

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155157	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/06/2014
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-RICHMOND	STREET ADDRESS, CITY, STATE, ZIP CODE 1042 OAK DR RICHMOND, IN 47374
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F000000	<p>This visit was for the Investigation of Complaint IN00143695</p> <p>Complaint IN00143695 -Substantiated. Federal/State deficiencies related to the allegations are cited at F225, F323 and F498.</p> <p>Survey dates: February 3, 4 and 6, 2014</p> <p>Facility number: 000077 Provider number: 155157 AIM number: 100266490</p> <p>Survey team: Penny Marlatt, RN, TC</p> <p>Census bed type: SNF/NF: 84 Total: 84</p> <p>Census payor type: Medicare: 8 Medicaid: 69 Other: 7 Total: 84</p> <p>Sample: 3 Supplemental Sample: 1</p> <p>These deficiencies reflect State</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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	findings cited in accordance with 410 IAC 16.2. Quality review completed on February 13, 2014, by Janelyn Kulik, RN.				

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F000225 SS=E	<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> <p>Based on interview and record</p>	F000225	The corrective actions	02/28/2014			

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	<p>review, the facility failed to ensure an assisted fall to the floor was reported in a timely manner, which in turn resulted in an untimely physical assessment for a resident who was assisted to the floor for 1 of 3 residents reviewed for assisted falls to the floor in a total sample of 4. The resident was diagnosed with bilateral femur fractures 4 days after the assisted fall. (Resident #A)</p> <p>Findings include:</p> <p>Resident #A's clinical record was reviewed on 2-3-14 at 2:55 p.m.. Her diagnoses included, but were not limited to, cardiovascular disease, congestive heart failure, history of thrombosis/embolism (blood clots) with anticoagulant therapy (blood thinners), high blood pressure, diabetes, osteoarthritis and osteoporosis.</p> <p>Her most recent Quarterly Minimum Data Set (MDS) Assessment, dated 11-27-13, indicated she was severely cognitively impaired, required extensive assistance of 2 or more persons for bed mobility and was dependent of 1-2 persons with transfers from one surface to another. It indicated she did not stand or walk; it indicated she was</p>		<p>accomplished for those residents found to have been affected by the deficient practice are as follows: C.N.A. #1 was immediately suspended upon the facility being made aware of allegation, pending termination of employment for failure to report lowering a patient to the floor.</p> <p>Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows: Staff was in serviced of the Company Guideline on 1-30-14 on immediately reporting unusual occurrences such as lowering a patient to the floor and alleged violations involving Mistreatment, Abuse, Injuries of unknown source, and misappropriation of resident property or Neglect. New staff will have education of the Company Guideline on immediately reporting alleged violations involving Mistreatment, Abuse, Injuries of unknown source, and misappropriation of resident property or Neglect and protecting the Resident suspected of being subject of an alleged violation prior to working with residents. The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows: Staff was in serviced on the Company Guideline1-30-14 on immediately reporting unusual occurrences such as lowering a patient to the</p>				

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	<p>able to move from one surface to another or on/off the toilet, but was unsteady and required human assistance to stabilize her with these movements.</p> <p>Her care plan indicated she required the use of a mechanical lift and 2 persons for transfers from one surface to another, such as transfer from bed to wheelchair.</p> <p>An "Aide Assignment Sheet" for the last week of January, 2014, was provided by the Assistant Director of Nursing on 2-3-14 at 10:15 a.m. It indicated Resident #A was totally dependent for care and required the use of a mechanical lift for transfers.</p> <p>A quarterly nursing assessment, dated 11-27-13, indicated Resident #A was at low risk for falls. Her care plan indicated she was at risk for potential falls. Her MDS assessment, dated 11-27-13, indicated she had no falls in the previous quarter.</p> <p>Review of "Post Fall Investigation/Plan", dated 2-2-14, indicated, "CNA lowered her [Resident #A] to the floor and then got her back up using a gait belt per CNA interview-resident is a Marissa</p>		<p>floor and alleged violations involving Mistreatment, Abuse, Injuries of unknown source, and misappropriation of resident property or Neglect. New staff, during initial orientation, will have education on the Company Guideline on immediately reporting alleged violations involving Mistreatment, Abuse, Injuries of unknown source, and misappropriation of resident property or Neglect and protecting the Resident suspected of being subject of an alleged violation prior to working with residents. These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following: ED and DNS or designee will continue to monitor daily the 24 hour reports, nurses notes, concern forms, and observations of staff and residents for any allegations of Mistreatment, Abuse, Injuries of unknown source, misappropriation of resident property or Neglect Any patterns or trends will be reported to monthly QA meeting and appropriate action plans will be written and implemented.</p>		

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	<p>[mechanical] lift. CNA should have reported immediately after she lowered her [Resident #A] to the floor for a nurse to assess." This document indicated this incident occurred 1-25-14 at 9:30 a.m.</p> <p>Review of "Verification of Investigation" for Resident #A indicated, "Upon interview with [name of CNA #1], she states that on 1-25-14 in the am, she was making resident's bed and had her sitting on the side of the bed and she started to lean to one side and then started sliding off the bed. CNA states that she lowered her [Resident #A] to the floor and then got her back into bed using a gait belt. CNA did not report at this time...States that she was trying to straighten out the bed linens and had resident sitting on the side of the bed. Resident began to lean over and then started sliding off the bed. States that she lowered her to the floor. States she got her up of [sic] the floor with a gait belt by herself. States that she had another CNA come help straighten her up in the bed."</p> <p>In an interview with the Executive Director (ED) on 2-3-14 at 8:15 a.m., he indicated he was informed on</p>			

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	<p>1-30-14 at 5:30 a.m. by the Director of Nursing (DON) that X-ray results from overnight for Resident #A indicated she had bilateral femur fractures and the facility was unaware of how this occurred. He indicated Resident #A had been monitored closely by the facility since 1-27-14 due to declining oral intake and with increasing lethargy by 1-29-14. He indicated the family and physician had been notified of these events with the attending physician and nurse practitioner providing care for the resident. He indicated he was aware of Resident #A being treated by the physician for an elevated anticoagulant level on 1-29-14 and the staff had not noted any bruising of any kind until the same date. The ED indicated in the multiple staff interviews he had conducted in regards to Resident #A, only one CNA indicated she had noticed the resident being in any pain during the last week of January, 2014.</p> <p>The ED indicated a family member of Resident #A had come into the facility on Wednesday, 1-29-14, to visit. He indicated Resident #D, the roommate of Resident #A, told the family member during this visit that on Friday, 1-24-14, that a CNA "had</p>						

