| 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 |
|---|---|---|---|
| | 155042 | | 06/30/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WILLOW MANOR | 3801 OLD BRUCEVILLE RD BOX 136<br>VINCENNES, IN 47591 |

| (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 |
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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey.<br><br>Survey dates: June 24, 25, 26, 29, 30, 2015<br><br>Facility number: 000016<br>Provider number: 155042<br>AIM number: 100291500<br><br>Census bed type:<br>SNF/NF: 143<br>Total: 143<br><br>Census payor type:<br>Medicare: 22<br>Medicaid: 97<br>Other : 24<br>Total: 143<br><br>These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2-3.1 | F 0000 | By submitting the enclosed material we are not admitting thetruth or accuracy of any specific findings or allegations. We reserve the rightto contest the findings or allegations as part of any proceedings and submitthese responses pursuant to our regulatory obligations. The facility that theplan of correction be considered our record of compliance effective 7/30/2015to the annual survey conducted on 6/30/2015 | |
| F 0161<br>SS=E<br>Bldg. 00 | 483.10(c)(7)<br>SURETY BOND - SECURITY OF PERSONAL FUNDS<br>The facility must purchase a surety bond, or otherwise provide assurance satisfactory to | | | |

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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| | the Secretary, to assure the security of all personal funds of residents deposited with the facility.<br><br>Based on record review and interview, the facility failed to ensure resident trust accounts were sufficiently insured, in that, the amount of coverage provided by the surety bond was less than the current amount of money in the resident trust accounts. This had the potential to affect 109 of 143 residents in the facility.<br><br>Findings include:<br><br>The facility surety bond was reviewed on 6/30/15 at 9:03 A.M. The amount of coverage provided on the Surety bond was $25,000.00.<br><br>The facility statement of resident trust accounts was reviewed on 6/30/15 at 9:32 A.M. The total balance for all resident trust accounts (109 accounts) on 6/30/15 was $32,911.61 ($5,489.09 over the covered amount).<br><br>During an interview with the Business Office Manager on 6/30/15 at 9:32 A.M., she indicated the current surety bond for 25,000.00 was not enough to cover resident trust accounts for $32,911.61.<br><br>3.1-6(j) | F 0161 | **F 161 What Correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice:** A surety bond was put into place that will cover theResident Trust funds. **How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken:** All residents that have a resident trust account have thepotential to be affected by the deficient practice **What measures willbe put into place or what systemic changes will be made to ensure that thedeficient practice does not recur:** The surety bond amount will be monitored monthly when theresident trust fund bank statement is received for proper coverage. **How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place:** There will be an audit tool in place to monitor theresident trust fund amount and the surety bond coverage monthly. This will be reported Quarterly to the Quality Assurance Team for compliance. | 07/30/2015 |

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| | | | This monitoring will be ongoing and monitoring will be on day shift **By what date thesystemic changes will be completed:** 7/30/2015 | |
| F 0164<br>SS=D<br>Bldg. 00 | 483.10(e), 483.75(l)(4)<br>PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS<br>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.<br><br>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.<br><br>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.<br><br>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.<br><br>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.<br><br>Based on observation, interview, and record review, the facility failed to ensure | F 0164 | **F 164 What Correctiveaction(s) will be accomplished for those residents found to have been** | 07/30/2015 |

