	2325 S MILLER ST SHELBYVILLE, IN 46176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on interview and record review, the facility failed to ensure a resident was free from physical contact by staff member for 1 of 1 residents reviewed for abuse. (Resident 80) Findings include: The clinical record for Resident 80 was reviewed on 2/23/24 at 3:44 p.m. Resident 80's diagnoses included, but not limited to, chronic respiratory failure, chronic lung disease, congenital malformations of the brain-cerebral ventriculomegaly (enlarged brain ventricles). A reportable incident to the Indiana Department of Health dated 1/27/24 indicated, a nursing school instructor, contacted the facility's DON (Director of Nursing) with a concern of a resident allegation of abuse. The immediate action taken was "per facility protocol employee was suspended pending investigation. Nurse on the unit assessed resident for any signs/symptoms of redness, swelling, behavioral issues." The follow-up dated 1/30/24 indicated, "1/27/24 DON receives a text from [sic, name of Nursing School] RN [registered nurse] instructor that herself and three of her students witnessed the RT [sic, respiratory therapist] during a trach change	F 0600	F600 Requires the facility to ensure residents are free from physical contact by staff member. 1. Resident 80 had a head to toe assessment completed and no injuries were noted. There was no mental anguish noted as well. 2. All residents have the potential to be affected. The administrator and the DON were inserviced on the abuse policy immediately. An audit was conducted on all allegation of abuse in the last six months to ensure any abuse allegations were identified and properly handled. No concerns were noted. See below for corrective measures. 3. The abuse prohibition policy and procedure was reviewed with no changes made. (See attachment B) The staff was inserviced on the above procedure. 4. The nurse consultant will review all allegations of abuse to ensure the facility has identified and handled each allegation per policy. The nurse consultant or her	03/15/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15A011	A. BUILDING 00 B. WING	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ESPECIALLY KIDZ HEALTH & REHAB	2325 S MILLER ST SHELBYVILLE, IN 46176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	'spank/pat' a resident on the diapered bottom after the resident bit the RT. Investigation: RT was suspended pending investigation. Prior to leaving employee completed her written statement and the school instructor also spoke to the employee. She was not around the residents during that time. DON conducted [sic, the] investigation. Employee was changing the trach collar and the resident bit her finger. Employee states 'it was a knee-jerk reaction' that she open handed, 'patted the side of the residents diapered bottom.' Immediately the employee told the students it was inappropriate for her to do that. Investigation concluded the same event was seen by the instructor and students. The instructor told the employee after the fact that she was sorry she 'reported her' that this has been used as a teaching moment for the students...DON did an abuse inservice [sic] with the [name of Nursing School] students. All staff inservice initiated immediately and will continue until all staff have completed the training. Conclusion: The resident bit the employee while there was a trach change. The employee had a knee jerk reaction and patted the side of the diapered resident's bottom. The resident had no change in her behavior, no crying...no red marks, bruising or any other marking or behavior to cause concern. The employee immediately did discuss with there students that her behavior was not appropriate and she should have not done that...Conclusion: the allegation of abuse was unsubstantiated. Employee was inserviced and put back on the schedule." The investigation file for the above allegation of abuse included, but not limited to, a witness statement from DON, copy of an email from ED (Executive Director) to Ombudsman office, witness statements from facility staff, nursing		designee will utilize the monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100 percent compliance is obtained and maintained. (See attachment C) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly. If noncompliance continues, the nurse compliance and regulatory nurse will inservice all dept. managers on the abuse policy and procedure. The compliance and regulatory nurse would also review all allegation of abuse to ensure the facility had identified and handled each allegation per policy. 5. The above corrective measures will be completed on or before March 15, 2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15A011	A. BUILDING 00 B. WING	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ESPECIALLY KIDZ HEALTH & REHAB	2325 S MILLER ST SHELBYVILLE, IN 46176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	students, and nursing school instructor and an Accident & Incident Report and Investigation. The Accident & Incident Report and Investigation form indicated, on 1/27/24 at 9 a.m., Resident 80 had been receiving trach care from RT (Respiratory Therapist) 22 when Resident 80 bit RT 22 on her right thumb web space on her hand. In reaction to the bite, RT 22 gave a "swat" to resident's gluteal region through pants and brief as witnessed by the student instructor. In a written statement from RT 22 on 1/27/24, she indicated, the nursing students had given Resident 80 a bath and was wound up from playing with the students when she was performing trach care on Resident 80. She indicated, Resident 80 wouldn't sit still at first and when she went to change the trach ties, Resident 80 bit her right thumb. RT 22 then gave her "a pat on the diaper covered bottom- I immediately told the students I don't do that-and signed to Resident 80 'no-no'..." A written statement from DON dated 1/27/24 indicated, she had received a text from NI (nursing school instructor) 23 around 8:45 a.m. and indicated, she and her students witnessed RT 22 "swat"a resident after being bitten. NI stated that RT was doing trach care and the resident bit her resulting in the RT "spanking" the resident..."Once I arrived at facility, I spoke with [nursing school's name] instructor and students. Explained to them about abuse and asked if what RT did constituted abuse, (intentional intent to harm). 2 students said yes and another student and instructor said no. Asked all witnesses if they told anyone at facility and they stated 'no'...Notified DCS [sic, Department of Children Services] of incident stated they are sending it out w/[sic, with] no actions".			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15A011	A. BUILDING 00 B. WING	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ESPECIALLY KIDZ HEALTH & REHAB	2325 S MILLER ST SHELBYVILLE, IN 46176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A written statement from NS (nursing student) 24 on 1/27/24 indicated, "During trach care for [Resident 80's name] was some what agitated with the care and bit the nurse on the thumb and the nurse spanked her bottom (1 pat) then caught herself and told us to pretend that we didn't see what she did. The nurse explained that she's a grandmother and that it was a natural reaction for her." A written statement from NS 25 dated 1/27/24 indicated, "I witnessed the RT specialist spank patient, [Resident 80's name] on the butt after she stated that the patient bit her. I did see the pt [sic, patient] attempt to bite the RT specialist but I didn't see her connect to skin. After spanking the patient on her butt, the RT verbalized that she was so sorry and it was a habit because she has a grandchild around the same age." A written statement from NI 23 dated 1/27/24 indicated, "Myself and 3 students were observing the RT do trach care at the bedside. According to the RT the pt [sic, patient] bit her (saw pts [sic, patient's] head go down but did not observe the bite itself) and the RT moved the patient and spanked her buttocks with an open hand...RT said...it was just a reflex on why she did that." A written statement from NS 26 dated 1/27/24 indicated, "After bathing the patient the respiratory therapist came in to do trache[sic] care while caring for the patient she was bitten. I, along with my group and instructor[sic] observed the patient being spanked on her bottom then told 'no you dont bite'. The RT then apologized and stated your[sic] not supposed to hit the patients it was just a reflex of hers."