

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155698	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/05/2014
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NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012
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F000000	<p>This visit was for the investigation of Complaints IN00153155 and IN00153344.</p> <p>Complaint IN00153155-unsubstantiated. Complaint IN00153344-substantiated. Federal/State deficiencies related to the allegations are cited at F323.</p> <p>Survey dates: August 4 and 5, 2014</p> <p>Facility number: 011045 Provider number: 155698 AIM number: 200380790</p> <p>Survey team: Karen Lewis, RN TC Ginger McNamee, RN Toni Maley, BSW</p> <p>Census bed type: SNF/NF: 49 SNF: 16 Residential: 58 Total: 123</p> <p>Census payor type: Medicare: 37 Medicaid: 9 Other: 77 Total: 123</p>	F000000	<p>Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Complaint Survey on August 5, 2014. Please accept this plan of correction as the provider's credible allegation of compliance.</p> <p>The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</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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F000323 SS=D	<p>Sample: 6</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by Debora Barth, RN.</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to implement a resident's plan of care regarding fall prevention for 1 of 4 residents reviewed for falls in a sample of 6. (Resident #F)</p> <p>Findings include:</p> <p>Resident #F's clinical record was reviewed on 8/4/14 at 2:10 p.m. The resident's diagnoses included, but were not limited to, debility, gait apraxia with falls, head trauma from fall 4/3/13, Parkinson's Psychosis due to neuropsychiatric illness, Alzheimer's Dementia with behavior disturbance.</p>	F000323	<p>F 323</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #F is confidential as part of the complaint survey.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: Review of all fall circumstance and reassessment forms for the past 30 days to ensure the fall</p>	09/04/2014

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	<p>The resident's current physician's orders were signed 7/3/14. The resident's orders included, but were not limited to, mobility: up as tolerated with assist. Lap buddy to wheelchair with personal alarm attached to lap buddy to alert staff of unassisted transfer due to impaired safety awareness.</p> <p>The resident had a 7/25/14 annual Minimum Data Assessment. The assessment indicated the resident had severe cognitive impairment and needed the assistance of two for transfers and toileting.</p> <p>Resident #F had a 8/4/14 care plan. The care plan indicated "...I have Alzheimer's Dementia with behavior disturbance, Debility, Gait Apraxia with falls, Psychosis D/T [due to] psychiatric illness, Hx [history] of Head Trauma, Vit [vitamin] B12 and D deficiencies, Parkinson's disease with mood liability, anemia and HTN [hypertension]. All of these problems make me a HIGH FALL RISK because they cause me to be unsteady, make poor safety decisions and make me weak and unable to do things on my own. At times I may need 2 people for transfers, bed mobility and bathing 1 person for hygiene and dressing. I CANNOT be left alone on the toilet as I will forget that I can't transfer</p>		<p>prevention interventions identified were implemented into the residents plan of care and are in place.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Nursing staff on the following campus guidelines: Fall Management Program</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Review of the fall circumstance and reassessment forms of 5 residents per hallway to ensure the fall prevention interventions identified were implemented into the residents plan of care and are in place.</p> <p>The results of the audit observations will be reported, reviewed and trended for</p>	

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	<p>and I might fall. I have Osteoporosis so a fall could mean a fracture and I do not want to get a fracture....The nurses have implemented several safety interventions for my benefit;...a Lap Buddy with a clip alarm to alert the staff if I attempt independent transfers or ambulation....My goal is to be cared for in a safe and caring environment and to be fall free...."</p> <p>Resident #F had a "Fall Circumstance Assessment and Intervention" report in her record indicating she had fallen in her bathroom during a self transfer on 10/10/13 at 6:40 p.m. The report indicated the fall was an unsafe transfer due to poor safety awareness.</p> <p>A 7/5/14, 7:00 p.m., "Fall Circumstance Assessment and Intervention" report, in her record, indicated she had fallen in her bathroom while self transferring off of the toilet. The report indicated the resident had been left alone in the bathroom while the CNA was gathering supplies. New care plan interventions were to stay with the resident when she was in the bathroom and to gather supplies before beginning care.</p> <p>A 7/15/14, 7:15 a.m., "Fall Circumstance Assessment and Intervention" report in her record indicated the CNA left the resident in the bathroom on the toilet</p>		<p>compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>				

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	<p>alone while the CNA gathered supplies from the resident's room and the resident fell.</p> <p>During an interview with the Director of Nursing on 8/5/14 at 1:20 p.m., she indicated the resident's care plan was current and lacked the intervention of gathering the resident's supplies before beginning care.</p> <p>The revised 3/08, "Falls Management Program Guidelines" was provided by the Director of Nursing on 8/5/14 at 1:10 p.m. The policy indicated "Purpose:...to maintain a hazard free environment, mitigate fall risk factors and implement preventive measures....The nursing assistant assignment sheet and resident care plan should be updated to reflect any new or change in interventions."</p> <p>This Federal tag relates to complaint IN00153344.</p> <p>3.1-45(a)(2)</p>				