

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G079	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/20/2012
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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-NORTH WILLOW	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260
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W0000	<p>This visit was for the investigation of complaints #IN00101293 and #IN00102259.</p> <p>Complaint #IN00101293-Substantiated, Federal/state deficiencies related to the allegation(s) are cited at W149, W186, W210 and W331.</p> <p>Complaint #IN00102259-Substantiated, Federal/state deficiencies related to the allegation(s) are cited at W104 and W9999.</p> <p>Dates of survey: 1/11, 1/12 and 1/20/12</p> <p>Facility Number: 000622 Provider Number: 15G079 AIMS Number: 100272170</p> <p>Survey Team: Paula Chika, Medical Surveyor III-Team Leader</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality Review completed 1/27/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000	<p>DISCLAIMER STATEMENT</p> <p>Submission of the plan of correction is not an admission that a deficiency exists or that they were cited correctly. This Plan of Correction is a desire to continuously enhance the quality of care and services provided to our residents and is submitted solely as a requirement of the provision of Federal &amp; State Law.</p> <p>"This Plan of Correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements."</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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W0104	<p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation and interview for 2 of 4 sampled clients (B and C), the governing body failed to develop a written policy and procedure/guidelines in regard to bed bugs.</p> <p>Findings include:</p> <p>During the 1/11/12 observation period between 4:25 PM and 5:30 PM, at the facility on the first floor North unit, there was a metal bracket seen on room 117 (clients B and C's bedroom). At 4:30 PM, client C was standing in the hallway and asked Qualified Mental Retardation Professional (QMRP) #2, who was also in the hallway, how his room was doing. QMRP #2 responded/stated "It will be a couple of months." Client C responded/indicated he would not be able to go back in his room for awhile. Client C then asked QMRP #2 about his equipment in his room. QMRP #2 responded/stated "Nothing can come out of there."</p> <p>Interview with client C on 1/11/12 at 5:28 PM indicated the client was staying in a different bedroom on the North unit. Client C stated his bedroom was being treated for "bed bugs." Client C indicated</p>	W0104	<p>W 104 Governing Body The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>I Corrective Action for Cited Clients: A policy for pest control has been developed by North Willow. This policy is in effect for issues of bed bugs that affected clients B and C. Pest control action has been taken in the case of the bed bugs and is in concert with the written policy.</p> <p>II Other Clients Potentially at Risk: All client's have the potential to be affected by this deficient practice.</p> <p>III Corrective Measures or Systemic Changes: A policy for pest control has been developed by North Willow. This policy is in effect for issues like bed bugs and steps taken in the case of the bed bugs is in concert with the written policy.</p>	02/19/2012			

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	<p>he would not be able to move back into his bedroom for 30 days.</p> <p>Confidential interview A stated "I believe so," when asked if the facility had bed bugs. Confidential interview A did not know how many bedrooms were affected.</p> <p>Interview with QMRP #2 on 1/12/12 at 1:00 PM indicated bed bugs were found in client B and C's bedroom on the first floor North unit. QMRP #2 indicated the bed bugs were found in client C's Futon. QMRP #2 indicated clients B and C were moved to different bedrooms while their bedroom was being treated. QMRP #2 indicated client C brought the bed bugs into the facility from a home visit with his mother. QMRP #2 indicated as a precaution all the clients' clothes on the north hall were sent to the laundry to be washed.</p> <p>Interview with administrative staff #1 on 1/12/12 at 2:10 PM indicated bed bugs were found in the facility. Administrative staff #1 indicated a bed bug was seen when the client's clothes were sent down to the laundry room to be washed. Administrative staff #1 indicated the pest control was called to come to the facility but did not find evidence of bed bugs. Administrative staff #1 indicated the bed bugs were later seen on client C's Futon</p>		<p>IV Monitoring Corrective Measures: The pest control policy has been trained with staff and approved by North Willow's QAA committee. To be completed by 2-19-12.</p>				

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	<p>and the pest control was called back to the facility and confirmed they were bed bugs. Administrative staff #1 stated client C's Futon was "infested." Administrative staff #1 indicated clients B and C's bedroom was being treated along with the bedroom on each side of the affected bedroom. Administrative staff #1 indicated the facility's pest control service completed its first treatment/spray a few days ago and would be returning to the facility for 2 more treatments/sprays. Administrative staff #1 indicated the facility was doing what the pest control people recommended. Administrative staff #1 indicated the facility did not have a policy/procedure/guidelines in place which addressed how the facility would handle bed bugs and how the facility would prevent the spread of the bed bugs.</p> <p>This federal tag relates to complaint #IN00102259.</p> <p>3.1-13(a)</p>						

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W0149	<p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, interview and record review for 1 of 4 sampled clients (A), the facility failed to implement its policy and procedures to prevent neglect of a client in regard to the injuries a client received.</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 1/11/12 at 1:32 PM. The facility's 12/9/11 reportable incident report indicated "Client (client A) had a hematoma on left side of head, red in color size of a quarter. Right cheek swollen and red in color. Unknown how it happen to client (sic). Swollen area on face was about 2 inches long. Vitals taken T (temperature) 96.3 P (pulse) 64 R (respirations) 18 B/P (blood pressure) 100/50 Neuro checks done, pupils equal to light. No change in behavior noted." The reportable incident report indicated 911 was called to transport the client to the hospital. The facility's 12/14/11 follow-up report indicated client A had a history of falls and falls with injuries. The facility's 12/14/11 follow-up report/investigation indicated the following (not all inclusive):</p>	W0149	<p>W 149 Staff treatment of Clients The facility must develop and implement prohibit mistreatment, neglect or abuse I Corrective Action for Cited Clients: Client A now has a Physical Therapy re-evaluation and is now included in therapy. Client A's nurse has had retraining in thorough assessment of a resident, thorough documentation of an assessment, DQI (data for quality improvement which tracks injury and treatment of injury), SBAR, situation, background, assessment and response. CNA staff have had retraining as to use of BIR in reporting and communication with their nurse of issues of concern. Staff have also been retrained on pajamas and appropriate night wear. Client A has been assessed for sleep disturbance at night and any issues have been addressed with appropriate</p>	02/19/2012
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	<p>-On 12/9/11, client A was sitting up in the classroom in a T shirt and underwear with socks on her feet. The investigation indicated the CNA (Certified Nurse Aide) assisted client A to her bedroom and assisted the client to get back in bed at 10:30 PM.</p> <p>-"...The night nurse aide went onto (sic) continue her room checks, and [client A] began to wander again. The nurse aide called for assistance from the Night nurse on duty, and requested the night nurse give [client A] something to help her sleep. The night nurse told the night aide that [client A] had already given a 'sleeper' by the evening shift nurse, and the nurse aide would have to monitor [client A] on the unit...."</p> <p>-Between 10:30 PM and 11:30 PM, client A and another client were still up on the south hall unit. Client A went into a female peer's room and began going through the peer's dresser drawers. The reportable incident report indicated the CNA found client A sitting in a wheelchair in the peer's room with a hat on and again assisted client A back to her bedroom and into bed.</p> <p>-"..The aide reported that she continued with her night shift duties, and later went</p>		<p>interventions.</p> <p>II Other Clients Potentially at Risk: All client's have the potential to be affected by this deficient practice.</p> <p>III Corrective Measures or Systemic Changes: Nurses have had retraining in thorough assessment of a resident, thorough documentation of an assessment, DQI (data for quality improvement which tracks injury and treatment of injury), SBAR, situation, background, assessment and response. CNA staff have had retraining as to use of BIR in reporting and communication with their nurse of issues of concern. Staff have also been retrained on pajamas and appropriate night wear. For change in ambulation status of a resident, the IDT will determine if further assessment is required. All residents have been assessed for sleep disturbance at night and issues have been addressed with appropriate interventions.</p> <p>IV Monitoring Corrective</p>		

