

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155573	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/01/2016
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 981 BEECHWOOD AVE MIDDLETOWN, IN 47356
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00201141.</p> <p>Complaint IN00201141-Substantiated. Federal/state deficiencies related to the complaint are cited at F157, F309 and F514.</p> <p>Survey dates: May 31 and June 1, 2016</p> <p>Facility number: 000342 Provider number: 155573 AIM number: 100289140</p> <p>Census bed type: SNF: 5 SNF/NF: 32 Total: 37</p> <p>Census payor type: Medicare: 6 Medicaid: 23 Other: 8 Total: 37</p> <p>Sample: 3</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	<p><u>Plan of Correction for Substantiated Complaint#IN00201141</u></p> <p>-</p> <p><i>The facility submits the following as plan of correction for the alleged deficiencies identified during the May 31 & June1, 2016 survey conducted by the Indiana State Department of Health.</i></p> <p><i>The facility respectfully requests the Department consider a desk review for paper compliance.</i></p> <p>-</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0157 SS=D Bldg. 00	<p>Quality review completed by 30576 on June 6, 2016</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically</p>			

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	<p>update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review, the facility failed to ensure the physician and family were notified of an assisted fall for 1 of 3 residents in a sample of 3 reviewed for falls. (Resident #B)</p> <p>Findings include:</p> <p>Review of a nurse's progress note, dated as a late entry for 4-30-16, indicated Resident #B experienced an assisted fall from the bed to the floor. The documentation failed to indicate the resident's attending physician or family had been notified of the fall.</p> <p>In interview with LPN #1 on 6-1-16 at 10:35 a.m., she indicated she did not notify the attending physician or the family of the assisted fall on 4-30-16, occurring prior to the evening meal, or the following morning, 5-1-16, when she notified the attending physician and the family of the resident's change in condition. She indicated she had no explanation as to why she failed to notify the attending physician or the family.</p> <p>In interview with the attending physician on 6-1-16 at 2:21 p.m., he indicated he was not notified of a fall for Resident #B</p>	F 0157	<p>F157 CorrectiveAction for Resident found to have been effected – The facility conducted an internal investigation to identify needed areas of re-education. The facility conducted a Clinical Team in-service on May 20, 2016. Topics included, but were not limited to, Policy and Procedure review for Incident/Accident Report Procedure & Documentation, Family & Physician notification of condition changes and utilization of mechanical lift devices. All facility Nurses and Certified Nursing Assistants received this in-service education. Copies of these policies, and attendance sheets were provided to the surveyor during the course of the survey. The staff nurse responsible for failing to document and make notifications as indicated in facility policies was formally disciplined as outlined in facility policy regarding employee discipline. Identifying other residents having the potential to be effected: The facility contends that all residents of the facility would have the potential to be effected.</p> <p>Systemic Changes: The facility has re-educated clinical staff on policies related to incident/occurrence reporting, documenting and notifications.</p>	06/21/2016

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	<p>on 4-30-16 or 5-1-16. He indicated he was unaware of any type of fall for this resident until after xrays were conducted in May, 2016 which indicated bilateral fractures of the lower femur/knee areas. An xray of the left knee was ordered on 5-7-16 and conducted the same date with an xray of the right knee ordered on 5-9-16 and conducted on the same date.</p> <p>In interview with the Director of Nursing (DON) on 5-31-16 at 1:22 p.m., he indicated upon receiving the first xray indicating a fracture, the facility began an investigation to determine the cause of the fracture. He indicated, "We learned the resident had been assisted to the floor during care," on 4-30-16. He indicated, "The nurse said the reason she didn't chart the fall or notify the family, the doctor or us [facility administration] was she forgot."</p> <p>In an interview with a family member of Resident #B on 5-31-16 at 11:55 a.m., it was indicated the family did not learn of the fractures until about one week after the unassisted fall on 4-30-16. The family member indicated, later, on 5-16-16, the DON and Administrator met with family members to share information which included, but was not limited to, the facility's investigation regarding the fractures "showed on</p>		<p>Additionally, the facility will be adding a section to the Nursing 24 hour reporting form to include "Did any incidents occur during the shift? Yes or No" "Documented Per Policy? Yes or No" and "Notifications made per policy? Yes or No." Monitoring to prevent reoccurrence: The facility nurse management and Administration review the 24 hour report each morning during "Clinical Meeting." The Weekend Manager on Duty holds responsibility to review 24 hour reporting and incidents documented during non-"normal business" hours. Any concerns will be addressed immediately, recorded on a facility QA tracking log and the tracking log will be reviewed daily for the first two weeks, then once weekly for two months, and monthly thereafter at the monthly QA meeting with any new recommendations implemented. Compliance Date: June 21, 2016</p>				