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	<p>dropped" the resident [Resident #A] onto her knees. He indicated when he interviewed Resident #D, it was determined this event happened after breakfast on Saturday, 1-25-14. He indicated in further interview with Resident #D, she did not tell anyone of this information until Tuesday, 1-28-14, when she shared this information with 2 CNA's who immediately shared this information with LPN #8. He indicated Resident #D also shared this information with RN #2, the Unit Manager, that same afternoon, during bingo.</p> <p>In an interview with CNA #1 on 2-3-14 at 1:17 p.m., she indicated she provided care for Resident #A on Saturday, 1-25-14, and Tuesday, 1-28-14. She indicated on 1-25-14, she was assisting the resident with care. She indicated she had the resident sitting on the side of bed while she was changing the sheets. She indicated the resident told her she felt like she was falling, so she went around the bed and found the resident to be sitting on the edge of the bed. She indicated she tried to scoot her back up onto the bed. She indicated she asked the resident if she could stand and the resident indicated she could not do</p>			

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	so. She indicated, "I then eased her, slid her, to the floor." She indicated she had placed a gait belt on the resident prior to sliding her onto the floor. She indicated the resident's bottom was on the floor. She indicated she did not recall the resident's knees coming in contact with the floor. She indicated she needed assistance to get her back onto the bed, so she stepped to the doorway and yelled for assistance from the first person she saw. She indicated CNA #4 came in to assist her get Resident #A back onto the bed. She indicated they were able to utilize the gait belt and placing their arms under Resident #A's arms to get her back onto the bed. She indicated she did not recall CNA #4 commenting on anything regarding the situation as she her priority at the time was getting the resident back to bed. CNA #1 indicated, "I didn't say anything to the nurse about her being on the floor, since she didn't actually fall, but I slid her down...No, I didn't report sliding [name of Resident #A] to the floor. I didn't let her fall, just slid her to the floor. With her legs like they were and her not being able to walk, I didn't really think of it as an unusual thing. So, no, I didn't say anything about it to the nurse. Well, I guess						

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	<p>looking back, I should have told the nurse she was slid to the floor. I guess I just didn't think about it."</p> <p>In an interview with CNA #4 on 2-3-14 at 12:14 p.m., she indicated CNA #1 had asked her to assist with repositioning Resident #A on 1-25-14 around 9:15 a.m. and she did so. She indicated Resident #A was lying on the bed when she arrived in the room. She indicated she did not recall seeing a gait belt on the resident. She indicated she did not recall the resident complaining of pain or seeming to be in pain.</p> <p>In an interview with RN #2 on 2-3-14 at 12:35 p.m., she indicated on Tuesday, 1-28-14, Resident #D informed her CNA #1 had tried to "make" Resident #A get up and Resident #A had told CNA #1 "no." She did not indicate she was aware of any type of fall with this resident. She indicated she did follow up with Resident #A that same day regarding if anyone had tried to force her to do anything she did not want to do. She indicated Resident #A shook her head "no." She indicated the resident indicated she was not in any pain. She did not indicate if she informed the ED or</p>				

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	<p>DON of this event.</p> <p>In an interview with CNA #5 on 2-3-14 at 12:45 p.m., she indicated during the weekend of 1-25-14 and 1-26-14, Resident #D had told her and CNA #7 that CNA #1 had attempted to get Resident #A up and the resident had fallen to her knees. She then indicated this conversation took place on Monday, 1-27-14. She indicated she then informed LPN #8 of this on Monday morning, 1-27-14. She indicated Resident #A did not complain of any pain during care and repositioning on 1-27-14, nor did she have any reddened areas or bruised areas on her skin.</p> <p>In review of the "as worked" nursing work schedule, CNA #5 was not scheduled to work on Saturday, 1-25-14, nor on Sunday, 1-26-14. She was scheduled to work day shift on Monday, 1-27-14, on the unit on which Resident #A resided. CNA #7 was scheduled to work on the unit on which Resident #A resided on evening shift on Saturday, 1-25-14 and day shift on Monday, 1-27-14.</p> <p>In an interview with CNA #7 on 2-3-14 at 1:05 p.m., she indicated she and CNA #5 worked with Resident #A on 1-27-14. She</p>				

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	<p>indicated while providing care to Resident #A, the resident complained of leg pain. She indicated the roommate, Resident #D, then told them on Saturday, 1-25-14, CNA #1 had tried to stand Resident #A up. She indicated Resident #D indicated since the curtain between them was closed, she could only hear what was going on. She indicated Resident #D indicated Resident #A kept telling CNA #1 that she could not stand. She indicated Resident #D did say if CNA #1 responded in any manner to Resident #A's statements of being unable to stand. She indicated Resident #D told them at some point, [date unknown] Resident #A did indicate to her [Resident #D] that she [Resident #A] had fallen to her knees. CNA #7 indicated on 1-27-14, Resident #A seemed to more uncomfortable than usual. She indicated she did not recall Resident #A having any reddened or bruised areas on her skin; that she appeared to be normal for the resident. She indicated immediately after completing Resident #A's care, she and CNA #5 went to inform the nurse, LPN #8 of what they had been told by Resident #D.</p> <p>In an interview with LPN #8 on</p>			

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	<p>2-3-14 at 11:50 a.m., she indicated she had worked with Resident #A on 1-27-14, 1-28-14 and 1-29-14. She indicated on 1-27-14, she notified the attending physician of the resident's weakened state, stable vital signs and an elevated white blood count obtained via a recent routine blood draw. She indicated the Nurse Practitioner ordered a urinalysis. She indicated she did notify the family of the change in condition and new orders. She indicated on 1-28-14, the urine sample was obtained and sent to the lab. She indicated the resident was running a low grade fever and treated with Tylenol. She indicated the attending physician ordered additional lab tests to rule out the flu. She indicated on 1-29-14, the resident seemed even weaker and was only taking small bites of food and sips of water. She indicated she asked CNA #6 to assist the resident into a geriatric chair [via mechanical lift] in order to go to the dining room for lunch with closer supervision with the lunch meal. She indicated a routine/weekly lab test for her anticoagulant was obtained around lunch which came back elevated. She indicated the attending physician ordered medication to correct the elevation.</p>						

