

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155766	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/01/2013
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NAME OF PROVIDER OR SUPPLIER MAPLE MANOR CHRISTIAN HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 643 W UTICA ST SELLERSBURG, IN 47172
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F000000	<p>This visit was for the Investigation of Complaint IN00133877 and Complaint IN00136407.</p> <p>Complaint IN00133877 - Substantiated. Federal/State deficiencies related to the allegations are cited at F225 and F319.</p> <p>Complaint IN00136407 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey Dates: September 27 & 30, 2013, October 1, 2013</p> <p>Facility number: 000563 Provider number: 155766 AIM number: 100267610</p> <p>Survey team: Gwen Pumphrey, RN-TC</p> <p>Census Bed Type: SNF: 52 Total: 52</p> <p>Census Payor Type: Medicare: 4 Medicaid: 35 Other: 13</p>	F000000		

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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	<p>Total: 52</p> <p>Sample: 7</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2</p> <p>Quality review completed on October 17, 2013 by Cheryl Fielden, RN</p>			

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F000225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p>	F000225	No other action can be taken for	11/01/2013			

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	<p>Based on record review and interview the facility failed to thoroughly investigate an injury of unknown origin resulting in harm of a resident. This deficient practice affected 1 of 4 sampled residents reviewed for requiring extensive assistance with activities of daily living (Resident #A).</p> <p>Findings include:</p> <p>A record review of Resident #A's medical record on 10/1/2013 at 11:30a.m., indicated he was admitted to the facility on 5/1/2008. He had diagnoses including but not limited to, heart disease, enlarged prostate, hypertension, and dementia.</p> <p>The MDS(Minimum Data Set) assessment dated 1/11/2013, indicated Resident #A had impaired functional status and required total assistance with activities of daily living. Resident #A had a BIMS(Brief Interview for Mental Status) score of 2, which indicated cognitive impairment.</p> <p>The nurse's notes dated 7/27/13 at 9:00p.m., indicated CNA's(Certified Nursing Assistant) Reported Resident A's daughter was trying to change resident brief and was pulling his leg up in the air, pulling at his arms and</p>		<p>this resident as he has since expired. His daughter did leave the building when C.N.A.'s entered room to complete care. Abuse checks with residents were being completed weekly when this occurred with 3 residents each week with no noted issues. (see attached) Staff interviews were being conducted per current procedure at this time also. (see attached) There have been no other residents with noted fractures not related to a fall with reports having been submitted on those. Being that there were witnesses to the incident with the daughter and it being reported immediately to administration with report made to ISDH it was deemed as an incident that did not warrant investigation for abuse as there was no willful negative action being performed. This was being deemed an accident. This facility administration investigates and reports all allegations of abuse, neglect, mistreatment, significant injuries, etc. as evidenced by the multiple reports that have been submitted to the ISDH. This process will continue. Current process of resident and staff interview QA's will continue as currently in place. (see attached QA's) Inservices are placed on the annual calendar related to abuse/neglect with one having been already scheduled for 10/11/13 (see attached).IDR reason is due to above reasons in</p>				

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	<p>tried to roll him over by holding him at his knee on right leg and pulling him. The nurses note indicated the CNA's intervened and provided incontinent care.</p> <p>The nurse's notes dated 7/28/13 at 2:30a.m., indicated the resident had been restless all night and complained of right leg pain. The nurse administered tylenol 650 milligrams by mouth for pain.</p> <p>The nurse's notes dated 7/28/13 at 6:00p.m., indicated during shift change, both day and night shift nurses assessed Resident #A's right leg and found pain with palpitation. At this time, the physician was notified.</p> <p>The nurse's notes dated 7/28/13 at 6:50p.m., an order was received for an x-ray and pain medication was changed.</p> <p>The nurse's notes dated 7/28/13 at 7:30p.m., indicate Resident #A's daughter was notified of his change in condition.</p> <p>The nurse's notes dated 7/28/13 at 11:15p.m., indicated the x-ray showed an acute fracture of the right femur. The physician adjusted</p>		POC		