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| | personal privacy was provided, in that, personal privacy was not provided during medical treatment and/or personal care for 3 of 7 observations of personal care. (Resident #154, Resident #172, Resident #149)<br><br>Findings include:<br><br>1. During a random observation of D hall on 6/24/15 at 1:01 P.M., Resident #154's room door was open and the privacy curtain was not pulled closed. Resident #154 was observed to be lying on the bed, shirtless, with his mouth open, and unresponsive. LPN (License Practical Nurse) #15 was listening to Resident #154's chest with a stethoscope, taking his blood pressure and talking to RN (Registered Nurse) #9 about Resident #154's condition. The door remained open and the curtain was not pulled closed. At 1:07 P.M., both nurses exited the room. During an interview at that time, LPN #15 indicated Resident #154 was unresponsive and said, "Oh, he is on his way out and his daughter is on vacation." LPN #15 and RN #9 continued down the hall to the nurses station. The privacy curtain was not pulled around the resident and the door was not closed as they exited the room.<br><br>During a continuous observation on | | **affectedby the deficient practice:** Resident # 154 passed away the same day. The staffassigned to Residents #154, #172, and #149 were re-educated the day thedeficient practice was observed. **How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken:** All residents would have the potential to be affected bythe deficient practice. **What measures willbe put into place or what systemic changes will be made to ensure that thedeficient practice does not recur:** A mandatory inservice will be held for all staff tore-educate on Resident rights including but not limited to privacy forResidents. **How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place:** The deficient practice will be monitored by observationand the results documented on a Privacy Observation tool. Observations will be completed weekly x 4 then monthly and the results reported Quarterly to the Quality Assurance Team. Monitoring will be on all three shifts and will be ongoing **By what date thesystemic changes will be completed:** 7/30/2015 | |

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| | 6/24/15 from 1:01 P.M., to 1:46 P.M., Resident #154 was observed to be lying on his bed, shirtless, with his mouth open, and unresponsive. The door remained open and the privacy curtain had not been pulled to shield Resident #154 from the view of other residents and visitors.<br><br>During an observation on 6/24/15 at 1:46 P.M., Resident #154 was observed to be lying on his bed, shirtless, with his mouth open, and unresponsive. A family member was at the bedside leaning over the top of Resident #154, crying and talking to him.<br><br>During an interview on 6/30/15 at 9:55 A.M., LPN #15 indicated that, while performing any procedure, the curtain should be pulled and the door closed to protect the resident's privacy and to the resident's ensure dignity.<br><br>2. During an observation on 6/25/15 from 9:00 A.M. through 9:16 A.M., RN #10 was observed from the hallway to propel Resident #172 backwards through an open doorway into a clean linen closet. RN #10 was then observed from the hallway, at that time, to cleanse and apply a clean dressing to a skin tear on the left arm of Resident #172. | | | |

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| | During an interview on 6/25/15 at 11:00 A.M. the DON (Director of Nursing) indicated Resident #172 should have been provided privacy during the dressing change.<br><br>3. During an observation on 6/29/15 at 10:15 A.M., Resident #149's window curtain was could not be pulled closed to provide privacy during incontinent care. CNA #18 tried to hold the curtain over the window, but CNA #18 was unable to continue holding it closed while assisting with Resident #149's care. During an interview at that time, LPN #12 indicated she had told maintenance about the curtain last week.<br><br>The "Resident Rights Protocol for All Nursing Procedures" was provided by the Director of Nursing on 6/30/15 at 3:45 P.M., and it read as follows: "...for any procedure that involves direct resident care, follow these steps:...Close the room entrance door and provide for resident's privacy..."<br><br>3.1-3(p)(2) | | | |
| F 0241<br>SS=E<br>Bldg. 00 | 483.15(a)<br>DIGNITY AND RESPECT OF INDIVIDUALITY<br>The facility must promote care for residents in a manner and in an environment that | | | |

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| | maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. | | | |
| | Based on observation, interview, and record review, the facility failed to ensure services were provided in a dignified manner, in that, tablemate's were not served meals at the same time (Resident #82, Resident #52) and/or staff did not sit down to assist residents with their meals (Resident #86, Resident #118, Resident #60) for 2 of 7 meal observations and personal care of a dying resident was observed through an open door from the hallway (Resident #154) and/or a resident was addressed by staff as "Grandma" (Resident #149) for 2 of 2 random observations.<br><br>Findings include:<br><br>The following was observed during dining observations:<br><br>1. On 6/24/15 the lower level main dining room was observed and the following was observed:<br><br>At 12:18 P.M., Resident #225 and Resident #82 were observed to be seated together. Resident #225 was served a tray by Certified Nursing Assistant (CNA) #21 and began eating. | F 0241 | **F 241 What Correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice:** Resident #154 passed away on 6.24.15 the same day theobservation was made. Staff was re-educated on the day of the observation aboutpassing trays one table at a time and when assisting residents to eat, staffneed to be seated. Staff was also re-educated on how to properly address a Resident. **How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by thedeficient practices. **What measures willbe put into place or what systemic changes will be made to ensure that thedeficient practice does not recur:** A mandatory inservice will be held for all staff tore-educate on Resident rights including but not limited to privacy forResidents and the procedure for assisting Residents to eat. **How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put** | 07/30/2015 |