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	<p>She indicated she notified Resident #A's daughter of the medication changes. She indicated during all of this, the resident did not complain of pain. She indicated toward the end of her shift, around the time of shift change report, she was notified by CNA #6 there seemed to be a problem with the resident's leg. She indicated the oncoming evening shift nurse went to check the resident's leg. LPN #8 did not indicate she was informed by CNA #5 or CNA #7 of the statements from Resident #D regarding Resident #A having a fall to her knees on 1-25-14.</p> <p>In an interview with CNA #6 she indicated she cared for Resident #A on Sunday, 1-26-14. She indicated the resident was able to sit on the side of the bed to eat breakfast as she normally did. She indicated that morning she seemed weaker than normal and only ate 25% of her meal. She indicated she reported this to the nurse. She indicated, for lunch, the resident was assisted into a wheelchair via a mechanical lift and seemed more alert, but only ate 25% of her meal. She indicated Resident #A did not appear to be in any pain, nor complained of any pain. She indicated she next cared for Resident #A on Wednesday,</p>				

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	<p>1-29-14. She indicated the resident seemed much more lethargic and her color seemed somewhat gray to her. She indicated LPN #8 asked her to get the resident up into a wheelchair for lunch. She indicated she did not feel comfortable doing this, so she and LPN #8 got her up with the mechanical lift into a geriatric chair for lunch. She indicated the resident seemed more alert once she was up. She indicated Resident #A did not appear to be in any pain, nor complained of any pain. She indicated in the afternoon, when she went to roll her in bed during care, her left leg did not roll with her. She indicated Resident #A could usually assist with rolling or turns. She indicated she reported this to LPN #8.</p> <p>In an interview with RN #3, on 2-3-14 at 10:57 a.m., he indicated he had worked with Resident #A on the evening shift on 1-25-14, 1-26-14, 1-27-14 and 1-29-14. He indicated, "She seemed to be herself until Wednesday [1-29-14]." He indicated on 1-29-14, he indicated he observed her to be lethargic and appeared to have declined. He indicated he received new orders around 4:00 p.m. from</p>						

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	<p>the attending physician in regards to the elevated coagulant level and labs to be obtained. He indicated he spoke to the resident's daughter in regards to the new orders. He indicated when he spoke to the daughter, she indicated she had been told by the roommate, Resident #D, that on Saturday, 1-25-14, a CNA had stood Resident #A up and the resident had fallen. He indicated the daughter did not say if she had spoken to Resident #D in person or via telephone. He indicated when he heard this, he documented the conversation on a grievance form and placed it in the Unit Manager's folder for her to review. He indicated he then went to assess Resident #A. He indicated her lower extremities appeared as they normally did with a slight amount of swelling around the left ankle. He indicated the knees had several "spots" of a gray-colored bruising which he indicated he attributed to the elevated coagulant levels. He indicated the resident did not complain of any pain. He indicated a family member was present and requested to have the resident repositioned in bed. He indicated he and another staff member did as requested. He indicated during the repositioning,</p>			

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	<p>the resident did utter, "oh," but he indicated this was a normal response for this resident with any positioning. He indicated around 9:30 p.m., family members requested to speak to the physician. He indicated around 10:00 p.m., the attending physician called the facility and ordered for the resident to be sent to the local emergency room for evaluation of leg pain and elevated coagulant levels.</p> <p>In an interview with Resident #D on 2-3-14 at 2:40 p.m., she indicated she could not recall if the events with her roommate, Resident #A occurred on Friday, 1-24-14 or Saturday, 1-25-14. She indicated her memory is not as good as it used to be. She indicated she did not actually see anything, as the curtain was pulled by CNA #1 while she provided care to Resident #A. She indicated, "I only heard things." She indicated on that morning, she heard CNA #1 talking with Resident #A. She indicated the CNA was needing to change the bed linens as apparently there were food crumbs in the bed. She indicated she heard Resident #1 say, "I can't stand," several times. She indicated she heard CNA #1 respond in a somewhat gruff tone several times,</p>						

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	<p>"Don't say can't" or "Can't, can't do anything." She indicated she then heard Resident #A say, "Oh, no. Help me, Lord." She indicated after CNA #1 left the room, she asked Resident #A if she was okay. She indicated, Resident #A told her she had told CNA #1 that she could not stand, but ended up on her knees. She indicated she later asked CNA #1 if she had dropped Resident #A and was told "no." She indicated she did not recall anyone coming into the room to help get Resident #A up off of the floor or to reposition her in the bed during the care while the curtain was pulled. She indicated she told the Unit Manager, RN #2, during a bingo game on Monday, 1-27-14. She did not elaborate as to what information was shared with the nurse. The activities calendar for January, 2014 indicated bingo was played in the facility on 1-27-14 and 1-28-14.</p> <p>In an interview with the ED on 2-6-14 at 9:15 a.m., he indicated the facility expects any type of fall, including assisted falls, to be reported immediately to the nurse in order for an assessment to be conducted. He indicated once the facility was made aware of the fractures of Resident #A, an</p>						

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	<p>immediate investigation was initiated. He indicated the investigation was conducted as an unusual occurrence, as well as an injury of unknown origin. He indicated he would consider an assisted fall to be an unusual occurrence as it does not occur on a regular basis.</p> <p>On 2-3-14 at 2:30 p.m., the ED provided a copy of policy entitled, "Investigation and Reporting of Alleged Violations of Federal and State Laws Involving Mistreatment, Neglect, Abuse, Injuries of Unknown Source and Misappropriation of Property." This policy indicated, "It is the policy of the Company to take appropriate steps to prevent the occurrence of abuse, neglect, injuries of unknown origin and misappropriation of resident property and to ensure that all alleged violations of Federal or State laws while involve mistreatment, neglect, abuse, injuries of unknown origin and misappropriation of resident property ("alleged violations"), are reported immediately to the Executive Director (hereinafter "ED") of the facility. Such violations will also be reported to state agencies in accordance with existing state law...During orientation, new</p>						