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15A011	A. BUILDING 00 B. WING	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ESPECIALLY KIDZ HEALTH & REHAB	2325 S MILLER ST SHELBYVILLE, IN 46176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	An interview with ED conducted on 2/23/24 at 4:37 p.m. indicated, the facility does not have a separate abuse policy for students/instructors that come to the building. Instead, they are required to watch the same orientation video the facility staff members watch. She indicated, the orientation video thoroughly goes over resident's rights, abuse, and how/when to report abuse. ED indicated, she expected the students/instructor to report any allegations of abuse immediately. When asked why this allegation of abuse was not substantiated she indicated, the instructor said it was more like a pat with an open hand and not spank. ED indicated, what RT 22 had done was not appropriate but she didn't try to hide it and took accountability. An Abuse Prohibition, Reporting and Investigation policy received on 2/20/24 at 11:32 a.m. from ED. The policy indicated, "This facility shall prohibit and prevent abuse, neglect...and exploitation. This includes but is not limited to freedom from corporal punishment...Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish...Instances of abuse of a resident, irrespective of any mental or physical condition, case physical harm, pain or mental anguish...Physical abuse - Includes, hitting, slapping, pinching and kicking. It also includes controlling behavior through corporal punishment. Corporal punishment - which is a physical punishment, is used as a mean to correct or control behavior. Corporal punishment includes, but is not limited to, pinching, spanking, slapping of hands, flicking, or hitting with an object." 3.1-27(a)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15A011	A. BUILDING 00 B. WING	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ESPECIALLY KIDZ HEALTH & REHAB	2325 S MILLER ST SHELBYVILLE, IN 46176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on observation, interview and record review, the facility failed to ensure accuracy of a resident's Minimum Data Set (MDS) Assessment for 1 of 1 residents reviewed for restraints. (Resident 80) Findings include: The clinical record for Resident 80 was reviewed on 2/20/22 at 3:00 p.m. The diagnosis for Resident 80 included, but was not limited to, respiratory failure. The matrix that includes resident assessments was provided by the Director of Nursing (DON) on 2/20/24 at 12:01 p.m. It indicated Resident 80 utilized restraints. Observations were made of Resident 80 on 2/20/24 at 3:21 p.m., and 2/22/24 at 11:59 a.m. The resident was observed in a wheelchair with a chest harness, lap belt and lap tray. The resident was able to move around in wheelchair. During interview with the DON on 2/22/24 at 2:06 p.m., she indicated Resident 80 was not in a restraint. The lap tray was not preventing the resident from moving around. If the lap tray was removed the resident's movement would be the same. The MDS was coded inaccurately. The facility does not have a policy regarding accuracy of the MDS. The facility follows the RAI (Resident Assessment Instrument) manual.	F 0641	F641 Requires the facility to ensure accuracy of a resident's MDS assessment. 1. Resident 80's MDS was corrected to reflect that she was free of any restraints. 2. All residents have the potential to be affected. A complete audit was conducted on all MDS in the last 3 months to ensure accuracy when coding for restraints. No concerns were noted. See below for corrective measures. 3. The RAI manual regarding coding of a restraint was reviewed. The staff was inserviced on the above procedure. 4. The DON will review five MDS a day to ensure accuracy of coding a restraint per the RAI guidelines. The DON or her designee will utilize the nursing monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100 percent compliance is obtained and maintained. (See attachment D) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly. If noncompliance continues, the MDS staff will be	03/15/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15A011	A. BUILDING 00 B. WING	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ESPECIALLY KIDZ HEALTH & REHAB	2325 S MILLER ST SHELBYVILLE, IN 46176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			inserviced 1:1 regarding the RAI manual regarding the definition of a restraint. The nurse consultant would also complete an audit of all new MDS daily to ensure accuracy of coding a restraint is followed per the RAI manual. 5. The above corrective measures will be completed on or before March 15, 2024.	
F 0646 SS=D Bldg. 00	483.20(k)(4) MD/ID Significant Change Notification §483.20(k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review. Based on interview and record review, the facility failed to submit an updated Level 1 PASRR (pre-admission screening resident review) assessment for a resident with a significant change in her mental health for 1 of 1 residents reviewed for PASRR. (Resident Y) Findings include: The clinical record for Resident 25 was reviewed on 2/22/24 at 1:30 p.m. Her diagnoses included, but were not limited to, schizo-affective disorder. The 10/5/17 PASRR indicated there were no known mental health behaviors which affected interpersonal interactions, and there were no known recent or current mental health symptoms. It indicated she was on 1200 mg a day of	F 0646	F646 Requires the facility to submit an updated Level 1 PASSRR assessment for a resident with a significant change in her mental health. 1. BDDS office was contacted to complete a new Level 1 on resident Y. 2. All residents have the potential to be affected. An audit was conducted on all resident's current Level 1, diagnosis and medications to ensure an updated Level 1 is completed. Residents needing a new Level 1 were referred to the BDDS office. No further concerns were noted. See below for corrective measures.	03/15/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15A011	A. BUILDING 00 B. WING	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ESPECIALLY KIDZ HEALTH & REHAB	2325 S MILLER ST SHELBYVILLE, IN 46176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Quetiapine (antipsychotic medication,) but a diagnosis was not indicated and her anxiety disorder was described in the medical record as 'very mild.' The 10/5/17 Notice of PASRR Level II Outcome Nursing Facility Approval notice read, "If you experience a significant change in your physical or mental health, you may need a new Level II evaluation. The nursing facility must submit an updated Level I screening to Ascend to see if further PASRR evaluation is needed." The 6/19/23 annual review certification for nursing facility services indicated she had a developmental disability, but did not have a mental illness. She had medical needs that took precedence over other service needs, long term. She met the PASRR Level II criteria for continued residence in a nursing facility. The current physician's orders indicated she was no longer on the Quetiapine, effective 8/7/23 and began taking Zyprexa 2.5 mg twice daily, starting 8/15/23. The 12/5/23 Note To Attending Physician/Prescriber indicated she was receiving Zyprexa for a diagnosis of disorder of brain and lacked a complete/allowable diagnosis to support its use. The 12/12/23 physician/prescriber response section indicated a new diagnosis of schizo-affective disorder. The 1/9/24 Note To Attending Physician/Prescriber indicated the GDR (gradual dose reduction) for Zyprexa 2.5 mg twitchy daily was denied/clinically contraindicated last month and to please include completed documentation		3. The regulatory guidance regarding when to submit for a Level 1 was reviewed with the Social Service Designee and the Assistant Administrator. (See attachment B) The staff was inserviced on the above procedure. 4. The DON/SSD will review all new diagnosis and medications in the morning meeting to ensure the BDDS office is contacted for a new Level 1 if a resident has a change in diagnosis or medication. The DON or her designee will utilize the monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100 percent compliance is obtained and maintained. (See attachment D) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly. If noncompliance continues, the social service consultant will inservice the SSD and AED 1:1 regarding the Level 1 requirement. The Social Service consultant would also review all new medications and diagnosis to ensure requirements are met regarding Level 1. 