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| | At 12:45 PM Resident #82 was observed to say "I don't have a tray" CNA #22 was observed to walk past and say nothing to her.<br><br>At 12:59 P.M., Resident #82 was observed to start repetitively stating "I don't have a tray". Staff was observed to continue passing trays to the other residents in the dining room.<br><br>Resident #225 was observed to finish eating at 1:02 P.M.<br><br>At 1:04 P.M., Resident #82 received her tray and began eating without assistance.<br><br>2. During observations on 6/24/15 in the GHI/EF unit dining room. Resident #187 and Resident #52 were observed sitting together at a table. Resident #187 was served a tray at 12:35 P.M. The staff was observed to continue passing trays to there residents. At 12:59 P.M. Resident #52 was passed his tray and started immediately began to feed himself.<br><br>3. On 6/24/15 at 1:03 P.M., in the dining room for the C and D hall, 6 residents in the restorative area were at the restorative table and had their noon lunch trays. One CNA, CNA #8 was observed to assist Resident #86, Resident #118, and Resident #60 to eat, by walking around | | **into place:** The deficient practice will be monitored by observationand the results documented on a Dignity Observation tool. Observations will becompleted weekly x 4 and then monthly and the results reported Quarterly to the Quality Assurance Team. This will be monitored all 3 shifts and will be ongoing **By what date thesystemic changes will be completed:** 7/30/2015 | |

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| | the table giving the three residents each a bite or a drink and then repeated the process. CNA #8 was observed to stand and assist the residents standing until 8 minutes later when Restorative CNA # 20 from the D unit came and sat down to feed Resident #86, Resident #60 and CNA #8 then sat down and began to feed Resident #118.<br><br>A facility policy entitled, "Dining Room Procedure (undated) included but was not limited to: "...5. When the trays of the Resident who must be fed come out, then the certified staff will assist those Resident's as needed...6. Dependent Residents: Each staff member can feed no more than two completely dependent Residents at one time..."<br><br>The following was observed during random observations:<br><br>4. During a random observation on 6/24/15 at 1:01 P.M., Resident #154's door was open and the curtain was not pulled closed. Resident #154 was observed to be lying on the bed, shirtless, with his mouth open, and unresponsive. Registered Nurse (RN) #9 was listening to Resident #154's chest with a stethoscope, taking his blood pressure and talking to RN # 9 about Resident #154's condition. The door remained | | | |

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| | opened and curtain was not pulled closed. At 1:07 P.M., both nurses exited the room. During an interview at that time, RN #9 indicated Resident #154 was unresponsive and then said, "Oh, he is on his way out and his daughter is on vacation." LPN #15 and RN #9 continued down the hall to the nurses station. The privacy curtain was not pulled around the resident and the door was not closed as they exited the room.<br><br>During a continuous observation on 6/24/15 from 1:01 P.M., to 1:46 P.M., Resident #154 was observed to be lying on his bed, shirtless, with his mouth open, and unresponsive. The door remained open and the privacy curtain had not been pulled closed to shield Resident #154 from the view of residents and visitors.<br><br>During an observation on 6/24/15 at 1:46 P.M., Resident #154 was observed to be lying on his bed, shirtless, with his mouth open, and unresponsive. A family member was at the bedside leaning over the top of Resident #154, crying and talking to him.<br><br>During an interview on 6/30/15 at 9:55 A.M., LPN #15 indicated that, while performing any procedure, the curtain should be pulled and the door closed to | | | |