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F000323 SS=G	<p>employees shall be trained or the obligation to report alleged violations. Training shall include definitions of alleged violations and examples of reportable incidents to assist staff in detection of such incidents....Any employee who suspects an alleged violation shall immediately notify the ED or his/her designee.</p> <p>This Federal tag relates to Complaint IN00143695.</p> <p>3.1-28 (c)</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 interview and record review, the facility failed to ensure an assisted fall to the floor was reported in a timely manner, which in turn resulted in an untimely physical assessment for a resident who was assisted to the floor for 1 of 3 residents reviewed for falls in a total sample of 4. The resident was diagnosed with bilateral femur fractures 4 days after the assisted fall. (Resident #A)</p>	F000323	F323The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows: Resident A no longer resides at the facility Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows: All Residents had a head to toe skin assessment completed and new interventions implemented if indicated. All	02/28/2014

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	<p>Findings include:</p> <p>Resident #A's clinical record was reviewed on 2-3-14 at 2:55 p.m.. Her diagnoses included, but were not limited to, cardiovascular disease, congestive heart failure, history of thrombosis/embolism (blood clots) with anticoagulant therapy (blood thinners), high blood pressure, diabetes, osteoarthritis and osteoporosis.</p> <p>Her most recent Quarterly Minimum Data Set (MDS) Assessment, dated 11-27-13, indicated she was severely cognitively impaired, required extensive assistance of 2 or more persons for bed mobility and was dependent of 1-2 persons with transfers from one surface to another. It indicated she did not stand or walk; it indicated she was able to move from one surface to another or on/off the toilet, but was unsteady and required human assistance to stabilize her with these movements.</p> <p>Her care plan indicated she required the use of a mechanical lift and 2 persons for transfers from one surface to another, such as transfer from bed to wheelchair.</p>		<p>Residents were interviewed to identify any concerns with care that they have been provided. For those Residents who did voice concerns, a grievance form was initiated and follow up was completed. C.N.A. assignment sheets were reviewed and updated as needed to ensure residents at risk for falls had any interventions documented on the CNA assignment sheet. The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows: Staff was in serviced on immediately reporting unusual occurrences such as lowering a patient to the floor and alleged violations involving Mistreatment, Abuse, Injuries of unknown source, and misappropriation of resident property or Neglect. All CNA's are being in serviced on "Give yourself a lift" video this discusses what to do when a patient is lowered to the floor. New staff will have education on immediately reporting alleged violations involving Mistreatment, Abuse, Injuries of unknown source, and misappropriation of resident property or Neglect and protecting the Resident suspected of being subject of an alleged violation prior to working with residents. New staff will also watch the video "Give yourself a lift" prior to providing patient care. The DNS/Designee will question C.N.A's regarding what to do if a</p>	

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	<p>An "Aide Assignment Sheet" for the last week of January, 2014, was provided by the Assistant Director of Nursing on 2-3-14 at 10:15 a.m. It indicated Resident #A was totally dependent for care and required the use of a mechanical lift for transfers.</p> <p>A quarterly nursing assessment, dated 11-27-13, indicated Resident #A was at low risk for falls. Her care plan indicated she was at risk for potential falls. Her MDS assessment, dated 11-27-13, indicated she had no falls in the previous quarter.</p> <p>Review of "Post Fall Investigation/Plan", dated 2-2-14, indicated, "CNA lowered her [Resident #A] to the floor and then got her back up using a gait belt per CNA interview-resident is a Marissa [mechanical] lift. CNA should have reported immediately after she lowered her [Resident #A] to the floor for a nurse to assess." This document indicated this incident occurred 1-25-14 at 9:30 a.m.</p> <p>Review of "Verification of Investigation" for Resident #A indicated, "Upon interview with [name of CNA #1], she states that</p>		<p>patient is lowered to the floor 5 times a week for 4 weeks, then 3 times a week for 4 weeks then weekly for 4 months or ongoing if indicated. The DNS/Designee will audit C.N.A. assignment sheets 5 times a week for 4 weeks, then 3 times a week for 4 weeks, then weekly for 4 months or ongoing if indicated. These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following: The DNS/Designee will question C.N.A's regarding what to do if a patient is lowered to the floor 5 times a week for 4 weeks, then 3 times a week for 4 weeks then weekly for 4 months or ongoing if indicated. The DNS/Designee will audit C.N.A. assignment sheets 5 times a week for 4 weeks, then 3 times a week for 4 weeks, then weekly for 4 months or ongoing if indicated. Results of audits will be reviewed at the monthly QAA meetings for 6 months then audits will be conducted randomly then reviewed during monthly QAA. The Facility will evaluate the audits for trends or patterns and action plans will be implemented if indicated.</p>		

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	<p>on 1-25-14 in the am, she was making resident's bed and had her sitting on the side of the bed and she started to lean to one side and then started sliding off the bed. CNA states that she lowered her [Resident #A] to the floor and then got her back into bed using a gait belt. CNA did not report at this time...States that she was trying to straighten out the bed linens and had resident sitting on the side of the bed. Resident began to lean over and then started sliding off the bed. States that she lowered her to the floor. States she got her up of [sic] the floor with a gait belt by herself. States that she had another CNA come help straighten her up in the bed."</p> <p>In review of the nursing progress notes from 1-20-14 until transfer to the local emergency room on 1-29-14, there was no documentation which indicated any type of fall had occurred. Documentation on 1-30-14 at 4:07 a.m. which indicated Resident #A had been admitted to the local hospital with bilateral femur fractures.</p> <p>In an interview with the Executive Director (ED) on 2-3-14 at 8:15 a.m.,</p>				

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	<p>he indicated he was informed on 1-30-14 at 5:30 a.m. by the Director of Nursing (DON) that X-ray results from overnight for Resident #A indicated she had bilateral femur fractures and the facility was unaware of how this occurred. He indicated Resident #A had been monitored closely by the facility since 1-27-14 due to declining oral intake and with increasing lethargy by 1-29-14. He indicated the family and physician had been notified of these events with the attending physician and nurse practitioner providing care for the resident. He indicated he was aware of Resident #A being treated by the physician for an elevated anticoagulant level on 1-29-14 and the staff had not noted any bruising of any kind until the same date. The ED indicated in the multiple staff interviews he had conducted in regards to Resident #A, only one CNA indicated she had noticed the resident being in any pain during the last week of January, 2014.</p> <p>The ED indicated a family member of Resident #A had come into the facility on Wednesday, 1-29-14, to visit. He indicated Resident #D, the roommate of Resident #A, told the family member during this visit that</p>						