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	<p>4-30-16 [name of Resident #B] had been lowered to the floor by a CNA because she was slipping out of bed."</p> <p>On 6-1-16 at 2:15 p.m., the DON provided a copy of a policy entitled, "Physician & Family Notification of Condition Changes." This policy was indicated to be the policy currently utilized by the facility. This policy's purpose was indicated to be, "To keep the physician, resident and family apprised of all condition changes." It indicated, "Telephone notification is required for all emergencies or all condition changes that require an immediate response. Notify the physician of any change in condition that may or may not warrant a change in the treatment plan...Document the information reported to the physician in the nurses notes, including the time and date of notification. Be thorough and explicit. Document the response from the physician in the nurses notes. Document information to be faxed legibly and in black ink...Include all assessment information that the physician will need to make his decisions...Remember faxing does not eliminate nursing responsibility of follow-up assessment and further reporting to the physician, if necessary. Thoroughly document information reported to the physician in the nurses</p>			

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	<p>note. Be thorough and explicit, including that the physician was faxed, date and time. Document in the nurses notes, when the physician responds to the fax...Notify the resident and responsible party of any change in condition that may or may not warrant a change in the treatment plan."</p> <p>On 6-1-16 at 2:15 p.m., the DON provided a copy of a policy entitled, "Incident/Accident Report Procedure & Form." This policy was indicated to be the policy currently utilized by the facility. The policy identified its purpose as, "To document the events of an incident/accident, hereinafter also known as occurrence. To notify the physician and family in a timely manner..Notify the Physician immediately for emergencies and injuries requiring emergency treatment. Notify the Physician within 24 hours for all non-emergency incidents. Notify the responsibility party immediately for emergencies. Notify the responsible party between 6:30am and 10:00pm [sic] for non-emergencies requiring immediate treatment (unless otherwise requested by responsible party)..."</p> <p>This Federal tag relates to Complaint IN00201141.</p>			

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F 0309 SS=D Bldg. 00	<p>3.1-5(a)(1)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on interview and record review, the facility failed to ensure 1 of 3 residents in a sample of 3 reviewed for falls received care that included timely notification to the attending physician and family, follow up assessments post-fall, as well as timely and accurate documentation related to an assisted fall from the bed to floor. (Resident #B)</p> <p>Findings include:</p> <p>Resident #B's clinical record was reviewed on 5-31-16 at 11:05 a.m. It indicated her diagnoses included, but were not limited to, myasthenia gravis, Alzheimer's disease, dementia and arthritis. Her most recent Minimum Data Set (MDS) assessment, dated 4-20-16, indicated she was severely cognitively impaired, she did not ambulate, she required extensive assistance from</p>			F 0309	<p>F309 CorrectiveAction for Resident found to have been effected – The facility conducted an internal investigation to identify needed areas of re-education. The facility conducted a Clinical Team in-service on May 20, 2016. Topics included, but were not limited to, Policy and Procedure review for Incident/Accident Report Procedure & Documentation, Family & Physician notification of condition changes and utilization of mechanical lift devices. All facility Nurses and Certified Nursing Assistants received this in-service education. Copies of these policies, and attendance sheets were provided to the surveyor during the course of the survey. The staff nurse responsible for failing to document and make notifications as indicated in facility policies was formally disciplined as outlined in facility policy regarding</p>		06/21/2016