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	<p>by another male peers room, and saw [client A] sitting on the floor in that room, with a male peers shoes on. This reportedly was closer to the 11:00 o'clock hour. The nurse aide reported that as she walked by she heard one of the male peers in the room having a seizure because she could hear him grunting, and shaking. The night nurse aide then alerted the night nurse, who was on the unit taking vital signs, that [client A] was on the floor in the male peers room, and that the male peer had a 5 second seizure. The Night (sic) nurse reported when she observed [client A] around the 11:00 o'clock hour, [client A] was sitting near the doorway of the male peers room. She (night nurse) thought [client A] had the seizure, and was assessing her rather than the male peer that the night shift aide had earlier communicated to her...." The reportable incident report indicated after the nurse completed her assessment of client A, the CNA helped client A back to her bedroom. The reportable incident report indicated "...The Night Aide did not clarify with the Night Nurse that the male client had the seizure rather than [client A]...."</p> <p>-The CNA did another bed check around 1:00 to 1:30 AM where "...She (CNA) reportedly found [client A] 'playing like she was sleeping, while laying in bed with</p>		<p>Measures: DNS, ADNS, Program Directors and other designated staff review DQI and SBARS to assure quality and DNS/ADNS and DCE, Directors of Clinical Education, complete retraining as indicated or DNS/ADNS administers corrective actions in the form of discipline when warranted. DCE's train nursing staff during orientation on DQI, SBAR and staff on BIR including nursing employees. QMRPs have been in serviced as to the IDT determining further assessment when a resident has a change in ambulation status. The Functional Skills Assessment (FSA) has been modified to assess for sleep disturbance and when noted appropriate interventions will be put in place. To be completed by 2-19-12.</p>		

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	<p>her legs dangling over the side of the bed, with her body covered with a blanket. The night shift aide indicated she went onto (sic) to complete the rest of her rounds. About 2-2:30 AM, the night shift aide again visualized [client A] on the floor of her room. She reported that [client A] was sleeping 'hard' and snoring while she was on the floor. The night shift aide was not able to get up her on her own (sic), so she obtained assistance from another aide who helped her put [client A] back to bed. The Aide reported she did not turn on the light when this transfer was made from the floor to the bed, so she was not able to clearly describe what [client A] looked like at this point...."</p> <p>-The night nurse and the CNA clocked out for lunch at approximately 2:30 AM when the nurse went back to the nurse's station and sat for 10 to 15 minutes. The double doors to the South hall were closed while the nurse was in the nurse's station. The follow-up report indicated the nurse then went to the South hall and made rounds and saw client A laying in her bed, but did not turn on the light.</p> <p>-When the CNA returned she did rounds and "...physically provided incontinent care to [client A]...Once at approximately 3:30 AM, and again at 6:05 AM. The</p>						

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	<p>Night Nurse Aide did not turn on the lights in the client's room at any time during the client's incontinent care...."</p> <p>-The day shift CNA went to client A's room at 6:50 AM to take the client to shower. It was at that time, the day shift staff noticed client A's face was swollen and red. The CNA took client A to the shower room and asked a nurse to check client A. "...The Day Shift nurse indicated that she went to the shower room around 7:00 AM observed that [client A's] cheekbones were both swollen and red, and she had a red lump on her left forehead, as well as bright red discoloration between [client A's] scalp/hairline and her forehead. The Day Shift Nurse went back to the Night Shift nurse and asked her to come and look at [client A's] face. The Day (sic) shift nurse indicated that she wanted the Night Shift Nurse 'to see what I saw.' The Day (sic) shift nurse was unable to determine how a seizure earlier on the night shift could have caused the injuries to [client A's] face. The Night (sic) shift nurse did not respond to the Day Shift Nurse's request.</p> <p>-The day shift nurse was not able to determine the client had a seizure history per the nurse asking the staff.</p>						

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	<p>-At 10:30 AM, another nurse saw client A and did not think "...[Client A] looked liked herself..." At 10:35 AM, the nurse went to ask the ADON (Assistant Director of Nursing) to come look at client A. The ADON checked client A and instructed the nurse to send the client out for an evaluation. Client A was transported to the ER between 12:30 and 1:00 PM on 12/9/11.</p> <p>-At 4:20 PM, a social worker from the hospital called and indicated she had concerns in what was reported to the hospital in regard to client A's injuries, and they (the hospital) found "...old yellowish fading bruises to the clients (sic) chest and both upper thighs...." The follow-up report indicated client A was kept at the hospital for observation for 24 hours "...due to a reported 'indentation on her head!....'"</p> <p>The 12/14/11 follow-up report indicated "[Client A] returned to the facility on 12/10/2011, with additional diagnosis of 'abrasion to her forehead' with a 'hematoma' on her head..." The follow-up report indicated client A was placed on one to one staffing (1 staff to 1 client) until the client was able to resume her normal activities. The 12/14/11 follow-up report indicated "...The outcome of the investigation information</p>			
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	<p>was reviewed by the management team regarding the statements from each of the staff involved in the investigation of this event. The facility has been unable to absolutely confirm exactly how [client A's] head injuries occurred. However after reviewing the information provided from interviews, and the timeline of the findings, the facility has determined there is a strong probability that between 2-2:30 AM when the Night Shift Nurse aide found the client on the floor, she sought help to transfer [client A] back to bed, and did not report the event to the Night Nurse. During the remainder of the night shift, neither the Night Nurse or the Night Shift aide visualized the client's face to determine if she had any injuries...The facility administrator immediately responded to the problem of the nurse and and (sic) the nurse aide being clocked out for lunch by notifying all the facility staff of what to do in the event there is not a facility float staff aide to relieve aides for lunch breaks. Disciplinary Action was provided to the Night Shift Aide regarding her lack of reporting the client's event with a BIR (Behavior Incident Report) nor to the nurse on duty when she found the client on the floor. The Night Shift nurse also received disciplinary action for allowing the Night Shift CNA to go to lunch at the same time that Night Nurse was clocked out for lunch...The day</p>			
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	<p>Shift Nurse was given Disciplinary (sic) action in regard to her delay in initiating a thorough assessment of the client who had a head injury, which delayed her transport to the ER...."</p> <p>During the 1/12/12 observation period between 8:25 AM and 9:15 AM, on 2 South hallway, client A sat in a wheelchair with a seatbelt on in the classroom. Client A had light fading bruises around both eyes.</p> <p>Client A's record was reviewed on 1/12/12 at 10:30 AM. Client A's 12/10/11 Discharge Summary indicated client A was admitted to the hospital for observation "...to make sure that there were no further injuries resulting...." The 12/10/11 discharge summary indicated it was reported the client fell to the floor during a seizure. The 12/10/11 discharge summary indicated client A had "...2. Facial cranial abrasion and hematoma secondary to fall from seizures...."</p> <p>Client A's 12/8/11 Seizure Episode record indicated the facility's nurse documented client A "reportedly" had a seizure on 12/8/11 at 11:05 PM which lasted 5 seconds. Jerking of the extremities (arms and legs) was checked. Client A's seizure record did not indicate the client had any documented seizures prior to 12/8/11.</p>			
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	<p>Client A's 9/26/11 Neurological typed note indicated client A's diagnosis included, but was not limited to, Intractable Generalized Tonic-Clonic Seizures. The 9/26/11 report indicated "...she has fortunately been medically stable as of late...Seizure records are reviewed. She has not had any other seizures...."</p> <p>Client A's 12/9/11 BIR indicated "... [Client A] was lying on her back on the edge of the bed. One leg down the other one on bed. Her forehead (left side) was red and swollen. I took her for shower but seemed so weak &amp; (and) could not walk properly.-Bruise on the left hand behind the palm." The 12/9/11 BIR indicated client A was "Incoherent, listless."</p> <p>Client A's Nursing Progress Notes indicated the following:</p> <p>-12/9/11 at 1:20 PM "T96.3-P68-R18 B/P100/50 Client had a red swollen area on left forehead, size of a quarter. Forehead was red across scalp line into hair. Right cheek bone appeared swollen and red 2 inches in diameter. No pain when area was touched. Client listless and incoherent after breakfast and was put in bed. 12:00pm condition appeared to</p>			
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	<p>have not changed. Emas (emergency medical assistance service) called to take client to [name of hospital]."</p> <p>-12/9/11 at 1:37 PM "Skin assessment done on [client A] concerning injuries noted to face and neck. No injuries noted on other parts of her body. See skin assessment sheet." Client A's nursing notes failed to indicate any additional documentation/assessment of client A prior to 1:20 PM on 12/9/11 due to the client's change of health status, initial assessment, and/or neurological checks.</p> <p>Client A's 8/19/11 Physical Therapy (PT) Assessment indicated client A had 2 falls on 8/11/11. The report indicated one fall resulted in superficial abrasions to client A's knees and one fall had no injuries. The 8/19/11 PT assessment indicated "She is performing her normal tasks &amp; ambulating with no problems." Client A's 3/24/11 Individual Support Plan (ISP) and/or record indicated the facility and/or client's interdisciplinary team (IDT) had not re-assessed the client's motor skills/ambulation due to the client's mobility status/change.</p> <p>Client A's BIRs indicated the following:</p> <p>-12/8/11 "Client kept going in other clients room sitting in wheelchair &amp;</p>						