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| | protect the resident's privacy and to ensure the resident's dignity.<br><br>5. During an observation of a dressing change on 6/29/15 at 10:30 A.M., Resident #149 was addressed by LPN #12 as "Grandma", after which LPN #12 then said, "Oh, I mean [name of resident]."<br><br>6. During a random observation on C hall 6/30/15 at 9:40 A.M., Resident #149 was addressed by CNA #18 as "Grandma." CNA #18 was standing in Resident #149's doorway and said, "All right, Grandma."<br><br>During an interview on 6/30/1 at 9:40 A.M., CNA #18 indicated Resident #149 was not her Grandmother and should not have been called Grandma.<br><br>During an interview on 6/30/15 at 9:55 A.M., LPN #15 indicated a resident should be addressed by the name they have asked to be called.<br><br>The "Resident Rights Protocol for All Nursing Procedures" was provided by the Director of Nursing on 6/30/15 at 3:45 P.M., and it read as follows: "...Prior to having direct-care responsibilities for residents...staff must have training on...Resident dignity and respect..." | | | |

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| | 3.1-3(t) | | | |
| F 0246 SS=D Bldg. 00 | 483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. | | | |
| | Based on observation, interview, and record review, the facility failed to ensure call lights were within reach, in that, call lights were not in reach for 3 of 40 residents who met the criteria for review of call lights. (Resident #223, Resident #20, Resident #140) | F 0246 | **F 246 What Correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice:** Staff was re-educated on the proper placing of calllights within reach of the resident at all times. **How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken:** All Residents have the potential to be affected by thedeficient practice. **What measures willbe put into place or what systemic changes will be made to ensure that thedeficient practice does not recur:** A mandatory inservice will be held for all staff tore-educate on Resident rights including but not limited to call light placementfor Residents. **How the correctiveaction(s) will be monitored to ensure the deficient practice will not** | 07/30/2015 |
| | Findings include: | | | |
| | 1. On 6/25/15 at 10:35 A.M., Resident #223 was observed in her room, sitting in a recliner. The call light of Resident #223 was observed, at that time, to not be within reach. On 6/25/15 at 10:42 A.M., LPN #10 was notified the call light was not in reach and was observed to place the call light on the bedside rail next to the recliner. Resident #223 was then observed to not be able to reach the call light safely. During an interview, at that time, LPN #10 indicated maintenance | | | |

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| | would be notified.<br><br>2. On 6/29/15 at 8:35 A.M., a call light was observed clipped on the bed and not within reach of Resident #223. The resident was oserved seated in a chair away from the bed.<br><br>3. On 6/29/15 at 8:36 A.M., the call light of Resident #140 was observed to be lying on the bedside cabinet and out of reach of the resident sitting in a chair in the room.<br><br>During an interview on 6/25/15 at 10:42 A.M., LPN #10 indicated call lights located should be within the reach of a resident.<br><br>The Policy and Procedure for "Call Light" provided by the DON (Director of Nursing) on 6/30/15 at 12:20 P.M. indicated, "...Policy: The Resident's call light is to be within reach of the dependent Resident ...8. The call light must remain...within reach of the Resident..."<br><br>3.1-3(v)(1) | | **recur,i.e., what quality assurance program will be put into place:** The deficient practice will be monitored by observationand the results documented on a Call Light Observation tool. Observations willbe completed weekly x 4 then monthly andthe results reported Quarterly to the Quality Assurance Team. Monitoring will be completed on all three shifts and will be ongoing **By what date thesystemic changes will be completed:** 7/30/2015 | |
| F 0250<br>SS=D | 483.15(g)(1)<br>PROVISION OF MEDICALLY RELATED | | | |