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	<p>facility staff related to transfers, bed mobility, dressing, eating, bathing, hygiene, toileting and required the use of a wheelchair for mobility. Nursing notes and care plans indicated she required the use of a mechanical lift for transfers, such as from bed to chair.</p> <p>A nursing note, dated as a late entry for 4-30-16 at 4:33 p.m., indicated LPN #1 was conducting a medication administration pass when she heard someone calling for help. It indicated she went room to room to locate the source calling for assistance. It indicated she located Resident #B sitting on the floor with CNA #2 beside her. It indicated CNA #2 explained she had been assisting the resident with care and in the process of re-dressing the resident, "resident slid down and CNA helped her to the floor. CNA states she had resident in her arms and both went to the floor. Resident...denied pain...checked from head to toe and no redness, scratches or any marks seen on resident. Resident was then removed from the floor by CNA and placed in [brand name of specialty] chair."</p> <p>In interview with LPN #1 on 6-1-16 at 10:35 a.m., she indicated at approximately 4:30 p.m. on 4-30-16, she was passing medications when she heard</p>		<p>employee discipline. Identifying other residents having the potential to be effected: The facility contends that all residents of the facility would have the potential to be effected. Systemic Changes: The facility has re-educated clinical staff on policies related to incident/occurrence reporting, documenting and notifications. Additionally, the facility will be adding a section to the Nursing 24 hour reporting form to include "Did any incidents occur during the shift? Yes or No" "Documented Per Policy? Yes or No" and "Notifications made per policy? Yes or No." Monitoring to prevent reoccurrence: The facility nurse management and Administration review the 24 hour report each morning during "Clinical Meeting." The Weekend Manager on Duty holds responsibility to review 24 hour reporting and incidents documented during non-"normal business" hours. Any concerns will be addressed immediately, recorded on a facility QA tracking log and the tracking log will be reviewed daily for the first two weeks, then once weekly for two months, and monthly thereafter at the monthly QA meeting with any new recommendations implemented. Compliance Date: June 21, 2016</p>				

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	<p>someone calling for help, and she then went to look for the source. She indicated when she entered Resident #B's room, she found the resident and CNA #2 on the floor and learned CNA #3 had entered the room immediately prior to her. She found the resident with her legs stretched out in front of her, sitting parallel to the bed. She indicated CNA #2 shared with her that the resident did not fall out of bed, but she had lowered (assisted) her to the floor. LPN #1 indicated the resident did not appear uncomfortable and was initially laughing when she entered the room. She indicated during her assessment of Resident #B, the resident was able to grip her hands and to push her feet against her hands, vitals signs were "fantastic," and no skin irritation upon visual inspection. She indicated the resident "did not flinch when I checked her extremities and looked at her skin." She indicated after the assessment, CNA #3 assisted the resident into her wheelchair by placing his arms under the resident's armpits and CNA #2 assisted with her feet. She indicated she did not provide assistance as she had a cup of medications in her hand. She indicated the mechanical lift was not utilized, "didn't realize it went to the floor."</p> <p>LPN #1 indicated she could not recall</p>			

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	<p>when she actually documented the above nursing note, dated as a late entry for 4-30-16.</p> <p>LPN #1 indicated when she saw the resident after supper the same evening, she was seated in her wheelchair in the TV lounge and appeared her normal self. The next morning, 5-1-16, when she returned to work, she found Resident #B already up in her wheelchair, prior to breakfast. Nursing notes indicated shortly thereafter, the resident had a change in condition of becoming unresponsive.</p> <p>LPN #1 indicated she did not notify the attending physician or the family of the assisted fall on 4-30-16, occurring prior to the evening meal, or the following morning, 5-1-16, when she notified the attending physician and the family of the resident's change in condition. She indicated she had no explanation as to why she failed to notify the attending physician or the family or document the incident until later.</p> <p>In an interview with CNA #2 on 5-31-16 at 3:14 p.m., she indicated on 4-30-16, at approximately 3:30 p.m. to 4:00 p.m., she was assisting Resident #B with incontinence care. She indicated while the resident was rolled towards her, the</p>			

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	<p>resident's lower half of her body began to slide off of the bed, feet first. She held onto the resident's upper portion of the body and eased her down onto the floor, onto the resident's buttocks with her back against the recliner. She indicated she was able to activate the call light, as well as calling for help. Assistance arrived, initially from CNA #3 who then went to seek out LPN #1. She indicated the resident did not appear uncomfortable and several times the resident asked what was going on, but she did not recall the resident laughing. She indicated when LPN #1 arrived, she inquired as to what had occurred and if the resident had struck her head. CNA #2 indicated she shared what had happened with the resident to LPN #1. CNA #2 indicated she remained with the resident until after she was assisted into the wheelchair. CNA #2 indicated, "[Name of LPN #1] looked at her [Resident #B] for a few minutes. Did not see her do vital signs or touch her." She indicated shortly thereafter, LPN #1 told she and CNA #3 to assist the resident into the wheelchair; the resident was assisted from off of the floor by both CNA's by placing their arms under the resident's arms and holding onto the back of her pants. CNA #2 indicated the mechanical lift was not used to get the resident up, as she did not realize it would go all the way to the</p>			