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	<p>refused to go to sleep (sic)."</p> <p>-12/16/11 "Client through the night trying to get out of bed. Making it hard for me to do bed check answer bed alarms up at 3:45 AM doesn't want to stay setted (sic) in chair can't start bed (checks) till 5:00 AM wet beds and BM (bowel movement) and I (CNA #1) have to get clients up this is not a 15 min. (minute) check it is a 1:1 (one on one) and I have to work the floor and watch [clients E and F] through night and morning (sic)." Client A's BIRs did not indicate any additional documentation in client A's getting up at night and/or indicate any additional documentation in regard to the client's behaviors on 12/8/11 and/or being found on the floor during the early morning hours of 12/9/11.</p> <p>Client A's 12/16/11 IDT (interdisciplinary team) note indicated "IDT met to review [client A's] sleep data. Data revealed that [client A] have (sic) been sleeping well at night. There were no concerns by staff working with [client A] at this time. [Client A] continues to be on Trazodone 75 mg (milligrams) with upper limit of 150mg for insomnia. Team feels 1:1 staff with [client A] during night shift is no longer be warranted (sic). [Client A] will be on 15-minute checks during night shift."</p>			
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	<p>Client A's 24 Hour Flow Sheets indicated facility staff documented check marks for "Awake at times," on the 10:30 PM to 6:30 AM shift, on 12/11, 12/12, 12/13, 12/19, 12/21, 12/22, 12/23 and 12/24/11.</p> <p>Client A's 3/24/11 Behavior Support Plan (BSP) and/or ISP indicated the facility failed to develop an active treatment program for the client's Trazodone/staying up at night/insomnia.</p> <p>Interview with CNA #2 on 1/12/12 at 8:50 AM stated "Some times she sleeps and sometimes she is up at night." When asked if client A had seizures, CNA #2 stated "I have never seen her have a seizure." CNA #2 indicated client A did have falls in the past, but she was not aware of any recent falls. CNA #2 stated since client A returned from the hospital, client A had been "weak and unsteady with her ambulation. Ambulation being unsteady is a change. Will only walk so far and then sit down."</p> <p>Interview with LPN #2 on 1/12/12 at 11:00 AM stated client A's health status was "improving." LPN #2 indicated client A utilized a wheelchair for ambulation.</p> <p>Interview with Qualified Mental Retardation Professional (QMRP) #1 on</p>			

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	<p>1/12/12 at 11:10 AM indicated client A's facial/head injuries were discovered by the morning staff on 12/9/11 and client A did not go out to the emergency room until 11 or 12 noon. QMRP #1 indicated there should have been 1 CNA and a float CNA working on the South Hall on 12/8 to 12/9/11. QMRP #1 indicated client A was utilizing a wheelchair for ambulation at this time due to the client's unsteady gait to prevent a fall. QMRP #1 indicated the client's IDT had not re-assessed the client's motor/mobility skills since the last PT assessment was completed in 8/11 before the client's status/mobility changed. QMRP #1 indicated client A did not have an active treatment program for the use of the client's Trazodone to treat the client's Insomnia and/or to tell staff what they were to do with the client when she got up/did not sleep at night.</p> <p>Interview with administrative staff #1, #2 and #3 on 1/12/12 at 3:10 PM indicated mistakes were made by the CNA and nursing staff on 12/8-12/9/11 in regard to client A's injuries, and the CNA and nurses had been disciplined for their actions. Administrative staff #3 indicated there was an error in regard to which client had a seizure. Administrative staff #2 and #3 indicated the nurse checked/assessed client A for having a seizure when it was another client who</p>						