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| Bldg. 00 | SOCIAL SERVICE<br>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.<br><br>Based on observation, interview, and record review, the facility failed to ensure effective behavior management services were provided, in that, a resident with escalating and/or aggressive behaviors did not receive comprehensive monitoring by social services and a behavior management care plan was not developed in a timely manner for 2 of 2 residents who met the criteria for review of social services. (Resident #8, Resident #224)<br><br>Findings include:<br><br>1. On 06/25/15 at 9:30 A.M., Resident #8 was observed in a TV lounge sitting in a wheelchair with a cast on the left upper extremity.<br><br>During an interview 6/25/15 at 10:06 A.M., UM #10 indicated Resident #8 experienced behaviors.<br><br>The clinical record of Resident #8 was reviewed on 6/29/15 at 9:30 A.M. The record indicated Resident #8 was admitted on 1/29/15 with diagnoses including, but not limited to, major | F 0250 | **F 250 What Correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice:** A Social Service and Activities assessment will becompleted to determine past life interest and current interest to be utilizedin a behavior management careplan. **How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken:** All Residents have the potential to be affected by thedeficient practice. **What measures willbe put into place or what systemic changes will be made to ensure that thedeficient practice does not recur:** A behavior management program will be implemented. Allsocial and activities assessments will be updated. Staff will be educated onthe behavior management program and will be educated on how to recognizebehaviors and to report them. Careplans will be developed to reflect theResidents behavior and individualized interventions. **How the correctiveaction(s) will be monitored to ensure the** | 07/30/2015 |

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| | depressive disorder with psychotic features, dementia, and/or anxiety. The record further indicated Resident #8 had experienced the death of a close family member prior to admission.<br><br>The Admission MDS (Minimum Data Set) assessment dated 2/4/15 indicated Resident #8 experienced minimal cognitive impairment, experienced no mood impairments, and/or no behaviors.<br><br>A Quarterly MDS assessment dated 3/28/15 indicated Resident #8 experienced moderate cognitive impairment, experienced minimal mood impairment,and/or no behaviors.<br><br>The most recent Quarterly MDS assessment dated 6/3/15 indicated Resident #8 experienced moderate cognitive impairment, no mood impairments, and/or no behaviors.<br><br>A Care Plan dated 4/2/15 for "Psychoactive Medications r/t [related to] dementia with behavioral disturbances, major depression, anxiety...increase in hallucinations and confusion..." with the following interventions: "Administer medications as ordered. Monitor/document for side effects and effectiveness...Discuss with MD [medical doctor], family re [in regards to] ongoing | | **deficient practice will not recur,i.e., what quality assurance program will be put into place:** Careplans and behaviors will be monitored in a weeklymeeting that will be ongoing. New behaviors will be addressed as they arise andindividualized interventions will be assessed for effectiveness. This processwill be monitored using a behavior management tool. The Behavior managementtool will be utilized monthly 4 then monthly and reported to the QualityAssurance team Quarterly. Monitoring will be completed on all 3 shifts and will be ongoing **By what date thesystemic changes will be completed:** 7/30/2015 | |

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| | need for use of medication...Educate the resident/family/caregivers about risks, benefits, and the side effects and/or toxic symptoms of psychoactive medication drugs being given...IDT [Interdisciplinary team] Pharmacy, and physician to review [sic] periodically to consider dosage reduction or d/c [discontinue] of medication as clinically appropriate...Monitor/record report / to MD prn [as needed] side effects and adverse reactions of psychoactive medication:unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideation, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, behavior symptoms not usual to the person..The resident is on Hypnotics. The resident prefers the following sleep encouragement techniques. Limit Caffeine intake after supper, decrease noise level after 10 pm [sic] [evening] Provided lighting that is conducive for sleep, regular bedtime routine, maximize daily activities, encourage socialization, contact [name of psychiatrist] Luvox (a medication for depression and anxiety) as ordered" The plan of care lacked any intervention related to the ongoing monitoring of the behaviors of Resident | | | |