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	<p>on Friday, 1-24-14, that a CNA "had dropped" the resident [Resident #A] onto her knees. He indicated when he interviewed Resident #D, it was determined this event happened after breakfast on Saturday, 1-25-14. He indicated in further interview with Resident #D, she did not tell anyone of this information until Tuesday, 1-28-14, when she shared this information with 2 CNA's who immediately shared this information with LPN #8. He indicated Resident #D also shared this information with RN #2, the Unit Manager, that same afternoon, during bingo.</p> <p>In an interview with CNA #1 on 2-3-14 at 1:17 p.m., she indicated she provided care for Resident #A on Saturday, 1-25-14, and Tuesday, 1-28-14. She indicated on 1-25-14, she was assisting the resident with care. She indicated she had the resident sitting on the side of bed while she was changing the sheets. She indicated the resident told her she felt like she was falling, so she went around the bed and found the resident to be sitting on the edge of the bed. She indicated she tried to scoot her back up onto the bed. She indicated she asked the resident if she could stand and the</p>			

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	<p>resident indicated she could not do so. She indicated, "I then eased her, slid her, to the floor." She indicated she had placed a gait belt on the resident prior to sliding her onto the floor. She indicated the resident's bottom was on the floor. She indicated she did not recall the resident's knees coming in contact with the floor. She indicated she needed assistance to get her back onto the bed, so she stepped to the doorway and yelled for assistance from the first person she saw. She indicated CNA #4 came in to assist her get Resident #A back onto the bed. She indicated they were able to utilize the gait belt and placing their arms under Resident #A's arms to get her back onto the bed. She indicated she did not recall CNA #4 commenting on anything regarding the situation as she her priority at the time was getting the resident back to bed. CNA #1 indicated, "I didn't say anything to the nurse about her being on the floor, since she didn't actually fall, but I slid her down...No, I didn't report sliding [name of Resident #A] to the floor. I didn't let her fall, just slid her to the floor. With her legs like they were and her not being able to walk, I didn't really think of it as an unusual thing. So, no, I didn't say anything</p>			

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	<p>about it to the nurse. Well, I guess looking back, I should have told the nurse she was slid to the floor. I guess I just didn't think about it."</p> <p>In an interview with CNA #4 on 2-3-14 at 12:14 p.m., she indicated CNA #1 had asked her to assist with repositioning Resident #A on 1-25-14 around 9:15 a.m. and she did so. She indicated Resident #A was lying on the bed when she arrived in the room. She indicated she did not recall seeing a gait belt on the resident. She indicated she did not recall the resident complaining of pain or seeming to be in pain.</p> <p>In an interview with RN #2 on 2-3-14 at 12:35 p.m., she indicated on Tuesday, 1-28-14, Resident #D informed her CNA #1 had tried to "make" Resident #A get up and Resident #A had told CNA #1 "no." She did not indicate she was aware of any type of fall with this resident. She indicated she did follow up with Resident #A that same day regarding if anyone had tried to force her to do anything she did not want to do. She indicated Resident #A shook her head "no." She indicated the resident indicated she was not in any pain. She did not</p>			

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	<p>indicate if she informed the ED or DON of this event.</p> <p>In an interview with CNA #5 on 2-3-14 at 12:45 p.m., she indicated during the weekend of 1-25-14 and 1-26-14, Resident #D had told her and CNA #7 that CNA #1 had attempted to get Resident #A up and the resident had fallen to her knees. She then indicated this conversation took place on Monday, 1-27-14. She indicated she then informed LPN #8 of this on Monday morning, 1-27-14. She indicated Resident #A did not complain of any pain during care and repositioning on 1-27-14, nor did she have any reddened areas or bruised areas on her skin.</p> <p>In review of the "as worked" nursing work schedule, CNA #5 was not scheduled to work on Saturday, 1-25-14, nor on Sunday, 1-26-14. She was scheduled to work day shift on Monday, 1-27-14, on the unit on which Resident #A resided. CNA #7 was scheduled to work on the unit on which Resident #A resided on evening shift on Saturday, 1-25-14 and day shift on Monday, 1-27-14.</p> <p>In an interview with CNA #7 on 2-3-14 at 1:05 p.m., she indicated she and CNA #5 worked with</p>				

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	<p>Resident #A on 1-27-14. She indicated while providing care to Resident #A, the resident complained of leg pain. She indicated the roommate, Resident #D, then told them on Saturday, 1-25-14, CNA #1 had tried to stand Resident #A up. She indicated Resident #D indicated since the curtain between them was closed, she could only hear what was going on. She indicated Resident #D indicated Resident #A kept telling CNA #1 that she could not stand. She indicated Resident #D did say if CNA #1 responded in any manner to Resident #A's statements of being unable to stand. She indicated Resident #D told them at some point, [date unknown] Resident #A did indicate to her [Resident #D] that she [Resident #A] had fallen to her knees. CNA #7 indicated on 1-27-14, Resident #A seemed to more uncomfortable than usual. She indicated she did not recall Resident #A having any reddened or bruised areas on her skin; that she appeared to be normal for the resident. She indicated immediately after completing Resident #A's care, she and CNA #5 went to inform the nurse, LPN #8 of what they had been told by Resident #D.</p>			
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	In an interview with LPN #8 on 2-3-14 at 11:50 a.m., she indicated she had worked with Resident #A on 1-27-14, 1-28-14 and 1-29-14. She indicated on 1-27-14 , she notified the attending physician of the resident's weakened state, stable vital signs and an elevated white blood count obtained via a recent routine blood draw. She indicated the Nurse Practitioner ordered a urinalysis. She indicated she did notify the family of the change in condition and new orders. She indicated on 1-28-14, the urine sample was obtained and sent to the lab. She indicated the resident was running a low grade fever and treated with Tylenol for that. She indicated the attending physician ordered additional lab tests to rule out the flu. She indicated on 1-29-14, the resident seemed even weaker and was only taking small bites of food and sips of water. She indicated she asked CNA #6 to assist the resident into a geriatric chair [via mechanical lift] in order to go to the dining room for lunch with closer supervision with the lunch meal. She indicated a routine/weekly lab test for her anticoagulant was obtained around lunch which came back elevated. She indicated the attending						