5. The above corrective measures will be completed on or before March 15, 2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15A011	A. BUILDING 00 B. WING	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ESPECIALLY KIDZ HEALTH & REHAB	2325 S MILLER ST SHELBYVILLE, IN 46176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	for a Clinical Contraindication to a GDR or consider completing a GDR at this time. The 1/16/24 Physician/Prescriber response section read, "She still talks to people not there & has behaviors." Another 1/9/24 Note To Attending Physician/Prescriber indicated to re-evaluate the use of the Zyprexa 2.5 mg twice daily and the diagnosis of schizo-affective disorder for use. The 1/16/24 physician/prescriber response section, completed by Physician 25, indicated to continue the medication with the current diagnosis/medical rationale with a notation to "see other form," referencing the above 1/9/24 pharmacy recommendation response section. An interview was conducted with the DON (Director of Nursing) on 2/22/24 at 2:46 p.m. She indicated it was difficult to set residents up for psychological/psychiatric services. The appointments were 6 months out. Resident Y currently had no referral for psychological/psychiatric services. From what she understood, Resident Y was having behaviors and that's when the Zyprexa started in August, 2023. The medication helped with her behaviors like hitting herself and statements about hurting herself, but "she'll say there's people in her room talking and there's not." An interview was conducted with the NC (Nurse Consultant,) and DON on 2/23/24 at 11:10 a.m. The NC indicated Resident Y was "snowed" [medical slang term for when a person has reached a level of drug intoxication that greatly alters their level of consciousness] when she was admitted to the facility in 2017 on the 1200 mg of Quetiapine, and the family couldn't tell them why she was on it. The DON indicated eventually, they decided to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15A011	A. BUILDING 00 B. WING	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ESPECIALLY KIDZ HEALTH & REHAB	2325 S MILLER ST SHELBYVILLE, IN 46176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	GDR the Quetiapine, and as they did, Resident Y's behaviors of self harm and saying she was drowning began to exude. They ended up getting her off the Quetiapine completely and the Zyprexa was started to see if it would work better. An interview was conducted with the AED (Assistant Executive Director) on 2/22/24 at 3:40 p.m. She indicated she submitted PASRR assessments. The BDDS (Bureau of Developmental Disabilities Services) came to the facility for updates. The certification page for each resident was completed annually. She needed to consult with BDDS to see if they wanted a new Level 1 submitted for Resident Y due to her new diagnosis of schizo-affective disorder and/or her behaviors. An interview was conducted with the AED, DON, and SSC (Social Services Consultant) on 2/23/24 at 9:40 a.m. The AED indicated they did not submit an updated Level 1 to begin the process of figuring out whether Resident Y required mental health services after Resident Y's most recent 6/19/23 annual review certification.			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview and record review, the facility failed to clarify physician	F 0684	F684 Requires the facility to clarify physician orders.	03/15/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15A011	A. BUILDING 00 B. WING	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ESPECIALLY KIDZ HEALTH & REHAB	2325 S MILLER ST SHELBYVILLE, IN 46176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	treatment orders for 1 of 1 residents reviewed for skin conditions. (Resident 36) Findings include: The clinical record for Resident 36 was reviewed on 2/21/22 at 3:00 p.m. The diagnosis for Resident 36 included, but was not limited to, quadriplegic. A physician order dated 10/31/23 indicated staff to apply abdominal pad to the labia (inner skin folds to protect urethra and vagina). A physician order dated 11/17/22 indicated, "do not use packaged wipes, use only warm water wash cloths to cleanse peri area." A physician order dated 2/22/23 indicated, "Cleanse open area with vashe. Apply collagen powder and alginate rope with silver qs [every shift] and prn [as needed]." During an observation of a wound dressing change for Resident 36 with License Practical Nurse (LPN) 7 and Certified Nursing Aide (CNA) 6 on 2/23/24 at 1:37 p.m., the resident had stooled during that time. LPN 7 was observed utilizing disposable wipes to cleanse the resident. After the wound dressing was complete, LPN 7 was observed covering the resident up with a blanket and washing her hands. There was no observation of placement of an abdominal pad between the labia folds. An interview was conducted with LPN 7 and CNA 6 on 2/23/24 at 1:45 p.m. LPN 7 and CNA 6 indicated they were unaware of physician orders not to use wipes on Resident 36. They use the wipes on the resident. LPN 7 indicated she has seen the abdominal pads placed in the resident's		1. Resident 36 order was clarified. An order was obtained to D'C the order not to use packaged wipes. 2. All residents have the potential to be affected. An audit was conducted to ensure all treatment orders were correctly documented. No concerns were noted. See below for corrective measures. 3. The physician's order policy was reviewed and no changes made. (See attachment E) The staff was inserviced on the above procedure. 4. The DON or her designee will review all new physician orders and ensure they are properly documented in matrix. The DON will observe two dressing changes a day ensuring the physician order is followed regarding the wound care treatment. The DON or her designee will utilize the monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100 percent compliance is obtained and maintained. (See attachment D) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly. If noncompliance continues, the director of nursing will inservice the nurse 1:1 and a repeat demonstration will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15A011	A. BUILDING 00 B. WING	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ESPECIALLY KIDZ HEALTH & REHAB	2325 S MILLER ST SHELBYVILLE, IN 46176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	labia folds at times, but the resident stools a lot causing the abdominal pad to get soiled. An interview was conducted with the Director of Nursing on 2/23/24 at 2:12 p.m. She would be calling medical provider to clarify the physician orders. She believed the orders was written to not use wipes on labia not buttocks. A physician orders policy was provided by the DON on 2/23/24 at 3:00 p.m. It indicated "...Purpose: Physician's orders are administered upon the clear, complete and signed order of an individual lawfully authorized to prescribe. Policy: Facility nursing personnel will ensure clear, accurate and complete physician order's...Order Clarification Requests: 1...the license nurse will attempt to contact the prescribing physician to obtain a clarification of any order in question. Any communication/communication attempt should be documented in the clinical record." 3.1-37		completed prior to her completing any further wound treatments. 5. The above corrective measures will be completed on or before March 15, 2024.	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15A011	A. BUILDING 00 B. WING	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ESPECIALLY KIDZ HEALTH & REHAB	2325 S MILLER ST SHELBYVILLE, IN 46176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to ensure a resident received care to prevent a pressure ulcer and received the necessary services to promote the healing of a pressure ulcer by not dressing the wound as per physician's orders for 1 of 2 residents reviewed for pressure ulcers (Resident 38) and failed to ensure a resident's foam boots were applied for 1 of 2 residents reviewed for limited range of motion (Resident 42). Findings include: 1. The clinical record for Resident 38 was reviewed on 2/23/24 at 9:41 a.m. Resident 38's diagnoses included, but not limited to, spastic quadriplegic cerebral palsy (a permanent neuromuscular disorder), dependence on a ventilator, epilepsy, and profound intellectual disabilities. A Wound Evaluation and Management Summary dated 1/17/24 indicated, Resident 38 had a right lower extremity wound present. The focused wound exam for site 2 (described as unstageable DTI, deep tissue injury, to the right anterior first toe) indicated, the etiology was pressure. At the time of the assessment, it had been present greater than 5 days and measured 0.5 cm (centimeters) in length and 0.3 cm in width. The skin was intact with purple/maroon discoloration and had no exudate. The dressing treatment plan was for skin prep to be applied daily for 30 days. Plan of care recommendations were for a pressure off-loading boot related to the patient rubbing their feet while up in chair. A Wound Evaluation and Management Summary	F 0686	F686 Requires the facility to ensure a resident receives care to prevent a pressure ulcer and receive necessary services to promote the healing of a pressure ulcer. 