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	<p>had the seizure, not client A.</p> <p>Administrative staff #2 and #3 indicated the night CNA saw the nurse checking client A but did not inform the nurse it was the wrong client. Administrative staff #3 indicated the facility could not determine the exact time and cause of client A's injuries, but it was thought the client may have been injured at the time the client was found on the floor by a CNA in which the CNA had to get assistance to get the client up off the floor. Administrative staff #1, #2 and #3 indicated the CNA did not inform the night nurse client A was found on the floor in her bedroom. Administrative staff #2 and #3 indicated facility staff had not documented and/or informed anyone client A was not sleeping through the night. Administrative staff #1, #2 and #3 indicated the night nurse and the CNA should not have gone on a lunch break at the same time as the client had been up and going into others bedrooms prior. Administrative staff #1 and #2 indicated the nurse was at the nurse's station with the door to the unit closed.</p> <p>Administrative staff #1, #2 and #3 indicated the nurse would not be able to see onto the unit from the nurse's station. Administrative staff #2 and #3 indicated the CNA did not document all the events of the night with client A and/or document she found the client on the</p>			
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	<p>floor on a BIR. Administrative staff #3 indicated no one actually saw the client's face when they checked on the client after she was placed in bed. Administrative staff #3 indicated a nursing staff came down to her office and asked administrative staff #3 to come and look at client A between 10 and 10:30 AM. Administrative staff #3 indicated she saw the client and told the nursing staff to send her to the emergency room to be evaluated. Administrative staff #3 indicated client A had injuries to her face and was leaning to the side. Administrative staff #2 and #3 indicated the nursing staff did not conduct and/or document assessments of client A's injuries at the time the injuries were discovered.</p> <p>The facility's policy and procedures were reviewed on 1/11/12 at 12:45 PM. The facility's March 2007 policy entitled Reporting Alleged Violations indicated "...It is the policy of this facility to take appropriate steps to prevent the occurrence of -abuse-neglect-injuries of unknown source..." The policy indicated "Neglect means failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness...."</p> <p>This federal tag relates to complaint #IN00101293.</p>						

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W0186	<p>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on interview and record review for 1 of 4 sampled clients, (A), the facility failed to deploy/ensure sufficient staff were available to monitor/ensure the safety of a client.</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 1/11/12 at 1:32 PM. The facility's 12/9/11 reportable incident report indicated "Client (client A) had a hematoma on left side of head, red in color size of a quarter. Right cheek swollen and red in color. Unknown how it happen to client (sic). Swollen area on face was about 2 inches long. Vitals taken T (temperature) 96.3 P (pulse) 64 R (respirations) 18 B/P (blood pressure) 100/50 Neuro checks done, pupils equal to light. No change in behavior noted." The reportable incident report indicated 911 was called to transport the client to the hospital. The facility's 12/14/11 follow-up report/investigation indicated the following (not all inclusive):</p>	W0186	<p>W 186 Direct Care Staff</p> <p>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>I Corrective Action for Cited Clients: Staffing has been assessed and assignments made according to resident needs and numbers established for each area. A procedure has been established to maintain appropriate amount of staff in cases of call offs. Retraining on staff for Client A has been completed as to never leaving the unit unsupervised. They must be</p>	02/19/2012			

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	<p>-On 12/9/11, client A was sitting up in the classroom in a T shirt and underwear with socks on her feet. The investigation indicated the CNA (Certified Nurse Aide) assisted client A to her bedroom and assisted the client to get back in bed at 10:30 PM.</p> <p>-"...The night nurse aide went onto (sic) continue her room checks, and [client A] began to wander again. The nurse aide called for assistance from the Night nurse on duty, and requested the night nurse give [client A] something to help her sleep. The night nurse told the night aide that [client A] had already given a 'sleeper' by the evening shift nurse, and the nurse aide would have to monitor [client A] on the unit...."</p> <p>-Between 10:30 PM and 11:30 PM, client A and another client was still up on the south hall unit. Client A went into a female peer's room and began going through the peer's dresser drawers. The reportable incident report indicated the CNA found client A sitting in a wheelchair in the peer's room with a hat on and again assisted client A back to her bedroom and into bed.</p> <p>-"...The aide reported that she continued with her night shift duties, and later went</p>		<p>relieved for break/lunch on night shift and if they must work through their lunch they will be paid for that time.</p> <p>II Other Clients Potentially at Risk: All client's have the potential to be affected by this deficient practice.</p> <p>III Corrective Measures or Systemic Changes: Staffing is regularly assessed as issues present as to adequate amounts and duties of those assigned. A procedure has been established to maintain appropriate amount of staff in cases of call offs. Retraining of staff has been completed as to never leaving the unit unsupervised. They must be relieved for break/lunch on night shift and if they must work through their lunch they will be paid for that time. On day and evening the break/ lunch schedule must be followed. CNAs need to tell the nurse and their fellow CNAs when leaving the unit.</p> <p>IV Monitoring Corrective Measures:</p>		

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	<p>by another male peers room, and saw [client A] sitting on the floor in that room, with a male peers shoes on. This reportedly was closer to the 11:00 o'clock hour...."</p> <p>-The CNA did another bed check around 1:00 to 1:30 AM where "...She (CNA) reportedly found [client A] 'playing like she was sleeping, while laying in bed with her legs dangling over the side of the bed, with her body covered with a blanket. The night shift aide indicated she went onto (sic) to complete the rest of her rounds. About 2-2:30 AM, the night shift aide again visualized [client A] on the floor of her room. She reported that [client A] was sleeping 'hard' and snoring while she was on the floor. The night shift aide was not able to get up her on her own (sic), so she obtained assistance from another aide who helped her out [client A] back to bed...."</p> <p>-The night nurse and the CNA clocked out for lunch at approximately 2:30 AM when the nurse went back to the nurse's station and sat for 10 to 15 minutes. The double doors to the South hall were closed while the nurse was in the nurse's station.</p> <p>The 12/14/11 follow-up report indicated "[Client A] returned to the facility on</p>		<p>Staffing is discussed as part of monthly QAA and as needed. Call offs are reviewed by ED, DNS, ADNS, CNA and Nursing scheduler. Procedure is in place for Nursing and CNA scheduler to assist with filling any open positions due to call ins for each shift. ED and DNS are communicated with when call ins occur. Hiring procedure is followed to obtain staff in appropriate numbers in order to have proper numbers of appropriate staff to fill the schedules. To be completed by February 19, 2012.</p>		

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	<p>12/10/2011, with additional diagnosis of 'abrasion to her forehead' with a 'hematoma' on her head..." The 12/14/11 follow-up report indicated one aide and the night nurse were responsible for the care of the clients on the South hall unit. The follow-up report/investigation indicated the nurse and the aide both clocked out at the same time and went to lunch leaving no staff to supervise/monitor client A and the other clients on the unit. The follow-up report indicated the night shift nurse received "...disciplinary action for allowing the Night Shift CNA to go to lunch at the same time that Night Nurse was clocked out for lunch..." The 12/14/12 follow-up report indicated "...The facility administrator immediately responded to the problem of the nurse and the nurse aide being out for lunch by notifying all the facility staff of what to do in the event there is not a facility float staff aide to relieve aides for lunch breaks..."</p> <p>Client A's record was reviewed on 1/12/12 at 10:30 AM. Client A's BIRs indicated the following:</p> <p>-12/8/11 "Client kept going in other clients room sitting in wheelchair &amp; refused to go to sleep (sic)."</p> <p>-12/16/11 "Client through the night trying</p>						

