

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155525	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/23/2015
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NAME OF PROVIDER OR SUPPLIER SHADY NOOK CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 36 VALLEY DR LAWRENCEBURG, IN 47025
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00180916.</p> <p>Complaint IN00180916 - Substantiated. Federal/state deficiencies related to the allegations are cited at F323.</p> <p>Survey dates: September 22 and 23, 2015</p> <p>Facility number: 000304 Provider number: 155525 AIM number: 100266810</p> <p>Census bed type: SNF/NF: 70 Total: 70</p> <p>Census payor type: Medicare: 6 Medicaid: 50 Other: 14 Total: 70</p> <p>Sample: 3</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed by 34849 on September</p>	F 0000		

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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F 0323 SS=D Bldg. 00	<p>29, 2015.</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 observation, interview and record review, the facility failed to provide adequate supervision to prevent falls for 1 resident who sustained 5 falls in a 36 hour period, with the fifth fall resulting in two fractures of the lumbar spine (Resident B).</p> <p>Findings include:</p> <p>The Resident Incident Log, provided by the Director of Quality Assurance on 9/22/2015 at 1:05 p.m., indicated Resident B sustained 20 falls between 6/22/2015 and 9/18/2015.</p> <p>A current copy of the Fall Policy and Procedure was provided by the DNS on 9/22/2015 at 1:12 p.m. The policy indicated, "...Procedure: 1. Complete Incident Report/Nurse's Note (IR/NN). 2. Initiate a new intervention for each fall, this includes ER/MD evaluation...7. Plan of care to be updated by MDS nurse...."</p>	F 0323	<p>Prior to the survey we instituted a new position called a sitter to check on and/or sit with resident's who are at high risk for falls. We will also continue to use activities/personnel, the supervisor, and ADON to help cover these residents as we adjust the new position. We have used different areas in the building to group these residents for activities, rest, eating etc... If the sitter is also an aide or nurse we have grouped them in a small dining room for a meal and depending on the ours and availability more than one meal. Again if the sitter is also an aide or nurse we have grouped them in a small dining/activity area for a meal and depending on the hours and availability may be for more than one need such as a meal/activity/rest period. Staff was immediately in-serviced on the removal if IDT team to evaluate but the 3 pages of potential interventions are still in use. The in-service also reviewed the use of gait5 belts and kardex (plan of care) kep0t locked in</p>	10/23/2015			

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	<p>Resident B was interviewed in her room on 9/22/2015 at 1:45 p.m. She was observed lying awake in bed. The resident indicated, "[I don't fall] not unless I have to go pee." The resident was observed to sit up on the side of the bed and attempt to get out of bed on her own. She was encouraged to push her call light and did. CNA [Certified Nursing Assistant] # 1 and CNA # 2 entered the room. CNA #1 placed Resident B's rolling walker in front of the resident and Resident B indicated, "You'll have to help me [get up]." CNA # 1 assisted Resident B up without a gait belt and assisted her to the bathroom across the room.</p> <p>Resident B's clinical record was reviewed on 9/22/2015 at 1:55 p.m. Diagnoses included, but were not limited to, dementia, urinary retention and "multiple falls."</p> <p>Quarterly Minimum Data Set (MDS) assessment, dated 7/14/2015, indicated a Brief Interview for Mental Status (BIMS) score of 4, indicating she was cognitively impaired. The resident required limited, one person physical assist for transfers and extensive, one person physical assist for dressing, toilet use and personal hygiene. She was frequently incontinent of urine and occasionally incontinent of</p>		<p>resident's room for staff to utilize when providing care. (See attachments 1,2,3,& 4)Quality Improvement/QAPI will continue to review each fall for new interventions and that IDT team to evaluate is no threat invention when reviewing I/R forms and physician orders on a weekly basis and the IDT team will continue to review the I?R form at the AM meeting which is held on routine business days M-F(except holidays). Nurses will continue to notify DON/ADON when a fall occurs.</p>				

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	<p>bowel. MDS assessment indicated Resident B, "had a fall with a resulting fracture in the six months prior and had fall(s) since the last admission/entry or reentry or the prior assessment. She had 2 falls with injury (except major)."</p> <p>Karadex [sic] Orders for Resident B, dated 9/10/2015, indicated, "Ambulation [with] rolling walker gait belt [and] stand by assist x 1."</p> <p>Incident Fax/Nurse's Note Protocol, dated 8/20/2015 at 3:00 p.m., indicated, "Date and Time: 8/20/15 [at] 1115 [11:15 a.m.]. Description of position/location by 1st person on the scene: [CNA # 6] noted res on floor as she was toileting residents prior to lunch. Res [resident] sitting on buttocks, legs str. [stretched] out in front of her....New Intervention: IDT [Interdisciplinary Team] to eval [evaluate]...."</p> <p>The associated Incident Report/Follow-up, dated 8/21/2015, indicated, "1. Date of Incident: 8/20/15 (1115). 2. Date Device Team Discussed: 8/21/15...5. Circumstances surrounding incident: staff observed res. lying in her bed...Approx. [approximately] 1 hour later res. noted on floor...6. Do behaviors contribute to Incident? Yes. Explain: Unsafe Behaviors. Poor awareness phy</p>			