1. Resident #38 wound order was clarified. Resident #42 had their foam boots applied. 2. All residents have the potential to be affected. Treatment orders were reviewed. All residents requiring foam boots were assessed to ensure foam boots were applied. No concerns were noted. See below for corrective measures. 3. The pressure ulcer policy and procedure was reviewed with no changes made. (See attachment F) The staff was inserviced on the above procedure. 4. The DON or her designee will observe two dressing changes a day ensuring that the treatment is applied per physician orders. The DON or her designee will also conduct rounds twice a day ensuring foam boots are applied for all residents with the physician orders for them to be applied. The DON or her designee will utilize the nursing monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100 percent compliance is obtained	03/15/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15A011	A. BUILDING 00 B. WING	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ESPECIALLY KIDZ HEALTH & REHAB	2325 S MILLER ST SHELBYVILLE, IN 46176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	dated 1/24/24 indicated, Resident 38's focused wound exam for site 2 (now described as stage 3 pressure wound of the right anterior first toe) measured 0.5 cm in length, 0.3 cm in width and had a depth of 0.2 cm with moderate serous (bloody) exudate. The wound bed had 20% slough (dead tissue) and 80% granulation tissue. The dressing treatment plan was to apply calcium alginate once daily for 30 days and cover with island gauze with a boarder once daily for 30 days. This wound required a surgical excisional debridement procedure to remove necrotic tissue and to establish the margins of viable tissue. A Wound Evaluation and Management Summary dated 2/12/24 indicated, Resident 38's focused wound exam for site 2 indicated the wound measured 0.2 cm in length, 0.2 cm in width and had a depth of 0.1 cm., had moderate serous exudate. The wound's progress was "exacerbated due to patient non-compliant with wound care". The dressing treatment plan was to apply calcium alginate, apply skin prep to peri-wound, and cover with bordered gauze daily for 30 days. A Wound Evaluation and Management Summary dated 2/14/24 indicated, Resident 38's focused wound exam for site 2 indicated, the wound measured 0.5 cm in length, 0.6 cm in width, and 0.3 cm in depth, had moderate serous exudate and the wound bed contained 10% slough. A surgical excisional debridement was required to remove necrotic tissue, biofilm and non-viable subcutaneous level tissue. The dressing treatment plan remained the same as the previous visit. A Wound Evaluation and Management Summary dated 2/21/24 indicated, Resident 38's focused wound exam for site 2 indicated, the wound		and maintained. (See attachment D) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly. If noncompliance continues, the staff member who does not follow the physician orders will be inserviced 1:1. Also, when the staff member works, at least one dressing change will be observed with this staff member each shift. 5. The above corrective measures will be completed on or before March 15, 2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15A011	A. BUILDING 00 B. WING	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ESPECIALLY KIDZ HEALTH & REHAB	2325 S MILLER ST SHELBYVILLE, IN 46176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	measured 0.5 cm in length, 0.5 cm in width, and had a depth of 0.25 cm, had moderate serous exudate. Another surgical excisional debridement was required to remove necrotic tissue. The dressing treatment changed to apply calcium alginate once daily for 16 days; Collagen powder apply once daily for 30 days; apply skin prep to peri-wound once daily for 16 days; and cover with a bordered island gauze daily for 16 days. An observation of Resident 38's wound was conducted on 2/22/24 at 3:55 p.m. with LPN (Licensed Practical Nurse) 4. LPN 4 removed the covers covering Resident 38's feet and when doing so, it was observed that the bordered gauze on the top of his right big toe as not firmly affixed. LPN 4 removed the bordered gauze exposing the calcium alginate pad which was stuck to the wound bed. LPN 4 left the bedside and returned with a sterile saline 10 ml syringe. She then squirted the saline onto the calcium alginate pad to loosen it and then removed it in its entirety. She then applied a new calcium alginate pad on the wound and covered with a bordered gauze. A physician's order for Resident 38's wound dated 2/21/24 indicated, to cleanse area to anterior right great toe with wound cleanser, pat dry, apply skin prep to peri wound, apply collagen powder, cover with silver alginate and border gauze daily and as needed. An interview was conducted immediately following the wound dressing observation with LPN 4. She indicated, she had not been aware that Resident 38's wound care orders had been updated and commented, she had done the dressing change that morning and didn't know the orders had changed from the previous day.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15A011	A. BUILDING 00 B. WING	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ESPECIALLY KIDZ HEALTH & REHAB	2325 S MILLER ST SHELBYVILLE, IN 46176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A care plan for Resident 38 dated 12/26/23 for open lesion on right foot with an underlying risk factor of spastic movements/seizures. Interventions included dressing change/treatments as ordered. Resident 38's care plan dated 1/24/24 for pressure ulcer risk indicated, the goal was for the resident to be free from pressure ulcers. Interventions included, but not limited to, staff to observe skin condition while providing care and encourage and assist resident with turning and repositioning at least every two hours. Another care plan dated 1/24/24 for pressure reducer bed/chair indicated, Resident 38 required pressure reducing device to bed and chair due to risk of skin breakdown and required staff assistance of two people with bed mobility due to potential for skin breakdown Interventions included, but not limited to, confirm device is available/in place for resident daily use; assess efficacy of devices and revise device use if observed to be ineffective; and to assist the resident to turn and reposition approximately every two hours or more. The care plans did not indicate what "devices" were to be used or where to be used; stated to encourage resident to shift weight and/or turn/reposition independently; and to explain to the resident the benefits of bed mobility vs. risk of immobility. The care plan was not individualized to the resident and his health conditions/lack of ability to move independently. A Pressure Ulcer policy was received on 2/23/24 at 9:46 a.m. from DON (Director of Nursing). The policy indicated, "Purpose: To assure that residents with pressure ulcers will receive necessary care and treatment to promote healing, prevent new ulcers from developing and prevent infection...Procedures: 3. Treatment orders will be obtained. Orders will be reviewed periodically...for			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15A011	A. BUILDING 00 B. WING	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ESPECIALLY KIDZ HEALTH & REHAB	2325 S MILLER ST SHELBYVILLE, IN 46176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	efficacy...5. Presence and/or risk for development of pressure ulcers shall be included on the resident's care plan. 6. Interventions to prevent further pressure ulcer formation shall be initiated. A Care Plan Development and Review policy received on 2/23/24 from DON at 9:46 a.m. indicated, "This facility shall then develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframe to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment...5. The comprehensive care plan...shall describe the...services that are to be furnished at attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being."2. The clinical record for Resident 42 was reviewed on 2/22/24 at 10:15 a.m. Her diagnoses included, but were not limited to, chronic lung disease. The 12/22/23 Quarterly MDS (Minimum Data Set) assessment indicated she had upper and lower extremity impairment on both sides of her body. She was dependent on staff for lower body dressing. The Pressure Ulcer Risk care plan indicated she was at risk for pressure ulcer