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	<p>floor.</p> <p>In an interview with CNA #3 on 5-31-16 at 3:55 p.m., he indicated on the afternoon of 4-30-16, prior to supper, he estimated between 3:30 p.m. and 4:00 p.m., he heard someone calling for help and he sought out the source. He found the call light on for Resident #B's room and CNA #2 on the floor, assisting Resident #B to sit up on the floor, with the resident's back against the recliner and her legs out stretched in front of her. He shared CNA #2 explained the resident slid off the bed while receiving care and CNA #2 assisted her to the floor. He indicated he then went to locate LPN #1 while CNA #2 stayed with the resident. When LPN #1 arrived, she asked if the resident had struck her head, to which CNA #2 and CNA #3 replied that she did not hit her head, but may have hit her knees on the floor. He indicated he did not observe LPN #1 obtain the resident's vital signs or conduct an assessment. He indicated, "Anytime there have been falls in the past, the nurse will do vital signs and check them out before they are moved. I didn't see [name of LPN #1] do any of that."</p> <p>CNA #3 indicated the resident was assisted off of the floor by he and CNA #2 lifting her under her arms and LPN #1</p>			

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	<p>holding onto the back of her pants and placing her in a wheelchair.</p> <p>CNA #3 indicated Resident #B did not appear to be uncomfortable. He recalled, as he worked a double shift, the next morning, he reported to the on-coming nurse, LPN #1, his observations of Resident #B's knees "were kind of swollen...so she could check her out." He recalled Resident #B was sent out to the hospital several hours later.</p> <p>In an interview with the Director of Nursing (DON) on 5-31-16 at 1:22 p.m., he indicated an investigation for an injury of unknown origin was initiated by the facility when xrays revealed a fracture for Resident #B on 5-7-16, with the other fracture being identified by xray on 5-9-16. He indicated the facility "Initially, could not come up with any explanation for the fractures...During staff interviews, we learned the resident had been assisted to the floor during care on 4-30-16." The DON indicated the late entry in the nursing progress notes, dated 4-30-16 at 4:33 p.m., "would have been entered sometime after both xrays were done." The DON indicated LPN #1 explained the reason she had not documented the incident, nor passed the information along in report in order for routine follow-up to be conducted, nor</p>			

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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 981 BEECHWOOD AVE MIDDLETOWN, IN 47356
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	<p>notified the physician, family, or the facility administration, "was she forgot." The DON indicated the resident was not assisted up off of the floor with the use of a mechanical lift. He indicated she normally was transferred by mechanical lift. "Generally, our policy is, if a resident normally uses a mechanical lift, it would be preferable to use it to get them up from a fall with one."</p> <p>In an interview on 6-1-16 at 2:25 p.m., the DON indicated the facility's investigation indicated CNA #2 and CNA #3 reported neither observed LPN #1 conduct an assessment of Resident #B after the assisted fall. However, he indicated LPN #1 did say she conducted an assessment, as well as the assessment being documented in the nursing note of the late entry for 4-30-16.</p> <p>In an interview with the attending physician on 6-1-16 at 2:21 p.m., he indicated he was not notified of a fall for Resident #B on 4-30-16 or 5-1-16. He indicated he was unaware of any type of fall for this resident until after xrays were conducted in May, 2016 which indicated bilateral fractures of the lower femur/knee areas. An xray of the left knee was ordered on 5-7-16 and conducted the same date with an xray of the right knee ordered on 5-9-16 and</p>			

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	<p>conducted on the same date.</p> <p>In an interview with a family member of Resident #B on 5-31-16 at 11:55 a.m., it was indicated the family did not learn of the fractures until about one week after the unassisted fall on 4-30-16. The family member indicated, later, on 5-16-16, the DON and Administrator met with family members to share information which included, but was not limited to, the facility's investigation regarding the fractures "showed on 4-30-16 [name of Resident #B] had been lowered to the floor by a CNA because she was slipping out of bed."</p> <p>The Administrator provided a copy of LPN #1's employee record for review on 6-1-16 at 9:15 a.m. It indicated she began employment with the facility two years previously and has been licensed as an LPN for eight years. Review of her initial orientation period included, but was not limited to, education related to "Review of Charge Nurse Job Description," "24 Hour Condition Report," "Shift Routines," including "Report from and between nurses," "Notifying Physicians," "Documentation Requirements," and "Incidents/accident reporting forms and follow-up procedures."</p>			

