STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 09/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTINA HOUSE	1435 CHRISTIAN BLVD FRANKLIN, IN 46131

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0000	This visit was for the Investigation of Complaint IN00115814. Complaint IN00115814-Substantiated, a State rule finding related to the allegation is cited at R0349. Survey dates: September 10 & 11, 2012. Facility number: 004017 Provider number: 004017 AIM number: N/A Survey team: Marcy Smith, RN TC Dinah Jones, RN Leia Alley, RN September 10, 2012 Census bed type: Residential: 60 Total: 60 Census payor type: Other: 60 Total: 60 Sample: 3 This state finding is cited in accordance with 410 IAC 16.2.	R0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	Quality review completed on September 13, 2012 by Bev Faulkner, RN			

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R0349	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on interview and record review, the facility failed to ensure clinical record documentation was maintained in that a Certified Nursing Assistant and a Licensed Practical Nurse did not document an injury which occurred when transporting a resident in a wheelchair. This had the potential to affect 1 of 3 residents reviewed for accurate documentation in a sample of 3. (Resident #B) Findings include: A review of the facility's August Incident Log on 9/10/12 at 12:30 P.M., indicated on 8/22/12 Resident B obtained a bruise on her left forearm. A review on 9/10/12 at 12:35 P.M., of the facility's Universal Incident/Occurrence Report, dated 8/22/12 at 10:30 P.M., indicated Resident B sustained an injury to her left elbow and left forearm	R0349	Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. **Citation #1** **R349** **410 IAC 16.2-5-8.1(a) (1-4)** **Clinical Records- Noncompliance** **What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?** No residents were found to be	10/25/2012

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	resulting in a bruise on her left forearm. The incident report was initiated and an assessment was completed by the night shift staff. A review on 9/10/12 at 12:50 P.M., of the facility's Disciplinary Action Report, signed by the Resident Assistance Director on 8/27/12, indicated Certified Nursing Assistant #2 "neglected to report or file an incident report after hitting the resident's arm on table edge causing injury." A review of Resident Services Notes for Resident B on 9/10/12 at 1:00 P.M., indicated no documentation of an injury, which incurred on 8/22/12 at 3:00 P.M. was recorded by Certified Nursing Assistant #2 or Licensed Practical Nurse #1. A review on 9/10/12 at 1:15 P.M., of Certified Nursing Assistant #2's statement of the incident indicated, "I know to notify supervision and to do an incident report, however, I forgot to do so." A review on 9/10/12 at 1:20 P.M., of Licensed Practical Nurse #1's statement indicated she witnessed the incident and indicated the resident did not voice any complaints during the evening.		affected. The community is unable to correct this specific issue for Resident #B. The Residence Director has re-educated staff as to our policy and procedure and state regulations regarding documentation with a monitoring plan implemented to ensure compliance via the Christina House QA process. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** A review of current resident files was completed to ensure continued compliance with the above referenced citation. No other residents were found to be affected. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** The Wellness Director and staff were re-educated to our policy and procedure regarding documentation and change of condition. The Wellness Director and/or Designee will be responsible for ensuring documentation will be completed per our policy and procedure to ensure compliance with R349 16.2-5-8.1(a) (1-4) Clinical Records. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**	

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	During an interview on 9/10/12 at 2:00 P.M., with the Assistant Resident Director [ARD], she indicated she was not made aware of the above incident until 8:15 A.M., on 8/23/12. She indicated she interviewed the resident and notified the resident's son and the resident's physician of the incident and injury. She indicated she interviewed the staff, who were working the evening shift when the incident occurred and had Certified Nursing Assistant #2 and Licensed Practical Nurse #1 each write a statement. The A.R.D. proceeded with an investigation and disciplinary actions. During an interview on 9/10/12 at 2:30 P.M., with Licensed Practical Nurse #1, she indicated she witnessed the incident, but did not fill out an occurrence report. She indicated she assessed the resident's arm at 9:00 P.M. on 8/22/12, but did not document her assessment. She indicated the resident was wearing long sleeves and she couldn't see the resident's arm, but that she did not see any bleeding. She indicated she either left a voice mail message on the A.R.D.'s phone or spoke with her, but could not remember. A facility policy entitled, "Incident Reporting Guidelines" reviewed on 9/11/12 at 10:00 A,M,, indicated, "The Universal Incident Report form should be		The Residence Director and/or Designee will perform random bi-weekly audits of resident records to ensure documentation is completed and compliant for a period of six months. The Regional Director of Quality and Care Management will audit random resident files quarterly to ensure compliance. Findings will be reviewed through the Christina House QA process after six months to determine the need for an ongoing monitoring plan. Findings suggestive of compliance will result in cessation of the monitoring plan. **By what date will the systemic changes be completed?** October 25, 2012	

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	completed for incidents and should be completed as soon as possible after an incident occurs. The employee who observes or first becomes aware of an incident should begin the Universal Incident Report." The policy indicated unusual incidents should be immediately reported to the Resident Director. A review of the job description entitled, "Licensed Vocational Nurse (LVN) Licensed Practical Nurse (LPN)" indicated Point number 18, "Observes changes in resident status, needs or preferences and communicates them appropriately to the Wellness Director and/or Residence Director." Point number 22 indicated, "Records resident information as required" and point number 26 indicated, "Notifies physician, RN and/designated agent(s) of resident status/change as appropriate. Receives and executes written and verbal orders from the physician or designated agent, as permitted by state regulations." This state residential tag is related to Complaint IN00115814.			

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