development related to decreased mobility. A preventative intervention was foam boots. The physician's orders for Resident 42 indicated foam boots to bilateral feet for offloading, every shift, starting 8/30/23. An observation of Resident 42 was made on 2/20/24 at 12:26 p.m. She was sitting in her wheel			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15A011	A. BUILDING 00 B. WING	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ESPECIALLY KIDZ HEALTH & REHAB	2325 S MILLER ST SHELBYVILLE, IN 46176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	chair, and she was not wearing foam boots. An observation of Resident 42 was made on 2/21/24 at 11:38 a.m. She was not wearing foam boots. An observation of Resident 42 was made with QMA (Qualified Medication Aide) 11 on 2/23/24 at 10:15 a.m. She was lying in bed and was not wearing her foam boots. QMA 11 and another staff member look through the chest of drawers next to Resident 42's bed, but were unable to locate her foam boots. An interview was conducted with QMA 11 on 2/23/24 at 10:15 a.m. during the above observation. She indicated Resident 42 should be wearing her foam boots while in bed and suggested perhaps they were sent to laundry and never came back. 3.1-40(a)(2) 3.1-40(a) 3.1-35(a) 3.1-35(b)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record	F 0689	F689 Requires the facility to ensure adequate supervision.	03/15/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15A011	A. BUILDING 00 B. WING	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ESPECIALLY KIDZ HEALTH & REHAB	2325 S MILLER ST SHELBYVILLE, IN 46176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	review, the facility to ensure adequate supervision for a resident with the ability to move by scooting from making contact with a mop water bucket for 1 of 1 resident reviewed for accidents. (Resident 85) Findings include: The clinical record for Resident 85 was reviewed on 2/21/24 at 10:10 a.m. The diagnoses included, but were not limited to, chronic respiratory failure, tracheostomy status, aphasia, intellectual disabilities, and global development delay. A Quarterly Minimum Data Set (MDS) assessment, dated 1/17/24, indicated resident was rarely/never understood regarding mental status. There were marked impairments on both lower extremities, utilization of a walker, partial/moderate assistance with sitting to standing, partial/moderate assistance with walking 10 feet, dependent for toileting, dependent for bathing, and dependent for personal hygiene. A care plan for activities of daily living (ADLs), updated 2/20/24, indicated the following, "delayed milestones...Res [resident] able to move by scooting [noted 11/6/23 and 1/22/24]...Interventions...Provide assist with ADLs as resident requires...Res [resident] to be in activities, playroom, school, therapy or w/ [with] staff when housekeeping on unit...." An observation conducted on 2/20/24 at 11:03 a.m., of Resident 85 on the floor, sitting on her knees, with her hands going up and down proceeding to splash water located within the mop bucket on the housekeeping cart. The housekeeping cart was located just outside of Resident 85's room by the nurses' station. Resident 85 had water noted on her shirt and		1. Resident 85 was immediately removed from the situation. Head to toe assessment completed with no injuries noted. Resident bathed per Minimum Data Set requirement. 2. All residents have the potential to be affected. When housekeeping mops the units, staff ensures residents are in bed or attending activities. Housekeeping staff coordinates time of mopping with the nursing department. Mop bucket covers were also purchased to be used. See below for corrective measures. 3. The staff was inserviced on the procedure of ensuring residents is in bed or in activities prior to mopping. This is communicated between nursing and housekeeping prior to mopping. Staff was educated on supervision of residents when cleaning is occurring on the units. The need to have mop covers placed on mop buckets while on the unit was also inserviced at this time. 4. The administrator will conduct a round daily to ensure mopping is being conducted when residents are in bed or in activities. The administrator or her designee will utilize the monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100 percent compliance is obtained	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15A011	A. BUILDING 00 B. WING	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ESPECIALLY KIDZ HEALTH & REHAB	2325 S MILLER ST SHELBYVILLE, IN 46176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	pants. Housekeeper 3 was dusting the ceiling vent in Resident 85's room and 2 staff members were on the opposite end of the nurses' station to where the view of Resident 85 on the floor would be impacted by the nurses' station. Housekeeper 3 was asked if Resident 85 was allowed to play with the water within the mop bucket and Housekeeper 3 proceeded to pick up Resident 85 and relocate her to her room. An observation, conducted on 2/20/24 at 11:13 a.m., of Resident 85 sitting on the floor, on her bottom, just outside of her room. Housekeeper 3 was cleaning Resident 85's room. The housekeeping cart that contained the bucket of mop water was moved to the room next to Resident 85's room, but no staff were near Resident 85 while she was sitting just outside of her room adjacent to the nurses' station. Resident 85 was able to move herself by scooting on her bottom. A progress note, dated 2/20/24 at 12:00 pm, indicated the following, "...Res [Resident] was noted in mop water. Res removed from mop water. SDS [Safety Data Sheet] consulted [symbol for and] MD [Medical Director] notified [symbol for with] orders to follow SDS. Res bathed [symbol for and] clothes changed. Res [symbol for no] issues or s/sx [signs and symptoms] distress. Attempted to notify mother [symbol for with] 0 [no] answer...." An interview conducted with Licensed Practical Nurse (LPN) 2, on 2/21/24 at 9:10 a.m., indicated Resident 85 can pull herself up, stand with assistance, but will crawl and scoot herself for the most part. Her green oxygen tubing is longer so she could be more free and not confined to her room. She had multiple toys to play with in her		and maintained. (See attachment D) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly. If noncompliance continues, the housekeeping staff will be inserviced 1:1, The housekeeper will then have to contact the housekeeping supervisor or administrator prior to starting the mopping on the unit so they can ensure residents are in bed or in activities. 5. The above corrective measures will be completed on or before March 15, 2024,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15A011	A. BUILDING 00 B. WING	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ESPECIALLY KIDZ HEALTH & REHAB	2325 S MILLER ST SHELBYVILLE, IN 46176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	room and the playroom located next to her room had toys as well. The staff are in and out and check on Resident 85 periodically, play with her if they have time, and the same goes for Respiratory Therapy. There was usually someone around. An interview conducted with Environmental Manager, on 2/21/24 at 9:38 a.m., indicated the mop buckets located on the housekeeping cart does contain chemicals. The solution comes premixed within the water and the housekeeping staff just fills up the mop buckets with such solution. There was a container labeled with "ammonium chloride" that was indicated to be utilized for the mop bucket water. Resident 85 had never been interested in the mop bucket prior to 2/20/24. The Vent Unit was the only unit that had "free roaming kids". The housekeeping staff can lock up the cleaning carts, which the cart was locked, but we cannot put a lock on the mop bucket. An interview conducted with Housekeeper 3, on 2/21/24 at 9:46 a.m., indicated 2/20/24 was the first time Resident 85 was ever interested in the mop water. Housekeeper 3 was able to lock the cleaning cart, which she did, but she cannot lock the mop water. Before the incident happened, Housekeeper 3 told the staff to move her cleaning cart because Resident 85 was getting close to it. The staff moved the cleaning cart, but it was not far enough to where Resident 85 could not reach it. She was connected to the green tubing, but Housekeeper 3 did not know the tubing could go that far. An SDS form was provided by the Executive Director (ED) on 2/21/24 at 9:55 a.m. The document indicated the following, "...Quick Defense AQ Disinfectant...Hazard			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15A011	A. BUILDING 00 B. WING	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ESPECIALLY KIDZ HEALTH & REHAB	2325 S MILLER ST SHELBYVILLE, IN 46176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Classification...CAUTION: causes moderate eye irritation. Avoid contact with eyes or clothing. Wash thoroughly with soap and water after handling and before eating, drinking, chewing gum, using tobacco, or using the toilet...Hazardous Ingredients ...Ethanol...Weight...72.5%...1000ppm...Didecyl Dimethyl Ammonium Chloride...Weight...0.33%...." An interview conducted with the Director of Nursing (DON), on 2/21/24 at 9:53 a.m., indicated when the incident occurred, the staff washed Resident 85 down with antimicrobial soap, called the physician, and they recommended what the staff had already conducted and to monitor Resident 85. The plan was to keep Resident 85 in a controlled environment when housekeeping was on the unit. Whether it was activities, her bed, or the playroom located next to her room. 3.1-45(a)(1) 3.1-45(a)(2)			