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| | #8.<br><br>The Nursing notes from 4/4/15 through 6/16/15 were reviewed and the following was noted:<br><br>4/4/15 at 8:00 A.M., "...Resident lying in bed no response to voice...res [resident] upset and states 'Can't you tell when someone is trying to act like they're dead!'..."<br><br>4/6/15 at 10:40 P.M., "...tearful around supper, thought someone took her daughter and then needed to take one of the residents to [name of nearby town]..."<br><br>4/13/15 at 4:00 P.M., "...resident wanting to leave...resident kicked staff in the leg...resident...took her [staff] arm grabbed wrist of staff twisting and pinching...'I don't care...' very tearful insist on wanting to go home..."<br><br>4/13/15 at 4:30 P.M., "...trying to get up wanting to go home nurse was giving her, her medication et [and] she refused stated 'I'm not taking them just throw them away, I said throw them in the trash' resident in front of refrigator [sic] not wanting to move from the spot continues to be tearful..."<br><br>4/13/15 at 7:00 P.M., "resident [up] in | | | |

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| | w/c [wheelchair] yelling out 'I'm here, I'm here'...tearful...saying 'I want to go home leave me alone'...resident in hallway tarful [sic]..."<br><br>4/15/15 at 10:40 P.M., "...Resident yelling out she wanted to go home...refused supper said 'take that away or you'll find it on the floor'...in w/c resident rolled down hall way [sic] yelling 'you all are liars' kicking on the doors wanting out, kicking...by nursing station sat in front of door tearful wanting to go home...resident continues to be tearful..."<br><br>4/16/15 at 10:30 P.M., "...very confused the pm [evening] wanting to go home-got very [up]set and threw her eye glasses [sic] yelled, uncooperative..."<br><br>4/17/15 at at 9:00 P.M., "Res had behaviors of kicking at staff..."<br><br>4/19/15 at 10:30 P.M., "...after supper was starting to yell out..."<br><br>4/20/15 at 11:25 P.M., "Resident wanting to go home..."<br><br>4/22/15 at 2:00 P.M., "Tearful this AM [morning]..."<br><br>4/22/15 at 11:30 P.M., "resident tearful | | | |

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| | before supper wanting to go home...continued with tears took resident for walk down to her room she continued to cry...continued with tears stated 'just leave me alone'..."<br><br>4/24/15 at 9:00 P.M., "...behaviors...increasing..."<br><br>4/26/15 at 3:05 P.M., "resident had been crying wanting to go home...very confused...began crying harder..."<br><br>4/26/15 at 5:00 P.M., "when supper arrived res slid her food down the table and anounced [sic] she was not eating-all through supper Res was instigating behaviors with other residents"<br><br>4/26/15 at 8:00 P.M., "behaviors increased through eve"<br><br>5/4/15 at 9:00 A.M., "Res tearful et [and] mean to staff in the PM..."<br><br>5/8/15 at 8:05 A.M., "Resident tearful the AM [morning] et resistant to assitance [sic] in transfers et [with] care. Res hitting et kicking @ (at) staff..."<br><br>5/16/15 at 9:00 A.M., "res not redirected easy wanting to 'go home'..."<br><br>5/18/15 at 3:00 P.M., "...Resident was | | | |

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| | agitated this pm..."<br><br>5/20/15 at 10:00 P.M., "...[increased] anxiety noted et episodes of crying..."<br><br>5/21/15 at 5:25 A.M. "...Res up until 0200 [2:00 A.M.] this morning with several episodes of tearfulness with [increased] anxiety, worrying over family..."<br><br>5/22/15 at 12:00 P.M., "Is kind of in a crying mood today. Talking about her [deceased family member]: think [sic] [name of another resident] is him and upset because her won't pay and [sic] attention to her..."<br><br>5/31/15 at 9:00 A.M., "Res upset, crying, screaming at... staff ...states 'I just want to die...I want to be with [deceased family member]..."<br><br>6/3/15 at 11:00 A.M., "...fights with staff...[increased] agitation..."<br><br>6/3/15 at 11:50 A.M., "Resident tearful et resistant to staff..."<br><br>6/5/15 at 2:00 P.M., "res crying looking for baby adamant to go find baby...still tearful..."<br><br>6/5/15 at 3:20 P.M., "res...stated 'I'm | | | |

