

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 12/23/2014
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NAME OF PROVIDER OR SUPPLIER CHRISTINA PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 1435 CHRISTIAN BLVD FRANKLIN, IN 46131
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R000000	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: December 19, 22, and 23, 2014</p> <p>Facility number: 004017 Provider number: 004017 AIM number: N/A</p> <p>Survey team: Dorothy Plummer, RN-TC Marsha Smith, RN (December 22 and 23, 2014)</p> <p>Census bed type: Residential: 61 Total: 61</p> <p>Census payor type: Total: 0</p> <p>Residential sample: 8</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed on December 26, 2014; by Kimberly Perigo, RN.</p>	R000000	<p>Submission of this response and Plan or Correction is not a legal admission that a deficiency exists or that this Statement of Deficiencies was correctly cited, and is also not to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in response or Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. We are requesting paper compliance with these deficiencies.</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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R000153	<p>410 IAC 16.2-5-1.5(j) Sanitation and Safety Standards - Deficiency (j) The facility shall observe safety precautions when oxygen is stored or administered in the facility. Residents on oxygen shall be instructed in safety measures concerning storage and administration of oxygen.</p> <p>Based on observation and interview, the facility failed to observe safety precautions with the administration of oxygen in the beauty shop and failed to ensure a resident receiving oxygen had been instructed in safety measures concerning the administration of the oxygen. (Resident #29)</p> <p>Findings include:</p> <p>During a random observation of the beauty shop on 12/22/14 at 4:35 p.m., Resident #29 was observed sitting in a wheelchair while the beautician styled the hair of the resident. Resident #29 was observed to have a nasal cannula (a tubing used to administer oxygen through the nose) connected to a green tank on the back of the wheelchair. The resident indicated oxygen was being administered through the tubing. Another resident was observed sitting under a hairdryer approximately 5 feet from Resident #29. The hairdryer was in use and functioning at the time of the observation.</p>	R000153	<p>What correction action will be accomplished for those residents found to have been affected by this deficient practice: No residents were found to be Affected.</p> <p>How the facility will identify Other residents having the Potential to be affected by the same deficient practice & what corrective action will be taken: The beautician and staff have been provided re-education regarding safety precautions when utilizing oxygen therapy within the community and beauty shop.. A physicians order to remove oxygen for a period of time while resident is in need of hair dryer services will be obtained if possible. No hair dryer service for any resident that is on Oxygen will be performed.</p> <p>What measures will be put into place systemic changes the facility will make to ensure that the deficient practice does not recur: The Executive Director and/or Designee will monitor the beauty shop weekly for a period of 2 months, then randomly For 6 months thereafter. Audits will be reviewed during the QA meeting at this</p>	01/05/2015
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	<p>During an interview with the beautician and Resident #29 , the beautician indicated the resident had been out with family and upon return had been wheeled into the beauty shop to have a wash and set. The beautician indicated the oxygen was in place upon the resident entering the beauty shop. The resident and the beautician indicated the tubing administering the oxygen was removed while the resident transferred into a chair to have hair washed and then the tubing was placed back into the nose of the resident when the resident returned to the wheelchair.</p> <p>The beautician indicated once the resident's hair was set with the hair rollers, the resident was then backed in the wheelchair into the area under the hair dryer to allow the resident's hair to dry under the dryer. The beautician and the resident indicated this process was followed each time the resident came to the beauty shop.</p> <p>The beautician and the resident indicated they were unaware of any safety precautions to be utilized while using oxygen in the beauty shop.</p> <p>During an interview with the Executive Director (ED) on 12/22/14 at 4:45 p.m.,</p>		time in order to determine the need for ongoing monitoring. Findings suggestive of compliance will result in cessation of the monitoring plan.	

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R000349	<p>the ED indicated the facility did not have a policy on the use of oxygen while in the beauty shop and agreed the administration of oxygen while under a hair dryer could potentially cause a fire.</p> <p>410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.</p> <p>Based on record review and interview, the facility failed to ensure documentation in a resident's clinical record included information on her discharge and care provided to the resident prior to her discharge for 1 of 7 clinical records reviewed for accurate and complete documentation. (Resident #62)</p> <p>Findings include:</p> <p>The closed clinical record of Resident #62 was reviewed on 12/22/14 at 2:50 p.m. Diagnoses for the resident included, but were not limited to, dementia and seizures.</p>	R000349	<p>What correction action will be accomplished for those residents found to have been affected by this deficient practice: No residents were found to be Affected.</p> <p>How the facility will identify Other residents having the Potential to be affected by the same deficient practice & what corrective action will be taken: Nursing staff have been provided re-education as to our policy and procedures regarding appropriate documentation.</p> <p>What measures will be put into place systemic changes the facility will make to ensure that the deficient practice does not recur: During morning meeting, care service</p>	01/05/2015

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	<p>A nurse's note dated 10/1/14 at 9:00 p.m., indicated Resident #62 was sent to the hospital for evaluation due to having, "seizure-like activity." She returned to the facility a few hours later.</p> <p>A nurse's note dated 10/2/14 at 11:10 a.m., indicated the resident had increased, "confusion and unsteady on feet @ [at] times. Res[ident] [up] and continues to ambulate."</p> <p>A nurse's note dated 10/2/14 at 7:00 p.m., indicated, "Res[ident] has [increased] confusion and is unsteady on feet...has [increased] wandering all shift, not easily redirected..."</p> <p>A nurse's note dated 10/3/14 at 1:00 p.m. indicated, "Res[ident] [with] [increased] confusion, moving furniture in apt [apartment] and in dining room. Unable to sit still for long periods of time, constantly wandering [without] purpose, redirection no longer effective..."</p> <p>A Behavior Strategy Plan, dated 10/3/14, indicated, "Increased wandering. Family has been notified. Increased safety checks on resident. All CNAs [Certified Nursing Assistants] and LPNs [Licensed Practical Nurses] aware. Family planning meeting [related to] future plans</p>		<p>manager, RN will receive updates on any changes and discharges on residents. The Care Service Manager and/or designated individual(s) will monitor records for a minimum of 3 times per week for a period of 1 month, then will perform random audits for 4 months. Audits will be reviewed during the QA meeting at this time in order to determine the need for ongoing monitoring. Findings suggestive of compliance will result in cessation of the monitoring plan.</p>	

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	<p>of resident."</p> <p>A nurse's note dated 10/4/14 at 10:10 a.m., indicated, "[increased] confusion. Res[ident] ambulating constantly [without] purpose..."</p> <p>A nurse's note dated 10/5/14 at 10:30 a.m. indicated, "...[Increased] confusion, redirected..."</p> <p>No documentation after 10/5/15, was found in the resident's record.</p> <p>On 12/23/14 at 12:10 p.m., the Care Manager indicated Resident #62 was discharged from the facility on 10/15/14. She indicated documentation of care, between 10/5/14 and 10/15/14, provided for the confused and wandering resident, and information regarding her discharge from the facility should have been in the resident's clinical record.</p> <p>On 12/22/14 at 12:45 p.m., the Executive Director provided a policy dated 7/1/14, titled, "Documentation," and indicated it was the policy currently used by the facility. The policy indicated, "The Resident Record is the primary site for documentation regarding resident health, care and services."</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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