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15A011	A. BUILDING 00 B. WING	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ESPECIALLY KIDZ HEALTH & REHAB	2325 S MILLER ST SHELBYVILLE, IN 46176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	§483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Based on observation, interview, and record review, the facility failed to ensure physician orders were followed regarding tube feedings for 2 of 4 residents reviewed for feeding tubes. (Resident 85 and Resident 115) Findings include: 1. The clinical record for Resident 85 was reviewed on 2/21/24 at 10:10 a.m. The diagnoses included, but were not limited to, chronic respiratory failure, tracheostomy status, aphasia, intellectual disabilities, and global development delay. A Quarterly Minimum Data Set (MDS) assessment, dated 1/17/24, indicated resident was rarely/never understood regarding mental status and a feeding tube was utilized. A care plan for tube feeding, updated 1/22/24, indicated the following, "The resident requires to be fed via enteral tube for nutrition/hydration...Interventions...Administer tube feeding as ordered...." A physician order, dated 11/2/23, was noted for tube feeding (Peptamen Junior); 180 milliliters per gastric tube with instructions to run via pump at 60 milliliters an hour twice a day at 10:00 a.m. and 2:00 p.m.	F 0693	F693 Requires the facility to ensure physician orders are followed regarding tube feedings. 1. Resident #85 and #115's tube feeding orders were clarified with the physician to ensure accuracy and that the orders are followed. 2. All residents have the potential to be affected. An audit was conducted to ensure all tube feeding orders are accurate and followed. No concerns were noted. See below for corrective measures. 3. The Medication Administration policy and procedure was reviewed and no changes made. (See attachment G) The staff was inserviced on the above procedure. 4. The DON will conduct rounds daily and observe 5 resident's tube feeding daily to ensure the physician orders are being followed. The DON or her designee will utilize the nursing monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100 percent compliance is obtained and maintained. (See attachment D)	03/15/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15A011	A. BUILDING 00 B. WING	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ESPECIALLY KIDZ HEALTH & REHAB	2325 S MILLER ST SHELBYVILLE, IN 46176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The following observations were conducted to where Resident 85 was not connected to the feeding pump: 2/20/24 at 11:03 a.m., 2/20/24 at 11:13 a.m., 2/20/24 at 2:43 p.m., 2/22/24 at 10:35 a.m., 2/22/24 at 2:25 p.m. A late entry date of 2/22/24 nurse's note for 2/21/24 at 10:00 a.m., indicated the following, "...Spoke with MD [Medical Director] r/t [related to] bolus feeds through pump on 2/21/24 ok to bolus res [resident][sic] @ [at] AM and afternoon feedings. If res tolerates bolus then ok to change to bolus [symbol for without] pump...." A physician order, dated 2/22/24, indicated the use for tube feeding at 180 milliliters via bolus feeding twice a day at 10:00 a.m. and 2:00 p.m. An interview conducted with the Director of Nursing (DON), on 2/23/24 at 11:20 a.m., indicated Resident 85's tube feeding order was changed from administration via pump to a bolus administration at 10:00 a.m. and 2:00 p.m. to see if they tolerate it. Other times Resident 85 would be up playing and occupied while the unit was being cleaned but the Unit Manager believes it was connected. An interview conducted with the DON, on 2/23/24 at 2:11 p.m., indicated a bolus feeding was administered for Resident 85 on 2/21/24 and 2/22/24. That was why she wasn't connected to the feeding pump. Resident 85 likes activities and we let her be active. Unit Manager (UM) 25 was present and indicated they administered the bolus feeding to Resident 85 on 2/22/24 and Licensed		The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly. If noncompliance continues, the nurse will be inserviced 1:1 regarding following physician orders for tube feeding. The DON will also conduct a round on the unit daily where the staff member works ensuring the residents tube feed is administered per physician's order. 5. The above corrective measures will be completed on or before March 15, 2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15A011	A. BUILDING 00 B. WING	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ESPECIALLY KIDZ HEALTH & REHAB	2325 S MILLER ST SHELBYVILLE, IN 46176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Practical Nurse (LPN) 2 administered the bolus feedings on 2/21/24. UM 25 indicated she had the physician order for the tube feeding changed from the pump to a bolus, but they did not write the order as specific as she should have. The tube feedings were 2 separate tube feedings at 10:00 a.m. and 2:00 p.m. 2. The clinical record for Resident 115 was reviewed on 2/22/24 at 2:30 p.m. The diagnoses included, but were not limited to, cerebral palsy, epilepsy, profound intellectual disabilities, gastrostomy status, and feeding difficulties. A tube feeding care plan, updated 12/14/23, indicated Resident 115 required to be fed via enteral tube for nutrition and hydration. The interventions included, but were not limited to, administer tube feeding as ordered and administer flushes as ordered. A physician order, dated 2/19/24, indicated the utilization of Pediasure Reduced Calorie tube feeding via pump to run at 65 milliliters an hour for 20 hours. This was to start at 12:00 p.m. and be completed at 8:00 a.m. An observation was conducted, on 2/21/24 at 11:10 a.m., of Resident 115 up in their wheelchair and connected to the tube feeding via pump. An observation was conducted, on 2/21/24 at 11:51 a.m., of Resident 115 connected to the tube feeding via pump. The tube feeding bag was labeled with a date and time of 2/20/24 at 11:15 a.m. An interview conducted with the DON, on 2/22/24 at 2:45 p.m., indicated the facility has 1 hour before and 1 hour after the time(s) listed for			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15A011	A. BUILDING 00 B. WING	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ESPECIALLY KIDZ HEALTH & REHAB	2325 S MILLER ST SHELBYVILLE, IN 46176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	medication administration. A policy titled "Medication Administration", revised 4/2017, was provided by the DON on 2/23/24 at 9:17 a.m. The policy indicated the following, "...TIME ELEMENT...1. Medications are to be administered within 1 hour of the scheduled administration time...GUIDELINES FOR MEDICATION ADMINISTRATION...2. Medications may be administered only upon the receipt of the order from the resident's physician...3. The medication order must be recorded in the resident's clinical record...." 3.1-44(a)(2)			