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	<p>physician ordered medication to correct the elevation. She indicated she notified Resident #A's daughter of the medication changes. She indicated during all of this, the resident did not complain of pain. She indicated toward the end of her shift, around the time of shift change report, she was notified by CNA #6 there seemed to be a problem with the resident's leg. She indicated the oncoming evening shift nurse went to check the resident's leg. LPN #8 did not indicate she was informed by CNA #5 or CNA #7 of the statements from Resident #D regarding Resident #A having a fall to her knees on 1-25-14.</p> <p>In an interview with CNA #6 she indicated she cared for Resident #A on Sunday, 1-26-14. She indicated the resident was able to sit on the side of the bed to eat breakfast as she normally did. She indicated that morning she seemed weaker than normal and only ate 25% of her meal. She indicated she reported this to the nurse. She indicated, for lunch, the resident was assisted into a wheelchair via a mechanical lift and seemed more alert, but only ate 25% of her meal. She indicated Resident #A did not appear to be in any pain, nor complained of any</p>			

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	<p>pain. She indicated she next cared for Resident #A on Wednesday, 1-29-14. She indicated the resident seemed much more lethargic and her color seemed somewhat gray to her. She indicated LPN #8 asked her to get the resident up into a wheelchair for lunch. She indicated she did not feel comfortable doing this, so she and LPN #8 got her up with the mechanical lift into a geriatric chair for lunch. She indicated the resident seemed more alert once she was up. She indicated Resident #A did not appear to be in any pain, nor complained of any pain. She indicated in the afternoon, when she went to roll her in bed during care, her left leg did not roll with her. She indicated Resident #A could usually assist with rolling or turns. She indicated she reported this to LPN #8.</p> <p>In an interview with RN #3, on 2-3-14 at 10:57 a.m., he indicated he had worked with Resident #A on the evening shift on 1-25-14, 1-26-14, 1-27-14 and 1-29-14. He indicated, "She seemed to be herself until Wednesday [1-29-14]." He indicated on 1-29-14, he indicated he observed her to be lethargic and appeared to have</p>			
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	<p>declined. He indicated he received new orders around 4:00 p.m. from the attending physician in regards to the elevated coagulant level and labs to be obtained. He indicated he spoke to the resident's daughter in regards to the new orders. He indicated when he spoke to the daughter, she indicated she had been told by the roommate, Resident #D, that on Saturday, 1-25-14, a CNA had stood Resident #A up and the resident had fallen. He indicated the daughter did not say if she had spoken to Resident #D in person or via telephone. He indicated when he heard this, he documented the conversation on a grievance form and placed it in the Unit Manager's folder for her to review. He indicated he then went to assess Resident #A. He indicated her lower extremities appeared as they normally did with a slight amount of swelling around the left ankle. He indicated the knees had several "spots" of a gray-colored bruising which he indicated he attributed to the elevated coagulant levels. He indicated the resident did not complain of any pain. He indicated a family member was present and requested to have the resident repositioned in bed. He indicated he and another staff</p>			

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	<p>member did as requested. He indicated during the repositioning, the resident did utter, "oh," but he indicated this was a normal response for this resident with any positioning. He indicated around 9:30 p.m., family members requested to speak to the physician. He indicated around 10:00 p.m., the attending physician called the facility and ordered for the resident to be sent to the local emergency room for evaluation of leg pain and elevated coagulant levels.</p> <p>In an interview with Resident #D on 2-3-14 at 2:40 p.m., she indicated she could not recall if the events with her roommate, Resident #A occurred on Friday, 1-24-14 or Saturday, 1-25-14. She indicated her memory is not as good as it used to be. She indicated she did not actually see anything, as the curtain was pulled by CNA #1 while she provided care to Resident #A. She indicated, "I only heard things." She indicated on that morning, she heard CNA #1 talking with Resident #A. She indicated the CNA was needing to change the bed linens as apparently there were food crumbs in the bed. She indicated she heard Resident #1 say, "I can't stand," several times. She indicated she</p>						

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	<p>heard CNA #1 respond in a somewhat gruff tone several times, "Don't say can't" or "Can't can't do anything." She indicated she then heard Resident #A say, "Oh, no. Help me, Lord." She indicated after CNA #1 left the room, she asked Resident #A if she was okay. She indicated Resident #A told her she had told CNA #1 that she could not stand, but ended up on her knees. She indicated she later asked CNA #1 if she had dropped Resident #A and was told "no." She indicated she did not recall anyone coming into the room to help get Resident #A up off of the floor or to reposition her in the bed during the care while the curtain was pulled. She indicated she told the Unit Manager, RN #2, during a bingo game on Monday, 1-27-14. She did not elaborate as to what information was shared with the nurse. The activities calendar for January, 2014 indicated bingo was played in the facility on 1-27-14 and 1-28-14.</p> <p>In an interview with the ED on 2-6-14 at 9:15 a.m., he indicated the facility expects any type of fall, including assisted falls, to be reported immediately to the nurse in order for an assessment to be conducted. He indicated once the</p>			
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	<p>facility was made aware of the fractures of Resident #A, an immediate investigation was initiated. He indicated the investigation was conducted as an unusual occurrence, as well as an injury of unknown origin. He indicated he would consider an assisted fall to be an unusual occurrence as it does not occur on a regular basis.</p> <p>On 2-3-14 at 2:30 p.m., the ED provided a copy of policy entitled, "Investigation and Reporting of Alleged Violations of Federal and State Laws Involving Mistreatment, Neglect, Abuse, Injuries of Unknown Source and Misappropriation of Property." This policy indicated, "It is the policy of the Company to take appropriate steps to prevent the occurrence of abuse, neglect, injuries of unknown origin and misappropriation of resident property and to ensure that all alleged violations of Federal or State laws while involve mistreatment, neglect, abuse, injuries of unknown origin and misappropriation of resident property ("alleged violations"), are reported immediately to the Executive Director (hereinafter "ED") of the facility. Such violations will also be reported to state agencies in</p>						