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	<p>to get out of bed. Making it hard for me to do bed check answer bed alarms up at 3:45 AM doesn't want to stay setted (sic) in chair can't start bed (checks) till 5:00 AM wet beds and BM (bowel movement) and I (CNA #1) have to get clients up this is not a 15 min. (minute) check it is a 1:1 (one on one) and I have to work the floor and watch [clients E and F] through night and morning (sic)."</p> <p>Client A's 12/16/11 IDT (interdisciplinary team) note indicated "IDT met to review [client A's] sleep data. Data revealed that [client A] have (sic) been sleeping well at night. There were no concerns by staff working with [client A] at this time. [Client A] continues to be on Trazodone 75 mg (milligrams) with upper limit of 150mg for insomnia...."</p> <p>Client A's 24 Hour Flow Sheets indicated facility staff documented check marks for "Awake at times," on the 10:30 PM to 6:30 AM shift, on 12/11, 12/12, 12/13, 12/19, 12/21, 12/22, 12/23 and 12/24/11.</p> <p>Interview with CNA #2 on 1/12/12 at 8:50 AM stated "Some times she sleeps and sometimes she is is up at night."</p> <p>Interview with Qualified Mental Retardation Professional (QMRP) #1 on 1/12/12 at 11:10 AM indicated there</p>						

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	<p>should have been 1 CNA and a float CNA working on the South Hall on 12/8 to 12/9/11 on the night shift. QMRP #1 indicated client A received Trazodone to treat the client's Insomnia.</p> <p>Interview with administrative staff #1, #2 and #3 on 1/12/12 at 3:10 PM indicated mistakes were made by the CNA and nursing staff on 12/8-12/9/12 in regard to client A's injuries, and the CNA and nurses had been disciplined for their actions. Administrative staff #1, #2 and #3 indicated the night nurse and the CNA should not have gone on a lunch break at the same time as the client had been up and going into others bedrooms prior. Administrative staff #1 and #2 indicated the nurse was at the nurse's station with the door to the unit closed. Administrative staff #1, #2 and #3 indicated the nurse would not be able to see onto the unit from the nurse's station.</p> <p>This federal tag relates to complaint #IN00101293.</p> <p>3.1-13(b)</p>				

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W0210	<p>Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.</p> <p>Based on observation, interview and record review for 1 of 4 sampled clients (A), the client's interdisciplinary team (IDT) failed to re-assess a client's ambulation/motor skills when warranted.</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 1/11/12 at 1:32 PM. The facility's 12/9/11 reportable incident report indicated "Client (client A) had a hematoma on left side if head, red in color size of a quarter. Right cheek swollen and red in color. Unknown how it happen to client (sic). Swollen area on face was about 2 inches long. Vitals taken T (temperature) 96.3 P (pulse) 64 R (respirations) 18 B/P (blood pressure) 100/50 Neuro checks done, pupils equal to light. No change in behavior noted." The reportable incident report indicated 911 was called to transport the client to the hospital. The facility's 12/14/11 follow-up report indicated client A had a history of falls and falls with injuries. The facility's 12/14/11 follow-up report/investigation indicated "...She (CNA) reportedly found [client A]</p>	W0210	<p>W 210 Individual Program Plan Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.</p> <p>I Corrective Action for Cited Clients: Client A now has a Physical Therapy re-evaluation and is now included in therapy. Client A's nurse has had retraining in thorough assessment of a resident, thorough documentation of an assessment, DQI (data for quality improvement which tracks injury and treatment of injury), SBAR, situation, background, assessment and response. CNA staff have had retraining as to use of BIR in reporting and communication with their nurse of issues of concern. Staff have also been retrained on</p>	02/19/2012	

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	<p>'playing like she was sleeping, while laying in bed with her legs dangling over the side of the bed, with her body covered with a blanket. The night shift aide indicated she went onto (sic) to complete the rest of her rounds. About 2-2:30 AM, the night shift aide again visualized [client A] on the floor of her room. She reported that [client A] was sleeping 'hard' and snoring while she was on the floor. The night shift aide was not able to get up her on her own (sic), so she obtained assistance from another aide who helped her put [client A] back to bed...."</p> <p>During the 1/12/12 observation period between 8:25 AM and 9:15 AM, on 2 South hallway, client A sat in a wheelchair with a seatbelt on in the classroom. Client A had light fading bruises around both eyes.</p> <p>Client A's record was reviewed on 1/12/12 at 10:30 AM. Client A's 12/9/11 BIR indicated "...[Client A] was lying on her back on the edge of the bed. One leg down the other one on bed. Her forehead (left side) was red and swollen. I took her for shower but seemed so weak &amp; (and) could not walk properly.-Bruise on the left hand behind the palm." The 12/9/11 BIR indicated client A was "Incoherent, listless."</p>		<p>pajamas and appropriate night wear. Client A has been assessed for sleep disturbance at night and any issues have been addressed with appropriate interventions.</p> <p>II Other Clients Potentially at Risk: All client's have the potential to be affected by this deficient practice.</p> <p>III Corrective Measures or Systemic Changes: Nurses have had retraining in thorough assessment of a resident, thorough documentation of an assessment, DQI (data for quality improvement which tracks injury and treatment of injury), SBAR, situation, background, assessment and response. CNA staff have had retraining as to use of BIR in reporting and communication with their nurse of issues of concern. Staff have also been retrained on pajamas and appropriate night wear. For change in ambulation status of a resident, the IDT will determine if further assessment is required.</p>				

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	<p>Client A's 8/19/11 Physical Therapy (PT) Assessment indicated client A had 2 falls on 8/11/11. The report indicated one fall resulted in superficial abrasions to client A's knees and one fall had no injuries. The 8/19/11 PT assessment indicated "She is performing her normal tasks &amp; ambulating with no problems." Client A's 3/24/11 Individual Support Plan (ISP) and/or record indicated the facility and/or client's interdisciplinary team (IDT) had not re-assessed the client's motor skills/ambulation due to the client's mobility status/change.</p> <p>Interview with CNA #2 on 1/12/12 at 8:50 AM stated since client A returned from the hospital, client A had been "weak and unsteady with her ambulation." Ambulation being unsteady is a change. Will only walk so far and then sit down."</p> <p>Interview with LPN #2 on 1/12/12 at 11:00 AM stated client A's health status was "improving." LPN #2 indicated client A utilized a wheelchair for ambulation.</p> <p>Interview with Qualified Mental Retardation Professional (QMRP) #1 on 1/12/12 at 11:10 AM indicated client A was utilizing a wheelchair for ambulation at this time due to the client's unsteady gait to prevent a fall. QMRP #1 indicated</p>		<p>All residents have been assessed for sleep disturbance at night and issues have been addressed with appropriate interventions.</p> <p>IV Monitoring Corrective Measures: DNS, ADNS, Program Directors and other designated staff review DQI and SBARS to assure quality and DNS/ADNS and DCE, Directors of Clinical Education, complete retraining as indicated or DNS/ADNS administers corrective actions in the form of discipline when warranted. DCE's train nursing staff during orientation on DQI, SBAR and staff on BIR including nursing employees. QMRPs have been in serviced as to the IDT determining further assessment when a resident has a change in ambulation status. The Functional Skills Assessment (FSA) has been modified to assess for sleep disturbance and when noted appropriate interventions will be put in place. To be completed by 2-19-12.</p>				