F 0740 SS=D Bldg. 00	483.40 Behavioral Health Services §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health 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. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. Based on interview and record review, the facility failed to ensure a resident received behavioral health care and services to attain or maintain the highest practicable mental and psychosocial well-being for a resident with major depressive disorder with psychotic features and anxiety for 1 of 1 residents reviewed for behavioral/emotional health. (Resident 99) Findings include:	F 0740	F740 Requires the facility to ensure a resident receives necessary behavioral health care and services. 1 Resident 99 was seen by Buckingham Associates on 3/14/24. 2 All residents have the potential to be affected. Any resident that requires behavioral health care and	03/15/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15A011	A. BUILDING 00 B. WING	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ESPECIALLY KIDZ HEALTH & REHAB	2325 S MILLER ST SHELBYVILLE, IN 46176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The clinical record for Resident 99 was reviewed on 2/22/24 at 1:43 p.m. Resident 99's diagnoses included, but not limited to, Duchenne muscular dystrophy (inherited disorder of progressive muscular weakness), congestive heart failure, dependence on a respirator, hypertension, anxiety disorder, major depressive disorder with severe psychotic symptoms. Resident 99's quarterly MDS (Minimum Data Set) dated 12/1/23 indicated, he was cognitively intact. A Preadmission Screening and Resident Review (PASRR) level II dated 12/9/21 indicated, Resident 99 was approved for Long Term Approval with Specialized Services. A related condition was Duchenne Muscular Dystrophy which had affected his life skills including independent living, self-care, self-direction, learning and mobility. Resident 99 also had a diagnoses of Depression and Dysphoric Mood and had thoughts of ending their life about a year prior to this evaluation but no concerns at time of assessment. Resident 99's medical and functional needs included, a trach tube and ventilator, feeding tube, special eating utensils, suctioning and trach and ventilator care, skin care treatments, needed staff to turn and position in bed to prevent skin issues; use of a wheelchair to get around, and total support with eating, bathing, dressing, hygiene, toileting, and getting in and out of a bed or chair. The rehabilitative services Resident 99 needed to be provided included, but not limited to, Mental Health services-Group Therapy, Mental Health services-Individual Therapy, and Mental Health services-Outpatient treatment services. A Social Services note dated 12/17/21 indicated,		services were reviewed to ensure proper behavioral services are provided. No concerns were noted. See below for corrective measures. 3. The staff was inserviced on reviewing the level 2 and ensuring that residents receive behavioral health care and services based on the recommendation as well as additional referrals from physicians requesting residents to receive behavioral health services 4. The administrator or her designee will review all new level 2 and orders daily to ensure that if behavioral health care and services are needed for a resident that services are set up. The administrator or her designee will utilize the monitoring tool daily times for weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100 percent compliance is obtained and maintained. (See attachment A) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly. If noncompliance continues, the social service director will be inserviced 1:1 rearding the regulatory guidance. The Social Service consultant would also review all orders and Level 2 to ensure behavioral health services are being provided to residents	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15A011	A. BUILDING 00 B. WING	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ESPECIALLY KIDZ HEALTH & REHAB	2325 S MILLER ST SHELBYVILLE, IN 46176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	"Resident[99] admitted on 11/8/21. Received Level II where resident was approved for LTC [sic, Long Term Care] with specialized services to include mental health services (group, individual, outpatient tx[sic, treatment]. SSD [sic, Social Service Director] attempted to schedule an appointment for resident for outpatient services d/t[sic, due to] not having in house psych[sic, psychology] and was unsuccessful d/t[sic] COVID Restrictions as well as providers unwilling to see resident d/t being on a vent." A Social Services note dated 12/4/23 indicated, "Resident[99] returned from hospital on 11/28/23 with order to follow up with psych[sic]. On 12/4/23, SSD[sic] contacted [name of local hospital] to schedule appointment and was notified that they would see resident, however the next available appointment would be 12-18 months out. Notified MD[sic, Medical Doctor] and will follow-up with [name of local hospital] in May to follow up with scheduling appointment. A physician's note dated 2/14/24 indicated, he was informed by the facility that "psych cannot see res[sic, resident] for at least 12 months r/t[sic, related to] res[sic] condition-Abilify to cont[sic, continue] r/t[sic] res[sic] behaviors continuing". A Palliative care physician's note dated 10/17/23 indicated, Resident 99 was interested in establishing with counseling/therapy and agreeable to IBH [sic, Integrated Behavioral Health program] referral. A Palliative care consult note dated 1/3/24 indicated, "...Anxiousness...followed with psychiatrist but hasn't seen...they are working to get in touch with them for follow-up...agreeable to IBH referral which was placed but now working to		that are in need. 5. The above corrective measures will be completed on or before March 15, 2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15A011	A. BUILDING 00 B. WING	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ESPECIALLY KIDZ HEALTH & REHAB	2325 S MILLER ST SHELBYVILLE, IN 46176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	get psych and counseling follow-up more locally". A Psychiatry Consult request for Resident 99 dated 11/28/23 indicated, to re-establish with psych, adjustment to illness, anticipatory grief as the reason for the needed consult. An interview with SSC (Social Services Consult) conducted on 2/23/24 at 12:17 p.m. indicated, Resident 99 should have been on Psychiatry services as soon as COVID restrictions were lifted. SSC indicated, she was unable to locate documentation which would indicate the further attempts to contract psychiatric services for Resident 99 in his clinical record. An interview with UM (Unit Manager) 25 conducted on 2/23/24 at 12:27 p.m. indicated, at the time of the survey, Resident 99 still did not have an appointment with a mental health provider because they were "still working on" referrals from May 2023. She indicated, the IBH program referred by Palliative Care had completed a phone intake for Resident 99 but, later called her back and stated Resident 99 was not appropriate for their services. When asked, if she had documented any of these attempts to find behavioral health services for Resident 99 since the new referral in November of last year, she indicated, she had not put those notes into the clinical record. An interview with DON (Director of Nursing) conducted on 2/23/24 at 3:28 p.m. indicated, she remembered a nursing note written in Resident 99's chart regarding behavioral health/psychiatric services and provided a copy of the note which stated, "Resident in room crying. Writer entered room to speak [sic, symbol for 'with'] resident. Resident said, "I'm just sad". Writer asked if she			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15A011	A. BUILDING 00 B. WING	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ESPECIALLY KIDZ HEALTH & REHAB	2325 S MILLER ST SHELBYVILLE, IN 46176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	could do anything for him. "no" per resident. Writer asked if he would like to see pych[sic, psychiatry] No, per resident. SS[sic, Social Service] Director offered. 'No'." The nursing note nor the clinical record did not indicate if Resident 99 had a psychiatric provider to see had he said yes nor did it indicate if Resident 99 meant 'no' to ever participating in behavior health services or just at that moment. Resident 99's depression care plan dated 12/8/22 and last revised on 12/13/23 indicated, the goal was episodes of depressed moods will be re-directed and diffused daily. Interventions included, Psychiatric care with (this was left blank) and to encourage activities of interest such as (left blank). The anxiety care plan dated 12/8/22 and last revised on 12/13/23 included interventions to provide mental health services as ordered and document moods and behaviors. The psychotropic drug (antidepressant) care plan last updated on 12/4/23 included interventions to refer for psychological evaluation as indicated and to attempt gradual dose reduction per policy. Resident 99's Interdisciplinary Care Plan Conference records from 12/8/22 to present were provided by SSC (Social Services Consult) on 2/23/24. They indicated, under behavioral and emotional status, depression, isolation, anxiety, insomnia, refusal of care. In the section labeled "other (school, specialized services...), there was no mention of attempts to gain psychiatric services for the resident. 3.1-37 3.1-43(a)(1)			