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	<p>accordance with existing state law...During orientation, new employees shall be trained or the obligation to report alleged violations. Training shall include definitions of alleged violations and examples of reportable incidents to assist staff in detection of such incidents....Any employee who suspects an alleged violation shall immediately notify the ED or his/her designee.</p> <p>On 2-3-14 at 2:30 p.m., the ED provided a copy of policy entitled, "Falls Management Clinical Guidelines." This policy indicated, "Following a fall:...The licensed nurse [immediately] assesses the resident for injuries (including neuro checks if indicated) and provides necessary treatment and initiates the Change in Condition Report - Post Fall/Trauma. The physician and resident's representative is notified..."</p> <p>This Federal tag relates to Complaint IN00143695.</p> <p>3.1-45 (a)</p>				

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F000498 SS=G	<p>483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.</p> <p>Based on interview and record review, the facility failed to ensure a CNA demonstrated the competency to safely care for a resident in that the resident was lowered to the floor and the nurse was not notified of the incident. The resident was diagnosed with bilateral femur fractures 4 days after the assisted fall. This deficient practice affected 1 of 3 residents reviewed for falls in a total sample of 4. (Resident #A, CNA #1)</p> <p>Findings include:</p> <p>Her most recent Quarterly Minimum Data Set (MDS) Assessment, dated 11-27-13, indicated she was severely cognitively impaired, required extensive assistance of 2 or more persons for bed mobility and was dependent of 1-2 persons with transfers from one surface to another. It indicated she did not stand or walk; it indicated she was able to move from one surface to</p>	F000498	F498The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows: Resident A no longer resides at the facility Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows: All Residents had a head to toe skin assessment completed and new interventions implemented if indicated. All Residents were interviewed to identify any concerns with care that they have been provided. For those Residents who did voice concerns, a grievance form was initiated and follow up was completed. C.N.A. assignment sheets were reviewed and updated as needed to ensure residents at risk for falls had interventions documented on the CNA assignment sheet. All CNA's are being in serviced on "Give yourself a lift" video this discusses what to do when a patient is lowered to the floor. The measures put into place and the systemic changes made to	02/28/2014			

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	<p>another or on/off the toilet, but was unsteady and required human assistance to stabilize her with these movements.</p> <p>Her care plan indicated she required the use of a mechanical lift and 2 persons for transfers from one surface to another, such as transfer from bed to wheelchair.</p> <p>An "Aide Assignment Sheet" for the last week of January, 2014, was provided by the Assistant Director of Nursing on 2-3-14 at 10:15 a.m. It indicated Resident #A was totally dependent for care and required the use of a mechanical lift for transfers.</p> <p>A quarterly nursing assessment, dated 11-27-13, indicated Resident #A was at low risk for falls. Her care plan indicated she was at risk for potential falls. Her MDS assessment, dated 11-27-13, indicated she had no falls in the previous quarter.</p> <p>Review of "Post Fall Investigation/Plan", dated 2-2-14, indicated, "CNA lowered her [Resident #A] to the floor and then got her back up using a gait belt per CNA interview-resident is a Marissa [mechanical] lift. CNA should have</p>		<p>ensure that this deficient practice does not recur are as follows: Staff was in serviced on immediately reporting unusual occurrences such as lowering a patient to the floor and alleged violations involving Mistreatment, Abuse, Injuries of unknown source, and misappropriation of resident property or Neglect. All C.N.A's are being in serviced on Give you self a lift video this discusses what to do when a patient is lowered to the floor. New staff will have education on immediately reporting alleged violations involving Mistreatment, Abuse, Injuries of unknown source, and misappropriation of resident property or Neglect and protecting the Resident suspected of being subject of an alleged violation prior to working with residents. New staff also watch the video "Give yourself a lift" prior to providing patient care. The DNS/Designee will question C.N.A's regarding what to do if a patient is lowered to the floor 5 times a week for 4 weeks, then 3 times a week for 4 weeks then weekly for 4 months or ongoing if indicated. The DNS/Designee will audit C.N.A. assignment sheets 5 times a week for 4 weeks, then 3 times a week for 4 weeks, then weekly for 4 months or ongoing if indicated. These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice</p>				

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	<p>reported immediately after she lowered her [Resident #A] to the floor for a nurse to assess." This document indicated this incident occurred 1-25-14 at 9:30 a.m.</p> <p>Review of "Verification of Investigation" for Resident #A indicated, "Upon interview with [name of CNA #1], she states that on 1-25-14 in the am, she was making resident's bed and had her sitting on the side of the bed and she started to lean to one side and then started sliding off the bed. CNA states that she lowered her [Resident #A] to the floor and then got her back into bed using a gait belt. CNA did not report at this time...States that she was trying to straighten out the bed linens and had resident sitting on the side of the bed. Resident began to lean over and then started sliding off the bed. States that she lowered her to the floor. States she got her up of [sic] the floor with a gait belt by herself. States that she had another CNA come help straighten her up in the bed."</p> <p>In an interview with the Executive Director (ED) on 2-3-14 at 8:15 a.m., he indicated he was informed on 1-30-14 at 5:30 a.m. by the Director</p>		<p>will not recur per the following: The DNS/Designee will question C.N.A's regarding what to do if a patient is lowered to the floor 5 times a week for 4 weeks, then 3 times a week for 4 weeks then weekly for 4 months or ongoing if indicated. The DNS/Designee will audit C.N.A. assignment sheets 5 times a week for 4 weeks, then 3 times a week for 4 weeks, then weekly for 4 months or ongoing if indicated. Results of audits will be reviewed at the monthly QAA meetings for 6 months then audits will be conducted randomly then reviewed during monthly QAA. The Facility will evaluate the audits for trends or patterns and action plans will be implemented if indicated.</p>	