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	<p>the client's IDT had not re-assessed the client's motor/mobility skills since the last PT assessment was completed in 8/11 before the client's status/mobility changed.</p> <p>This federal tag relates to complaint #IN00101293.</p> <p>3.1-31(a) 3.1-31(d)</p>			
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W0312	<p>Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.</p> <p>Based on interview and record review for 1 of 3 sampled clients (A) with behavioral medications, the facility failed to ensure a behavioral medication was incorporated into the client's program plan, included an active treatment program for which the medication was ordered and/or included a plan of reduction based on the behaviors for which the medication was prescribed.</p> <p>Findings include:</p> <p>Client A's record was reviewed on 1/12/12 at 10:30 AM. Client A's 12/11 physician's order indicated client A received Trazodone HCL 150 milligrams 1/2 tablet at bedtime (Insomnia).</p> <p>Client A's 12/16/11 IDT (interdisciplinary team) note indicated client A received Trazodone 75 mg (milligrams) with upper limit of 150mg for insomnia.</p> <p>Client A's 3/24/11 Behavior Support Plan (BSP) indicated the use of the Trazodone had not been incorporated into the client's BSP. Client A's BSP indicated the client did not have an active treatment program for insomnia/staying up at night nor a plan of reduction based on the behaviors</p>	W0312	<p>W312 Drug Usage</p> <p>Drugs used for control of inappropriate behavior must be used only as an integral part of the client's program plan and that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.</p> <p>I Corrective Action for Cited Clients: Client A has been assessed for sleep disturbance at night and any issues have been addressed with appropriate interventions. If placed on an intervention for sleep disturbance and resident is taking a sleep medication, Client A will have a plan of reduction goal following a two week baseline for sleep disturbance.</p> <p>II Other Clients Potentially at Risk: All client's have the potential to be affected by this deficient practice.</p> <p>III Corrective Measures or</p>	02/19/2012	

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	<p>for which the medication was prescribed.</p> <p>Interview with Qualified Mental Retardation Professional (QMRP) #1 on 1/12/12 at 11:10 AM indicated client A did not have an active treatment program for the use of the client's Trazodone to treat the client's Insomnia and/or to tell staff what they were to do with the client when she got up/did not sleep at night.</p> <p>This federal tag relates to complaint #IN00101293.</p>		<p>Systemic Changes: All residents have been assessed for sleep disturbance at night and issues have been addressed with appropriate interventions. If placed on an intervention for sleep disturbance and resident is taking a sleep medication, that resident will have a plan of reduction goal following a two week baseline for sleep disturbance.</p> <p>IV Monitoring Corrective Measures: QMRPs have been in serviced as to the appropriate method of addressing resident needs in cases of sleep disturbance. The Functional Skills Assessment (FSA) has been modified to assess for sleep disturbance and when noted appropriate interventions will be put in place. To be completed by 2-19-12.</p>		

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W0331	<p>The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on interview and record review for 1 of 4 sampled clients (A), the facility's nursing services failed to meet the nursing/health needs of the client.</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 1/11/12 at 1:32 PM. The facility's 12/9/11 reportable incident report indicated "Client (client A) had a hematoma on left side if head, red in color size of a quarter. Right cheek swollen and red in color. Unknown how it happen to client (sic). Swollen area on face was about 2 inches long. Vitals taken T (temperature) 96.3 P (pulse) 64 R (respirations) 18 B/P (blood pressure) 100/50 Neuro checks done, pupils equal to light. No change in behavior noted." The reportable incident report indicated 911 was called to transport the client to the hospital. The facility's 12/14/11 follow-up report indicated client A had a history of falls and falls with injuries. The facility's 12/14/11 follow-up report/investigation indicated the following (not all inclusive):</p> <p>-On 12/9/11, client A was sitting up in the classroom in a T shirt and underwear with</p>	W0331	<p>W 331 Nursing Services</p> <p>The facility must provide clients with nursing services in accordance with their needs.</p> <p>I Corrective Action for Cited Clients: Client A now has a Physical Therapy re-evaluation and is now included in therapy. Client A's nurse has had retraining in thorough assessment of a resident, thorough documentation of an assessment, DQI (data for quality improvement which tracks injury and treatment of injury), SBAR, situation, background, assessment and response. CNA staff have had retraining as to use of BIR in reporting and communication with their nurse of issues of concern. Staff have also been retrained on pajamas and appropriate night wear. Client A has been assessed for sleep disturbance at night and any issues have been addressed with</p>	02/19/2012			

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	<p>socks on her feet. the investigation indicated the CNA (Certified Nurse Aide) assisted client A to her bedroom and assisted the client to get back in bed at 10:30 PM.</p> <p>-"...The night nurse aide went onto (sic) continue her room checks, and [client A] began to wander again. The nurse aide called for assistance from the Night nurse on duty, and requested the night nurse give [client A] something to help her sleep. The night nurse told the night aide that [client A] had already given a 'sleeper' by the evening shift nurse, and the nurse aide would have to monitor [client A] on the unit...."</p> <p>-Between 10:30 PM and 11:30 PM, client A and another client were still up on the south hall unit. Client A went into a female peer's room and began going through the peer's dresser drawers. The reportable incident report indicated the CNA found client A sitting in a wheelchair in the peer's room with a hat on and again assisted client A back to her bedroom and into bed.</p> <p>-"..The aide reported that she continued with her night shift duties, and later went by another male peers room, and saw [client A] sitting on the floor in that room, with a male peers shoes on. This</p>		<p>appropriate interventions.</p> <p>II Other Clients Potentially at Risk: All client's have the potential to be affected by this deficient practice.</p> <p>III Corrective Measures or Systemic Changes: Nurses have had retraining in thorough assessment of a resident, thorough documentation of an assessment, DQI (data for quality improvement which tracks injury and treatment of injury), SBAR, situation, background, assessment and response. CNA staff have had retraining as to use of BIR in reporting and communication with their nurse of issues of concern. Staff have also been retrained on pajamas and appropriate night wear. For change in ambulation status of a resident, the IDT will determine if further assessment is required. All residents have been assessed for sleep disturbance at night and issues have been addressed with appropriate interventions.</p>		

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	<p>reportedly was closer to the 11:00 o'clock hour. The nurse aide reported that as she walked by she heard one of the male peers in the room having a seizure because she could hear him grunting, and shaking. The night nurse aide then alerted the night nurse, who was on the unit taking vital signs, that [client A] was on the floor in the male peers room, and that the male peer had a 5 second seizure. The Night (sic) nurse reported when she observed [client A] around the 11:00 o'clock hour, [client A] was sitting near the doorway of the male peers room. She (night nurse) thought [client A] had the seizure, and was assessing her rather than the male peer that the night shift aide had earlier communicated to her...." The reportable incident report indicated after the nurse completed her assessment of client A, the CNA helped client A back to her bedroom. The reportable incident report indicated "...The Night Aide did not clarify with the Night Nurse that the male client had the seizure rather than [client A]...."</p> <p>-The CNA did another bed check around 1:00 to 1:30 AM where "...She (CNA) reportedly found [client A] 'playing like she was sleeping, while laying in bed with her legs dangling over the side of the bed, with her body covered with a blanket. The night shift aide indicated she went</p>		<p>IV Monitoring Corrective Measures: DNS, ADNS, Program Directors and other designated staff review DQI and SBARS to assure quality and DNS/ADNS and DCE, Directors of Clinical Education, complete retraining as indicated or DNS/ADNS administers corrective actions in the form of discipline when warranted. DCE's train nursing staff during orientation on DQI, SBAR and staff on BIR including nursing employees. QMRPs have been in serviced as to the IDT determining further assessment when a resident has a change in ambulation status. The Functional Skills Assessment (FSA) has been modified to assess for sleep disturbance and when noted appropriate interventions will be put in place. To be completed by 2-19-12.</p>		