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	<p>On 6-1-16 at 2:15 p.m., the DON provided a copy of a policy entitled, "Physician & Family Notification of Condition Changes." This policy was indicated to be the policy currently utilized by the facility. This policy's purpose was indicated to be, "To keep the physician, resident and family apprised of all condition changes." It indicated, "Telephone notification is required for all emergencies or all condition changes that require an immediate response. Notify the physician of any change in condition that may or may not warrant a change in the treatment plan...Document the information reported to the physician in the nurses notes, including the time and date of notification. Be thorough and explicit. Document the response from the physician in the nurses notes. Document information to be faxed legibly and in black ink...Include all assessment information that the physician will need to make his decisions...Remember faxing does not eliminate nursing responsibility of follow-up assessment and further reporting to the physician, if necessary. Thoroughly document information reported to the physician in the nurses note. Be thorough and explicit, including that the physician was faxed, date and time. Document in the nurses notes, when the physician responds to the</p>			

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	<p>fax...Notify the resident and responsible party of any change in condition that may or may not warrant a change in the treatment plan."</p> <p>On 6-1-16 at 2:15 p.m., the DON provided a copy of a policy entitled, "Incident/Accident Report Procedure & Form." This policy was indicated to be the policy currently utilized by the facility. The policy identified its purpose as, "To document the events of an incident/accident, hereinafter also known as occurrence. To notify the physician and family in a timely manner...Assess resident's condition and for possible injury/accident. Provide any immediate emergency care that is needed. Do not move resident before a thorough assessment is completed. Assess extremities fro injury (note any rotation inward or outward, any shortening of the limb, any complaints of pain.) If there is is any evidence of fracture or severe head trauma, do not move resident until emergency services arrive. If there is obvious injury to the head, begin neurological assessment...Assess for any injury to other body, such as cuts, skin tears, abrasions, hematoma, etc...Check vital signs. After resident is thoroughly assessed and is safe for moving, assist resident up if they have fallen or assist resident to bed or chair if needed. For a</p>			

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	<p>resident that requires moderate assistance and is on the floor, a mechanical lift (and at least two staff members) should be used to get resident up off the floor...Notify the Physician immediately for emergencies and injuries requiring emergency treatment. Notify the Physician within 24 hours for all non-emergency incidents. Notify the responsibility party immediately for emergencies. Notify the responsible party between 6:30am and 10:00pm [sic] for non-emergencies requiring immediate treatment (unless otherwise requested by responsible party). Complete the form located in the EMR titled "nursing occurrence initial" [sic] and also the paper investigation form. Complete each fully with identical information...Document time and date of occurrence and of all notification...Follow-up must be documented on the EMR form titled "nursing occurrence follow-up" [sic] every shift for 24 hours for non-injuries and every shift for 3 days if there is injury noted...Notify DON and Administrator of incidents with injury immediately so that ISDH may be notified if appropriate..."</p> <p>This Federal tag relates to Complaint IN00201141.</p> <p>3.1-37(a)</p>			

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F 0514 SS=D Bldg. 00	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on interview and record review, the facility failed to ensure timely documentation of an assisted fall for 1 of 3 residents in a sample of 3 reviewed for falls. (Resident #B)</p> <p>Findings include:</p> <p>Resident #B's clinical record was reviewed on 5-31-16 at 11:05 a.m. It indicated her diagnoses included, but were not limited to, myasthenia gravis, Alzheimer's disease, dementia and arthritis.</p> <p>A nursing note, dated as a late entry for 4-30-16 at 4:33 p.m., indicated LPN #1 was conducting a medication administration pass when she heard</p>	F 0514	<p>F514 _ CorrectiveAction for Resident found to have been effected – The facility conducted an internal investigation to identify needed areas of re-education. The facility conducted a Clinical Team in-service on May 20, 2016. Topics included, but were not limited to, Policy and Procedure review for Incident/Accident Report Procedure & Documentation, Family & Physician notification of condition changes and utilization of mechanical lift devices. All facility Nurses and Certified Nursing Assistants received this in-service education. Copies of these policies, and attendance sheets were provided to the surveyor during the course of the survey. The staff</p>	06/21/2016			