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	<p>of Nursing (DON) that X-ray results from overnight for Resident #A indicated she had bilateral femur fractures and the facility was unaware of how this occurred. He indicated Resident #A had been monitored closely by the facility since 1-27-14 due to declining oral intake and with increasing lethargy by 1-29-14. He indicated the family and physician had been notified of these events with the attending physician and nurse practitioner providing care for the resident. He indicated he was aware of Resident #A being treated by the physician for an elevated anticoagulant level on 1-29-14 and the staff had not noted any bruising of any kind until the same date. The ED indicated in the multiple staff interviews he had conducted in regards to Resident #A, only one CNA indicated she had noticed the resident being in any pain during the last week of January, 2014.</p> <p>The ED indicated a family member of Resident #A had come into the facility on Wednesday, 1-29-14, to visit. He indicated Resident #D, the roommate of Resident #A, told the family member during this visit that on Friday, 1-24-14, that a CNA "had dropped" the resident [Resident #A]</p>			
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	<p>onto her knees. He indicated when he interviewed Resident #D, it was determined this event happened after breakfast on Saturday, 1-25-14. He indicated in further interview with Resident #D, she did not tell anyone of this information until Tuesday, 1-28-14, when she shared this information with 2 CNA's who immediately shared this information with LPN #8. He indicated Resident #D also shared this information with RN #2, the Unit Manager, that same afternoon, during bingo.</p> <p>In an interview with CNA #1 on 2-3-14 at 1:17 p.m., she indicated she provided care for Resident #A on Saturday, 1-25-14, and Tuesday, 1-28-14. She indicated on 1-25-14, she was assisting the resident with care. She indicated she had the resident sitting on the side of bed while she was changing the sheets. She indicated the resident told her she felt like she was falling, so she went around the bed and found the resident to be sitting on the edge of the bed. She indicated she tried to scoot her back up onto the bed. She indicated she asked the resident if she could stand and the resident indicated she could not do so. She indicated, "I then eased</p>			

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	<p>her, slid her, to the floor." She indicated she had placed a gait belt on the resident prior to sliding her onto the floor. She indicated the resident's bottom was on the floor. She indicated she did not recall the resident's knees coming in contact with the floor. She indicated she needed assistance to get her back onto the bed, so she stepped to the doorway and yelled for assistance from the first person she saw. She indicated CNA #4 came in to assist her get Resident #A back onto the bed. She indicated they were able to utilize the gait belt and placing their arms under Resident #A's arms to get her back onto the bed. She indicated she did not recall CNA #4 commenting on anything regarding the situation as she her priority at the time was getting the resident back to bed. CNA #1 indicated, "I didn't say anything to the nurse about her being on the floor, since she didn't actually fall, but I slid her down...No, I didn't report sliding [name of Resident #A] to the floor. I didn't let her fall, just slid her to the floor. With her legs like they were and her not being able to walk, I didn't really think of it as an unusual thing. So, no, I didn't say anything about it to the nurse. Well, I guess looking back, I should have told the</p>				

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	<p>nurse she was slid to the floor. I guess I just didn't think about it."</p> <p>In an interview with CNA #4 on 2-3-14 at 12:14 p.m., she indicated CNA #1 had asked her to assist with repositioning Resident #A on 1-25-14 around 9:15 a.m. and she did so. She indicated Resident #A was lying on the bed when she arrived in the room. She indicated she did not recall seeing a gait belt on the resident. She indicated she did not recall the resident complaining of pain or seeming to be in pain.</p> <p>In an interview with the ED on 2-6-14 at 9:15 a.m., he indicated the facility expects any type of fall, including assisted falls, to be reported immediately to the nurse in order for an assessment to be conducted. He indicated once the facility was made aware of the fractures of Resident #A, an immediate investigation was initiated. He indicated the investigation was conducted as an unusual occurrence, as well as an injury of unknown origin. He indicated he would consider an assisted fall to be an unusual occurrence as it does not occur on a regular basis.</p>				

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	In review of CNA #1's employee record on 2-4-14 at 12:15 p.m., it indicated she began employment with the facility on 5-28-13. Her CNA certification indicated her initial certification was issued on 5-17-13. The "General Orientation Checklist" indicated the section on "Safety Videos" had been checked off to indicate she had viewed one entitled, "Slips, Trips and Falls" and was indicated to include general safety guidelines. In interview with the ED on 2-4-14 at 12:15 p.m., he indicated this video specifically indicated any kind of a fall or near fall should be reported to the nurse immediately so an assessment could be conducted on the person who had fallen. This orientation checklist was signed by CNA #1 and dated 5-28-13. CNA #1's "Certified Nursing Assistant Skills Checklist" indicated she had successfully completed all items on the checklist by 6-3-13, including "Instruction in prevention, management and reporting S/S [signs and symptoms] of Unusual Distress", as well as "Transfers, Ambulation, ROM [range of motion activities], Transfer Equipment." CNA #1's employee record also included 4 employment counselings she had received during			

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	<p>the time period of July through December, 2013 for poor job performance.</p> <p>On 2-3-14 at 2:30 p.m., the ED provided a copy of policy entitled, "Investigation and Reporting of Alleged Violations of Federal and State Laws Involving Mistreatment, Neglect, Abuse, Injuries of Unknown Source and Misappropriation of Property." This policy indicated, "It is the policy of the Company to take appropriate steps to prevent the occurrence of abuse, neglect, injuries of unknown origin and misappropriation of resident property and to ensure that all alleged violations of Federal or State laws while involve mistreatment, neglect, abuse, injuries of unknown origin and misappropriation of resident property ("alleged violations"), are reported immediately to the Executive Director (hereinafter "ED") of the facility. Such violations will also be reported to state agencies in accordance with existing state law...During orientation, new employees shall be trained or the obligation to report alleged violations. Training shall include definitions of alleged violations and examples of reportable incidents to assist staff in detection of such</p>						

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	<p>incidents....Any employee who suspects an alleged violation shall immediately notify the ED or his/her designee.</p> <p>The Indiana State Department of Health, Division of Long Term Care, "Nurse Aide Training Program" Manual (July, 1998) indicated, "Topic 3: Observing and Reporting 1. Observing and reporting is the most important way the CNA assists the nurse and other members of the health care team to identify the needs of the residents...1. b. 3. Immediate reporting must be done at the time the observation is made and includes:...(c) Unusual incidents (i.e., falls, signs or suspicions of abuse)...Topic 8: Emergencies...4.b Falls-preventing falls is the best way to avoid serious injury. If a resident begins to fall, never try to stop the fall. Gently ease the resident to the floor and 1) Call for help immediately. Keep the resident in the same position until the nurse examines the resident. 2) Be calm, reassure the resident and follow nurse's instructions."</p> <p>This Federal tag relates to Complaint IN00143695.</p> <p>3.1-14 (i)</p>				

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