F 0812 SS=E	483.60(i)(1)(2) Food			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15A011	A. BUILDING 00 B. WING	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ESPECIALLY KIDZ HEALTH & REHAB	2325 S MILLER ST SHELBYVILLE, IN 46176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
Bldg. 00	Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure beard covers were worn in the kitchen and properly store food in the refrigerator. This had the potential to affect 21 of 116 residents in the facility. Findings include: A tour of the kitchen was conducted with the DM (Dietary Manager) on 2/20/24 at 11:10 a.m. During the tour, a preparation refrigerator was observed with an open container of prune juice with no lid on one of the shelves. The DM informed DA (Dietary Aide) 8 that the prune juice needed a lid. DA 8 proceeded to dump the remaining contents of the open container of prune juice into a pitcher. DA 8 then filled another pitcher with water. The	F 0812	F812 Requires the facility to ensure beard covers are worn in the kitchen and food properly stored in the refrigerator. 1. DA #8 had a beard cover put on immediately. Prune juice was removed from the refrigerator and destroyed. 2. All residents have the potential to be affected. The refrigerator was immediately observed to ensure food was properly stored. All male employees were inserviced on beard covers being required if facial hair present. No concerns were noted. See below for corrective measures.	03/15/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15A011	A. BUILDING 00 B. WING	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ESPECIALLY KIDZ HEALTH & REHAB	2325 S MILLER ST SHELBYVILLE, IN 46176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	DM stopped DA 8 to question what he was doing and informed him the prune juice was ready to serve, as it was not concentrated, and that he needed to read the label. DA 8 had a beard an was not wearing a beard cover. An interview was conducted with the DM after the above prune juice observation. She indicated the prune juice needed a lid while stored in the refrigerator to protect it from any contaminants and stated, "I guess we should just throw it out." The DM indicated they did not have beard covers and hadn't thought about needing them. An observation was made in the kitchen on 2/20/24 at 12:25 p.m. DA 8 was pouring drinks into cups at a preparation counter. He was not wearing a beard cover. An interview was conducted with DA 8 on 2/20/24 at 12:25 p.m. He indicated no one had ever mentioned him needing a beard cover. The Hair Restraints policy was provided by the DM on 2/22/24 at 12:40 p.m. It read, "This facility shall adhere to 410 IAC [Indiana Administrative Code] 7-24-138 which states (b), food employees shall wear hair restraints, such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting: (1) exposed food; (2) clean equipment, utensils, and linens; and (3) unwrapped single-service and single-use articles....All employees shall be provided hair restraint. Hair restraint as described in 410 IAC 7-24-138 shall be worn by all employees while on duty." The Storage of Foods under Sanitary Conditions policy was provided by the DM on 2/22/24 at		3. The hair restraint policy and procedure and food storage policy and procedure were reviewed with no changes made. (See attachment H and I) The staff was inserviced on the above procedure. 4. The administrator or designee will conduct rounds in the kitchen daily to ensure all male residents wear a beard cover and that food in the refrigerator are properly stored . The administrator or her designee will utilize the monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100 percent compliance is obtained and maintained. (See attachment A) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly. If noncompliance continues, the dietary manager and staff will be inservice by the dietary consultant and the dietary consultant will have to audit the refrigerator for properly stored food with the dietary manager daily as well as observation of the male employees with a facial hair are wearing a beard cover. 5. The above corrective measures will be completed on or before March 15, 2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15A011	A. BUILDING 00 B. WING	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ESPECIALLY KIDZ HEALTH & REHAB	2325 S MILLER ST SHELBYVILLE, IN 46176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	12:40 p.m. It read, "All food items should be placed in seamless containers with tight-fitting lids." 3.1-21(i)(2) 3.1-21(i)(3)			
F 0814 SS=F Bldg. 00	483.60(i)(4) Dispose Garbage and Refuse Properly §483.60(i)(4)- Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to ensure garbage and refuse containers were in good condition and waste was properly contained in dumpsters with lids or otherwise covered. This affected 116 of 116 residents in the facility. Findings include: An observation of the outside dumpster area of the facility was made on 2/21/24 at 3:17 p.m. There was a set of 2 gray dumpsters on one side of the dumpster area. The gray dumpster on the right had an open side door. There was a set of 2 green recycling bins on another side of the dumpster area. The top left lid of the recycling bin on the left was not covering the dumpster. The recycling bin on the right had a piece of cardboard sticking out of the front of the bin and one of the top lids was open. An environmental tour of the facility was conducted with the AED (Assistant Executive Director,) Environmental Manger, and Maintenance Director on 2/23/24 at 11:35 a.m. During the tour an observation of the outside dumpster area was made. The 2 gray dumpsters were both full of trash and both top lids on both dumpsters were open. The side door to the gray	F 0814	F814 Requires the facility to ensure garbage/refuse containers are in good condition and waste is properly contained in dumpsters with lids. 1 The dumpster lids were immediately closed. 2 All residents have the potential to be affected. The dumpster lids were closed immediately. No concerns were noted. See below for corrective measures. 3. The staff was inserviced on properly containing waste in the dumpster/refuse container with the lids down. The staff was inserviced on the above procedure. 4. The administrator will observe the dumpster/refuse container area twice a day to ensure waste is properly contained in the dumpster/refuse container with lids closed. The administrator or her designee will utilize the monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100 percent	03/15/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15A011	A. BUILDING 00 B. WING	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ESPECIALLY KIDZ HEALTH & REHAB	2325 S MILLER ST SHELBYVILLE, IN 46176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	dumpster on the right was open. There was a rolling trash bin next to the right gray dumpster. There was no lid on the rolling trash bin where 5 blue gloves and some cardboard were observed inside of the bin. There was a blue glove on the ground next to the rolling trash bin. The top left lid of the green recycle bin on the left was not affixed to its' hinge and was not covering the bin. The side door to the left recycle bin was fully open and unable to be closed by the Maintenance Director as it could not slide past a protruding piece of metal. The left recycle bin was full of cardboard. The recycle bin on the right had the same piece of cardboard sticking out of the front of bin as was present during the 2/21/24, 3:17 p.m. observation. An interview was conducted withe the Environmental Manager and Maintenance Director during the 2/23/24, 11:35 a.m. tour and observation of the dumpster area. The Environmental Manger indicated she first cleaned out the rolling trash bin, prior to storing it in a nearby shed. She was behind today and hadn't had a chance to clean it out yet. The Maintenance Director indicated it was everyone's responsibility to ensure the doors and lids to the dumpsters were closed. An interview was conducted with the AED on 2/23/24 at 2:40 p.m. She indicated they did not have a policy associated with garbage and refuse. The expectation was for trash to be contained within the dumpster with lids and doors closed. 3.1-21(i)(5)		compliance is obtained and maintained. (See attachment A) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly. If noncompliance continues, the staff will again be educated about properly storing waste. The maintenance supervisor will also be responsible to observe the dumpster/refuse area twice a day to ensure waste is properly contained in the dumpster/refuse container with lids closed. 5. The above corrective measures will be completed on or before March 15, 2024.	