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	<p>[physical] deficits. 7. Does Device Team feel Intervention appropriate? Yes. Explain: IDT discussed - [no] further interventions [at] this x [time]...."</p> <p>The associated Incident Report/Supervisor Investigation, dated 8/20/2015 at 2:35 p.m., was provided by the Director of Nursing (DON) on 9/23/2015 at 1:08 p.m. The report indicated, "1. Date and time Supervisor notified: [no] Supervisor...8. Who was last person to see resident & what time? as [CNA # 6] went to lunch [at] 10:30 [a.m.], res. still in bed. What was resident doing, where, time seen? res was assisted to bed [at] approx. 10 AM after going to BR [bathroom] & taking meds. Who was caregiver for this shift? [RN (Registered Nurse) # 7], [CNA # 6]. Who and Where were staff assigned to this unit at time of incident? [RN # 7] finishing med pass, [CNA #6] had just started toileting residents prior to lunch...."</p> <p>Incident Fax/Nurse's Note Protocol, dated 8/20/2015 at 3:00 p.m., indicated, "Date and Time: 8/20/15 [at] 1420 [2:20 p.m.]. Description of position/location by 1st person on the scene: Act. [Activity] Aide came on hall [and] noted res. sitting on floor outside B/R [bathroom] door, walker tipped over on it's side...New</p>			

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	<p>Intervention: IDT [Interdisciplinary Team] to eval [evaluate]...."</p> <p>The associated Incident Report/Follow-up, dated 8/21/2015, indicated, "1. Date of Incident: 8/20/15 (1420). 2. Date Device Team Discussed: 8/21/15...6. Do behaviors contribute to Incident? Yes. Explain: Unsafe Behaviors. Poor awareness phy [physical] deficits. 7. Does Device Team feel Intervention appropriate? Yes. Explain: IDT discussed - 2nd of 3 falls for day. No new intervention...."</p> <p>The associated Incident Report/Supervisor Investigation, dated 8/20/2015 at 2:55 p.m., was provided by the DON on 9/23/2015 at 1:08 p.m. The report indicated, "1. Date and time Supervisor notified: [no] Supervisor...8. Who was last person to see resident & what time? Who and Where were staff assigned to this unit at time of incident? [QMA (Qualified Medication Aide) # 8] [at] inservice. [RN # 7] still on floor doing paperwork re [regarding] AM [previous] fall...."</p> <p>Incident Fax/Nurse's Note Protocol, dated 8/20/2015 at 5:00 p.m., indicated, "Date and Time: 8/20/15 [at] 1700 [5:00 p.m.]. Description of position/location by 1st person on the scene: Res. sitting on mat</p>			

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	<p>next to bed. What did resident say about incident? Res told QMA she sat down on the mat and told the nurse she fell down...New Intervention: [no] [changes] [at] this time - noted res sitting safely...."</p> <p>The associated Incident Report/Follow-up, dated 8/21/2015, indicated, "1. Date of Incident: 8/20/15 (1700). 2. Date Device Team Discussed: 8/21/15...6. Do behaviors contribute to Incident? Yes. Explain: Unsafe Behaviors. Poor awareness phy [physical] deficits. 7. Does Device Team feel Intervention appropriate? Yes. Explain: IDT discussed - 3rd [fall] of day - cont. [continue] to observe - day was safe...."</p> <p>The associated Incident Report/Supervisor Investigation, dated 8/20/2015 at 7:00 p.m., was provided by the DON on 9/23/2015 at 1:08 p.m. The report indicated, "...8. Who was last person to see resident & what time? [CNA # 10] [at] 1650 [4:50 p.m.]. What was resident doing, where, time seen? in bed. Who was caregiver for this shift? [LPN # 9] - [CNA # 10]. Who and Where were staff assigned to this unit at time of incident? [LPN (Licensed Practical Nurse) # 9] [on] C St [street] [different unit/hall]. [CNA # 10]...."</p>			