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	<p>onto (sic) to complete the rest of her rounds. About 2-2:30 AM, the night shift aide again visualized [client A] on the floor of her room. She reported that [client A] was sleeping 'hard' and snoring while she was on the floor. The night shift aide was not able to get up her on her own (sic), so she obtained assistance from another aide who helped her put [client A] back to bed. The Aide reported she did not turn on the light when this transfer was made from the floor to the bed, so she was not able to clearly describe what [client A] looked like at this point...."</p> <p>-When the CNA returned she did rounds and "...physically provided incontinent care to [client A]...Once at approximately 3:30 AM, and again at 6:05 AM. The Night Nurse Aide did not turn on the lights in the client's room at any time during the client's incontinent care...."</p> <p>-The day shift CNA went to client A's room at 6:50 AM to take the client to shower. It was at that time, the day shift staff noticed client A's face was swollen and red. The CNA took client A to the shower room and asked a nurse to check client A. "...The Day Shift nurse indicated that she went to the shower room around 7:00 AM observed that [client A]cheekbones were both swollen</p>			
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	<p>and red, and she had a red lump on her left forehead, as well as bright red discoloration between [client A's] scalp/hairline and her forehead. The Day Shift Nurse went back to the Night Shift nurse and asked her to come and look at [client A's] face. The Day (sic) shift nurse indicated that she wanted the Night Shift Nurse 'to see what I saw.' The Day (sic) shift nurse was unable to determine how a seizure earlier on the night shift could have caused the injuries to [client A's] face. The Night (sic) shift nurse did not respond to the Day Shift Nurse's request."</p> <p>-The day shift nurse was not able to determine the client had a seizure history per the nurse asking the staff.</p> <p>-At 10:30 AM, another nurse saw client A and did not think "...[Client A] looked like herself..." At 10:35 AM, the nurse went to ask the ADON (Assistant Director of Nursing) to come look at client A. The ADON checked client A and instructed the nurse to send the client out for an evaluation. Client A was transported to the ER between 12:30 and 1:00 PM on 12/9/11.</p> <p>-At 4:20 PM, a social worker from the hospital called and indicated she had concerns in what was reported to the</p>			
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	<p>hospital in regard to client A's injuries, and they (the hospital) found "...old yellowish fading bruises to the clients (sic) chest and both upper thighs...." The follow-up report indicated client A was kept at the hospital for observation for 24 hours "...due to a reported 'indentation on her head.'...."</p> <p>The 12/14/11 follow-up report indicated "[Client A] returned to the facility on 12/10/2011, with additional diagnosis of 'abrasion to her forehead' with a 'hematoma' on her head...." The 12/14/11 follow-up report indicated "...The outcome of the investigation information was reviewed by the management team regarding the statements from each of the staff involved in the investigation of this event. The facility has been unable to absolutely confirm exactly how [client A's] head injuries occurred. However after reviewing the information provided from interviews, and the timeline of the findings, the facility has determined there is a strong probability that between 2-2:30 AM when the Night Shift Nurse aide found the client on the floor, she sought help to transfer [client A] back to bed, and did not report the event to the Night Nurse. During the remainder of the night shift, neither the Night Nurse or the Night Shift aide visualized the client's face to determine if she had any</p>			
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	<p>injuries...Disciplinary Action was provided to the Night Shift Aide regarding her lack of reporting the clients event with a BIR (Behavior Incident Report) nor to the nurse on duty when she found the client on the floor...The day Shift Nurse was given Disciplinary (sic) action in regard to her delay in initiating a thorough assessment of the client who had a head injury, which delayed her transport to the ER...."</p> <p>During the 1/12/12 observation period between 8:25 AM and 9:15 AM, on 2 South hallway, client A sat in a wheelchair with a seatbelt on in the classroom. Client A had light fading bruises around both eyes.</p> <p>Client A's record was reviewed on 1/12/12 at 10:30 AM. Client A's 12/10/11 Discharge Summary indicated client was admitted to the hospital for observation "...to make sure that there were no further injuries resulting...." The 12/10/11 discharge summary indicated it was reported the client fell to the floor during a seizure. The 12/10/11 discharge summary indicated client A had "...2. Facial cranial abrasion and hematoma secondary to fall from seizures...."</p> <p>Client A's 12/8/11 Seizure Episode record indicated the facility's nurse documented</p>						

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	<p>client A "reportedly" had a seizure on 12/8/11 at 11:05 PM which lasted 5 seconds. Jerking of the extremities (arms and legs) was checked. Client A's seizure record did not indicate the client had any documented seizures prior to 12/8/11.</p> <p>Client A's 9/26/11 Neurological typed note indicated client A's diagnosis included, but was not limited to, Intractable Generalized Tonic-Clonic Seizures. The 9/26/11 report indicated "...he has fortunately been medically stable as of late...Seizure records are reviewed. She has not had any other seizures...."</p> <p>Client A's 12/9/11 BIR indicated "... [Client A] was lying on her back on the edge of the bed. One leg down the other one on bed. Her forehead (left side) was red and swollen. I took her for shower but seemed so weak &amp; (and) could not walk properly.-Bruise on the left hand behind the palm." The 12/9/11 BIR indicated client A was "Incoherent, listless."</p> <p>Client A's Nursing Progress Notes indicated the following:</p> <p>-12/9/11 at 1:20 PM "T96.3-P68-R18 B/P100/50 Client had a red swollen area on left forehead, size of a quarter.</p>			

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	<p>Forehead was red across scalp line into hair. Right cheek bone appeared swollen and red 2 inches in diameter. No pain when area was touched. Client listless and incoherent after breakfast and was put in bed. 12:00pm condition appeared to have not changed. Emas (emergency medical assistance service) called to take client to [name of hospital]."</p> <p>-12/9/11 at 1:37 PM "Skin assessment done on [client A] concerning injuries noted to face and neck. No injuries noted on other parts of her body. See skin assessment sheet." Client A's nursing notes failed to indicate any additional documentation/assessment of client A prior to 1:20 PM on 12/9/11 due to the client's change of health status, initial assessment, and/or neurological checks.</p> <p>Client A's 8/19/11 Physical Therapy (PT) Assessment indicated client A had 2 falls on 8/11/11. The report indicated one fall resulted in superficial abrasions to client A's knees and one fall had no injuries. The 8/19/11 PT assessment indicated "She is performing her normal tasks &amp; ambulating with no problems." Client A's 3/24/11 Individual Support Plan (ISP) and/or record indicated the facility and/or client's interdisciplinary team (IDT) had not re-assessed the client's motor skills/ambulation due to the client's</p>						