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	<p>Resident #A's pain medication and would make arrangements for the resident to be directly admitted "in a.m.[morning] to hospital" The note also indicates the resident's daughter and director of nursing was notified</p> <p>The radiology report completed on 7/28/13 at 9:02a.m., indicated an acute intertrochanteric fracture of the proximal right femur.</p> <p>The physician's orders indicated on 7/29/13 at 11:00a.m., resident was sent to the hospital for admission.</p> <p>The nurses notes dated 7/30/13 at 11:10a.m., indicated a late entry for 7/28/13 at 11:15a.m., indicated resident complained of pain when asked and pain medication given. Review of nurses notes 7/30/13 at 11:15a.m., indicated a late entry for 7/28/13 at 3:00p.m., indicated the resident had no complaints of pain or distress.</p> <p>The initial investigative report on 10/1/13 at 12:00p.m., indicated the initial report was filed on 7/29/13 at 9:00p.m. The report indicated, CNA#2 reported resident complained of pain with care and transfer. The report also indicated the resident complained of pain to the right leg to</p>			

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	<p>the nurse after getting up for lunch. The follow-up investigation dated 8/2/13 at 1:30p.m. included the nurse's notes, radiology report, and course of hospital stay. The follow up investigation indicated the injury was caused during incontinent care provided by the residents family member.</p> <p>In an interview on 10/1/13 at 4:15p.m., the DON(Director of Nursing) indicated 2 CNA's walked into the resident's room and the they observed the resident's leg in the air as the daughter tried to provide incontinent care. The DON indicated the resident's children visited frequently and some had been inappropriate with them.</p> <p>The investigation lacked documentation regarding staff and family interviews or other possible causes of the injury. The investigation did not indicate whether the Resident's daughter was allowed to continue to visit with the resident. The investigation did not indicate whether the CNA's providing care were allowed to continue to take care of the resident until the investigation was complete.</p> <p>A copy of the policy titled, "Abuse</p>			

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	<p>Investigation", was provided by Unit Manager #1 on 9/26/13 at 9:40a.m. The policy states, "The staff members and administration recognize that abuse may include physical abuse, physical neglect, medical neglect, emotional neglect, self-neglect, emotional abuse, financial or material exploitation, violation of personal rights or abandonment. Once such an event, pattern or trend is identified, it will be reported to the Administrator, Director of Nursing or designee without fear of reprisal". The policy indicated during an investigation of an allegation, the facility will take steps to protect residents from harm.</p> <p>This federal tag is related to Complaint IN00133877.</p> <p>3.1-28(c) 3.1-28(d)</p>			

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F000319 SS=D	<p>483.25(f)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem.</p> <p>Based on record review and interview, the facility failed to ensure residents displaying psychosocial behaviors receive proper assessment and treatment to correct the problems. This deficient practice affected 1 of 3 residents reviewed for assessments. (Resident A).</p> <p>Findings include:</p> <p>In an interview with the Social Services Director on 9/30/13 at 9:30a.m., indicated if a resident has a history of a behavior a care plan is initiated, the resident is observed, and a behavior log may be initiated. She indicated all residents are not monitored with a behavior log. When asked how the facility determines if the behavior is a psychosocial or medical, she also indicated when a resident displays a new behavior, the resident is evaluated for a UTI (urinary tract infection) and she is notified. If a resident displays a</p>	F000319	IDR Reasoning and POC: There was a care plan in place for sexually inappropriate behaviors as well as behavior logs (see attached). The family would not allow resident to be seen by psychiatrist for behaviors. (see attached social service notes regarding this) Care plan current diagnosis list included BPH w/ urinary obstruction. The ADL careplan addresses incontinence (see attached). Quarterly Bladder Assessment were being completed with last one date 7/4/13. Residents family did request urology appointment on 6/28/13 with appointment made for July 9, 2013 (see attached calendar). This appointment was rescheduled by the urologist office (see attached calendar) for July 16, 2013. On that date there was an issue with transportation picking resident up for appointment. Once resident arrived to appointment they would not see him (see nurses notes). Nurse Practitioner evaluated again on July 22, 2013 with urology appointment scheduled for August 6, 2013 (see nurses notes and calendar). However	11/01/2013			