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	<p>Incident Fax/Nurse's Note Protocol, dated 8/21/2015 at 12:25 p.m., indicated, "Date and Time: 8/21/15 [at] 0714 [7:14 a.m.]. Description of position/location by 1st person on the scene: Res. sitting [up arrow] right outside B/R door in her room - walker sitting in B/R...New Intervention: IDT [Interdisciplinary Team] to eval [evaluate]...."</p> <p>The associated Incident Report/Follow-up, dated 8/24/2015, indicated, "1. Date of Incident: 8/21/15 (0714). 2. Date Device Team Discussed: 8/24/15...6. Do behaviors contribute to Incident? Yes. Explain: Unsafe Behaviors. Poor awareness phy [physical] deficits D/T [due to] pattern ? [question] if falls or res. purposely sitting on floor - in front B/R door. 7. Does Device Team feel Intervention appropriate? Yes. Explain: IDT discussed - recent falls fall into pattern - [no] injuries - will observe...."</p> <p>The associated Incident Report/Supervisor Investigation, dated 8/21/2015 at 2:30 p.m., was provided by the DON on 9/23/2015 at 1:08 p.m. The report indicated, "1. Date and time Supervisor notified: [blank]...3. In Use At Time Of Incident List: bedpad alarm...Was alarm sounding? No...alarm didn't sound but did later in AM when</p>			

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	<p>res. got [up arrow] OOB [out of bed]...8. Who was last person to see resident & what time? appeared to be asleep...Who was caregiver for this shift? 7 - 2 [CNA # 11], 6 - 2 [LPN # 9]. Who and Where were staff assigned to this unit at time of incident? [CNA # 11] was in shower [with] another res. [LPN #9] was just returning to unit [with] meds..."</p> <p>Incident Fax/Nurse's Note Protocol, dated 8/21/2015 at 9:30 p.m., indicated, "Date and Time: 8/21/15 [at] 2100 [9:00 p.m.]. Description of position/location by 1st person on the scene: Sitting by bathroom door on bottom facing bed - garbage can behind her. What did the resident say about the incident? fell [and] hit her lower back...7. Head: swelling L [left] [down arrow] middle back...9. Trunk / peri-rectal: redness, bruising/discoloration L [down arrow] middle back. Pain L [down arrow] middle back. Swelling: L [down arrow] middle back. Swelling 14 x 12 cm [centimeters]. back 10 x 8.5 c.m. bruise from previous fall...13. Resident sent to hospital ASAP d/t [due to]: swelling on back...New Intervention: IDT [Interdisciplinary Team] to eval [evaluate]...."</p> <p>Transfer Sheet To Use For All Hospital Transfers, dated 8/21/2015 [no time</p>			

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	<p>indicated], indicated, "...8. Events Leading to Transfer: fall hit L [down arrow] middle back on garbage can....18. Mobility: X Ambulates X Self...."</p> <p>Resident B's Hospital History and Physical, dated 8/22/2015, indicated, "...Admit date: 8/22/2015...Chief Complaint: multiple falls and back pain. HPI: ...was brought to the Emergency Room from nursing home after she sustained multiple falls yesterday and today.... Apparently patient had several falls in the nursing home so she was brought to the hospital. She has a bruise on her back...She is currently complaining of back pain...Physical Examination: ...She has a bruise on the middle of her back...Imaging: She had a three view lumbar [lower] spine multilevel: ...Acute fracture noted...Combinations of abrasions and hematoma. Acute fracture of left transverse process L [lumbar] 1 and L2. Chronic-appearing bilateral rib fractures...Assessment and Plan: [Resident B] with fall, back pain...and lumbar spine trauma and fracture admitted in the hospital...."</p> <p>The only care plan update between 8/13/2015 and 9/5/2015 indicated, "8/20/15 - IDT eval/order d/t [due to] fall."</p>			

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	<p>Resident B returned to the facility 8/24/2015 and sustained a fall 9/5/2015 resulting in a skin tear to her right elbow, 9/9/2015 resulting in no injury, and 9/18/2015 resulting in complaint of pain to her left elbow.</p> <p>Nursing Staff # 3 was interviewed on 9/22/2015 at 2:45 p.m. She indicated "a lot of times" there were only two staff members on A unit; a nurse and a CNA or QMA. She indicated, "Ideally we would have three [staff] for supervision [to prevent falls]."</p> <p>On 9/23/2015 at 12:10 p.m., the DON indicated she did not know the root cause of Resident B's recent falls. The DON indicated one nurse and one CNA/QMA was adequate staffing to provide supervision and assistance to prevent falls. She indicated the nurse on the unit was available to assist the CNA/QMA with supervision, toileting, and transfers.</p> <p>This Federal tag relates to the Investigation of Complaint IN00180916.</p> <p>3.1-45(a)(2)</p>			

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

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