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	<p>someone calling for help. It indicated she went room to room to locate the source calling for assistance. It indicated she located Resident #B sitting on the floor with CNA #2 beside her. It indicated CNA #2 explained she had been assisting the resident with care and in the process of re-dressing the resident, "resident slid down and CNA helped her to the floor. CNA states she had resident in her arms and both went to the floor.</p> <p>Resident...denied pain...checked from head to toe and no redness, scratches or any marks seen on resident. Resident was then removed from the floor by CNA and placed in [brand name of specialty] chair."</p> <p>In interview with LPN #1 on 6-1-16 at 10:35 a.m., she indicated she could not recall when she actually documented the above nursing note, dated as a late entry for 4-30-16. She indicated she had no explanation as to why she failed to document the incident until later.</p> <p>In an interview with the Director of Nursing (DON) on 5-31-16 at 1:22 p.m., he indicated an investigation for an injury of unknown origin was initiated by the facility when xrays revealed a fracture for Resident #B on 5-7-16, with the other fracture being identified by xray on 5-9-16. He indicated the facility</p>		<p>nurses responsible for failing to document and make notifications as indicated in facility policies was formally disciplined as outlined in facility policy regarding employee discipline. Identifying other residents having the potential to be effected: The facility contends that all residents of the facility would have the potential to be effected.</p> <p>Systemic Changes: The facility has re-educated clinical staff on policies related to incident/occurrence reporting, documenting and notifications. Additionally, the facility will be adding a section to the Nursing 24 hour reporting form to include "Did any incidents occur during the shift? Yes or No" "Documented Per Policy? Yes or No" and "Notifications made per policy? Yes or No."</p> <p>Monitoring to prevent reoccurrence: The facility nurse management and Administration review the 24 hour report each morning during "Clinical Meeting." The Weekend Manager on Duty holds responsibility to review 24 hour reporting and incidents documented during non-"normal business" hours. Any concerns will be addressed immediately, recorded on a facility QA tracking log and the tracking log will be reviewed daily for the first two weeks, then once weekly for two months, and monthly thereafter at the monthly QA meeting with any new</p>	

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	<p>"Initially, could not come up with any explanation for the fractures...During staff interviews, we learned the resident had been assisted to the floor during care on 4-30-16." The DON indicated the late entry in the nursing progress notes, dated 4-30-16 at 4:33 p.m., "would have been entered sometime after both xrays were done." The DON indicated LPN #1 explained the reason she had not documented the incident "was she forgot."</p> <p>On 6-1-16 at 2:15 p.m., the DON provided a copy of a policy entitled, "Physician & Family Notification of Condition Changes." This policy was indicated to be the policy currently utilized by the facility. This policy's purpose was indicated to be, "To keep the physician, resident and family apprised of all condition changes." It indicated, "Telephone notification is required for all emergencies or all condition changes that require an immediate response. Notify the physician of any change in condition that may or may not warrant a change in the treatment plan...Document the information reported to the physician in the nurses notes, including the time and date of notification. Be thorough and explicit. Document the response from the physician in the nurses notes. Document information to be faxed</p>		<p>recommendations implemented. ComplianceDate: June 21, 2016</p>	

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	<p>legibly and in black ink...Include all assessment information that the physician will need to make his decisions...Remember faxing does not eliminate nursing responsibility of follow-up assessment and further reporting to the physician, if necessary. Thoroughly document information reported to the physician in the nurses note. Be thorough and explicit, including that the physician was faxed, date and time. Document in the nurses notes, when the physician responds to the fax...Notify the resident and responsible party of any change in condition that may or may not warrant a change in the treatment plan."</p> <p>On 6-1-16 at 2:15 p.m., the DON provided a copy of a policy entitled, "Incident/Accident Report Procedure & Form." This policy was indicated to be the policy currently utilized by the facility. The policy identified its purpose as, "To document the events of an incident/accident, hereinafter also known as occurrence. To notify the physician and family in a timely manner...Complete the form located in the EMR titled "nursing occurrence initial" [sic] and also the paper investigation form. Complete each fully with identical information...Document time and date of occurrence and of all</p>			

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	<p>notification...Follow-up must be documented on the EMR form titled "nursing occurrence follow-up" [sic] every shift for 24 hours for non-injuries and every shift for 3 days if there is injury noted..."</p> <p>This Federal tag relates to Complaint IN00201141.</p> <p>3.1-50(a)(1) 3.1-50(a)(2) 3.1-50(a)(3) 3.1-50(i)</p>			