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	<p>mobility status/change.</p> <p>Interview with CNA #2 on 1/12/12 at 8:50 AM when asked if client A had seizures, CNA #2 stated "I have never seen her have a seizure." CNA #2 indicated client A did have falls in the past, but she was not aware of any recent falls. CNA #2 stated since client A returned from the hospital, client A had been "weak and unsteady with her ambulation." Ambulation being unsteady is a change. Will only walk so far and then sit down."</p> <p>Interview with LPN #2 on 1/12/12 at 11:00 AM stated client A's health status was "improving." LPN #2 indicated client A utilized a wheelchair for ambulation.</p> <p>Interview with Qualified Mental Retardation Professional (QMRP) #1 on 1/12/12 at 11:10 AM indicated client A's facial/head injuries were discovered by the morning staff on 12/9/11 and client A did not go out to the emergency room until 11 or 12 noon. QMRP #1 indicated client A was utilizing a wheelchair for ambulation at this time due to the client's unsteady gait to prevent a fall. QMRP #1 indicated the client's motor/mobility skills had not been re-assessed since the last PT assessment was completed in 8/11.</p>			
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	<p>Interview with administrative staff #1, #2 and #3 on 1/12/12 at 3:10 PM indicated mistakes were made by the CNA and nursing staff on 12/8-12/9/11 in regard to client A's injuries, and the CNA and nurses had been disciplined for their actions. Administrative staff #3 indicated there was an error in regard to which client had a seizure. Administrative staff #2 and #3 indicated the nurse checked/assessed client A for having a seizure when it was another client who had the seizure, not client A. Administrative staff #2 and #3 indicated the night CNA saw the nurse checking client A but did not inform the nurse it was the wrong client. Administrative staff #3 indicated the facility could not determine the exact time and cause of client A's injuries, but it thought the client may have been injured at the time the client was found on the floor by a CNA in which the CNA had to get assistance to get the client up off the floor. Administrative staff #1, #2 and #3 indicated the CNA did not inform the night nurse client A was found on the floor in her bedroom. Administrative staff #2 and #3 indicated the CNA did not document she found the client on the floor on a BIR. Administrative staff #3 indicated no one actually saw the client's face when they checked on the client after</p>			
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	<p>she was placed in bed. Administrative staff #3 indicated a nursing staff came down to her office and asked administrative staff #3 to come and look at client A between 10 and 10:30 AM. Administrative staff #3 indicated she saw the client and told the nursing staff to send her to the emergency room to be evaluated. Administrative staff #3 indicated client A had injuries to her face and was leaning to the side. Administrative staff #2 and #3 indicated the nursing staff did not conduct and/or document assessments of client A's injuries at the time the injuries were discovered.</p> <p>This federal tag relates to complaint #IN00101293.</p> <p>3.1-17(a)</p>			
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W9999	<p>State Findings</p> <p>The following Health Facilities Rule was not met:</p> <p>410 IAC 16.2-3.1-13 "(g) The administrator is responsible for the overall management of the facility but shall not function as a departmental supervisor, for example, director of nursing or food service supervisor, during the same hours. The responsibility of the administrator shall include, but are not limited to, the following: (1) Immediately informing the division by telephone, followed by written notice within twenty-four (24) hours, of unusual occurrences that directly threaten the welfare, safety, or health of the resident or residents...."</p> <p>This state rule was not met as evidenced by:</p> <p>Based on observation, interview and record review for 2 of 4 sampled clients (clients B and C), the facility's administrator failed to report bed bugs being found in the facility.</p> <p>Findings include:</p>	W9999	<p>W9999 Final Observations 410 IAC 16.2-3.1-13 "(g) The administrator is responsible for the overall management of the facility but shall not function as a departmental supervisor, for example, director of nursing or food service supervisor, during the same hours. The responsibility of the administrator shall include, but are not limited to, the following: (1) Immediately informing the division by telephone, followed by written notice within 24 hours, of unusual occurrences that directly threaten the welfare, safety, or health of the resident or residents..." I Corrective Action for Cited Clients: A policy for pest control has been developed by North Willow. This policy is in effect for issues of bed bugs that affected clients B and C. Pest control action has been taken in the case of the bed bugs and is in concert with the written policy. The administrator will report all unusual</p>	02/19/2012	

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	<p>During the 1/11/12 observation period between 4:25 PM and 5:30 PM, at the facility on the first floor North unit, there was a metal bracket seen on room 117 (clients B and C's bedroom). At 4:30 PM, client C was standing in the hallway and asked Qualified Mental Retardation Professional (QMRP) #2, who was also in the hallway, how his room was doing. QMRP #2 responded/stated "It will be a couple of months." Client C responded/indicated he would not be able to go back in his room for awhile. Client C then asked QMRP #2 about his equipment in his room. QMRP #2 responded/stated "Nothing can come out of there."</p> <p>The facility's reportable incident reports were reviewed on 1/11/12 at 1:32 PM. The facility's reportable incident reports from 12/11 to 1/12 indicated the facility did not report bed bugs in the facility.</p> <p>Interview with client C on 1/11/12 at 5:28 PM indicated the client was staying in a different bedroom on the North unit. Client C stated his bedroom was being treated for "bed bugs." Client C indicated he would not be able to move back into his bedroom for 30 days.</p> <p>Confidential interview A stated "I believe so," when asked if the facility had bed</p>		<p>occurrences to ISDH within 24 hours of such an incident.</p> <p>II Other Clients Potentially at Risk: All client's have the potential to be affected by this deficient practice.</p> <p>III Corrective Measures or Systemic Changes: A policy for pest control has been developed by North Willow. This policy is in effect for issues like bed bugs and steps taken in the case of the bed bugs is in concert with the written policy. Administrator will follow current ISDH guidelines. Administrator will report unusual occurrences to ISDH within 24 hours of such an occurrence.</p> <p>IV Monitoring Corrective Measures: The pest control policy has been trained with staff and approved by North Willow's QAA committee. All unusual occurrences will be reported to QAA monthly along with any actions taken. To be completed by 2-19-12.</p>				

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	<p>bugs. Confidential interview A did not know how many bedrooms were affected.</p> <p>Interview with QMRP #2 on 1/12/12 at 1:00 PM indicated bed bugs were found in client B and C's bedroom on the first floor North unit. QMRP #2 indicated the bed bugs were found in client C's Futon. QMRP #2 indicated clients B and C were moved to different bedrooms while their bedroom was being treated. QMRP #2 indicated client C brought the bed bugs into the facility from a home visit with his mother. QMRP #2 indicated as precaution all the clients' clothes on the north hall were sent to the laundry to be washed.</p> <p>Interview with administrative staff #1 on 1/12/12 at 2:10 PM indicated bed bugs were found in the facility. Administrative staff #1 indicated a bed bug was seen when the client's clothes were sent down to the laundry room to be washed. Administrative staff #1 indicated the pest control was called to come to the facility but did not find evidence of bed bugs. Administrative staff #1 indicated the bed bugs were later seen on client C's Futon and the pest control was called back to the facility and confirmed they were bed bugs. Administrative staff #1 stated client C's Futon was "infested." Administrative staff #1 indicated clients</p>				

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	<p>B and C's bedroom was being treated along with the bedroom on each side of the affected bedroom. Administrative staff #1 indicated the facility's pest control service completed its first treatment/spray a few days ago and would be returning to the facility for 2 more treatments/sprays. Administrative staff #1 indicated the facility was doing what the pest control people recommended. Administrative staff #1 stated she did not report the bed bugs as it was not "widespread."</p> <p>This state tag relates to complaint #IN00102259.</p> <p>3.1-13(g)(1)</p>			
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