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	<p>severe behavior, the psychiatrist is notified. She indicated she is responsible for monitoring the behavior logs. She indicated a behavior log is rarely discontinued, " because if they have done it once they have the possibility to do it again.</p> <p>In an interview with LPN#1 on 10/1/13 at 11:00a.m., indicated when a resident displays a new behavior, the she attempts to redirect the behavior, perform an assessment, notify the social services director and the physician.</p> <p>Review of the medical record on 10/1/13 at 10:30a.m., indicated Resident #A had diagnoses including but not limited to, dementia, enlarged prostate, heart disease, and hypertension.</p> <p>The physician's progress note dated 2/20/13 indicated the resident had sexually acting out behaviors and was masturbating frequently. A medication estradiol patch was increased due to these behaviors. The physician's progress notes dated 3/13/13 and 7/29/13 indicated the behavior was stable.</p> <p>The care plan indicated Resident #A was monitored for inappropriate</p>		<p>resident was able to be seen in hospital by urology when admitted and did not have to wait until 8/6/13 appointment. In the 2567 it states that on the discharge summary dated 8/8/13 it was indicated that resident had difficulty voiding while inpatient and physician recommended catheter remain in place indefinitely. This is what the discharge summary states but what is incorrect is the date of 8/8/13 was the typed date of the summary the actual date of discharge and the summary date is 7/31/13 (see attached). Resident underwent outpatient urology procedure on 8/6/13 at hospital. Returned with order to remove catheter in 2 days - check void residual one day after removal - call physician if > 200cc (see attached). Catheter care was completed as ordered with I&O's monitored while catheter was in place (see attached). Per annual POC, the communication logs are monitored by SSD and DON with follow up on behaviors by DON to ensure SSD is addressing them with behavior careplans being updated as appropriate. This was initiated on or before 8/26/13 for all residents and continues 2x's weekly for any noted issues. This QA will be ongoing until re-evaluated in January by the QA committee.</p>		

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	<p>behaviors related to "coughing up mucus and spitting frequently..." and "...cusses, yells outand is combative...." The care plan lacked documentation of inappropriate behaviors related to sexually acting out. The care plan also lacked documentation regarding the resident's diagnosis of urinary retention related to an enlarged prostate.</p> <p>The clinical record lacked a behavior log to monitor the inappropriate behaviors related to sexually acting out. Review of the nurses notes did not consistently monitor inappropriate behaviors related to sexually acting out. Review of the nurses notes indicated Resident #A's family requested a urology consult on 6/28/13.</p> <p>The resident was seen by a urologist on 7/30/13 during an inpatient hospital stay. The consultation report indicated Resident #A had a history of recurrent urinary tract infections, urinary incontinence, and a transurethral resection of his prostate. The urologist indicated Resident #A had a "very full bladder" urethral stricture, voiding dysfunction, and blood in the urine.</p>			

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	<p>The discharge summary from the hospital dated 8/8/13 indicated the resident had difficulty voiding while inpatient. The physician recommended the catheter remain indefinitely due to the urinary retention and the difficulty in placing the catheter.</p> <p>Review of nurses notes dated 8/1/13 thru 8/6/13 after hospital stay indicated the resident had no inappropriate sexually acting out behaviors.</p> <p>A request for a policy related to resident assessments on 10/1/13 at 5:15p.m. In an interview on 10/1/13 at 5:20p.m., LPN#2 indicated a policy was not available for this writer's request. She provided the documents used to by the nurses to assess residents on admission, quarterly, monthly, and as needed.</p> <p>This federal tag is related to Complaint IN00133877.</p> <p>3.1-43(a)(1)</p>			