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| | going home...I'm leaving + [and] going home...crying..."<br><br>6/5/15 at 11:30 P.M., "Resident up in dining room crying stating 'I want to go home'...stating 'I am leaving, I will walk home'..."<br><br>6/6/15 at 8:00 P.M., "Res was angry + very adjitated [sic]...would have periods of crying..."<br><br>6/7/15 at 1:15 P.M., "Pt [patient] continue to cry off and on..."<br><br>6/7/15 at 9:00 A.M., "...was fine until this hour + began crying..."<br><br>6/8/15 at 2:00 P.M., "Res cont [continue] to be obsessed... [name of another resident]...Thinks he is 'cheating' on her..."<br><br>6/9/15 at 2:00 P.M., "Res has been kicking, scratching, pinching et cursing at staff, resistant to care, refused.., meds [medications]. Thinks everyone is against her..."<br><br>6/9/15 at 9:30 P.M., "Was trying to move CNA out of her way so she could go find her [name of deceased family member] what did we do with him: not right to keep them apart: which rm [room] is he | | | |

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| | in: I want to be with him, got really loud. Thought she was going to hit this nurse: Has been very unpleasant..."<br><br>6/14/15 at 8:00 A.M., "...refused to get [up] out of bed, crying, resisting care...'just wants to be left alone'..."<br><br>6/14/15 at 12:00 P.M., "Res [up] in w/c in dining room taking pull alarm off et throwing it across room, screaming at staff, pinching staff, crying..."<br><br>6/14/15 at 5:00 P.M., "...was combative when this nurse tried to obtain [blood glucose]..."<br><br>6/16/15 at 10:00 P.M., "Resident very agitated thru shift. Had spells of crying et would then become very hateful to staff..."<br><br>The nursing notes between 4/4/15 through 6/16/15 indicated Resident #8 experienced 39 episodes of mood disturbance and/or behaviors.<br><br>A Care Plan for behaviors dated 5/1/15 included, but was not limited to, an intervention of, "Monitor. [sic] document observed behavior and attempted interventions in behavior log"<br><br>During an interview on 6/29/15 at 4:00 | | | |

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| | P.M., the SSD [Social Service Director] #2 indicated Resident #8 was followed with a behavior management program and it was the usual practice for nursing staff to document behaviors on a tracking record. SSD #2 then indicated, the nursing notes were monitored for behavior documentation and presented All-Staff Behavior Tracking Records from 4/1/15 through 6/29/15. The records were reviewed and indicated Resident #8 experienced 4 episodes of behavior from 4/1/15 through 6/16/15.<br>2. On 6/26/15 at 9:30 A.M., Resident #224 was observed in secured unit A sitting on the edge of her bed, no distress or behaviors observed.<br><br>Resident #224's clinical record was reviewed on 6/26/15 at 3:00 P.M. Resident #224 had been admitted to facility on 6/8/15. Diagnoses included but not limited to, intermittent explosive D/O (disorder), psychosis, anxiety, dementia with behavioral disturbance, and diabetes mellitus.. Admission physician orders of 6/8/15 included but were not limited to, psychotropic medications: Xanax (antianxiety medication), Geodon (antipsychotic medication), Topamax (mood stabilizer medication),and Artane (medication to prevent EPS (extrapyramidal symptoms), and Ativan (antianxiety medication). | | | |

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| | The resident's current care plan with an initiation date of 6/9/15 addressed the problems of : "The resident has a behavior problem r/t [related to] intermittent explosive disorder. She has a history of slapping nurses and CNAs ripping their clothes, wondering in and out of other resident rooms, refuses medication, refuses adl (activities of daily living) care, and at times to eat and drink. She is also dx (diagnosed) with Alzheimer's dementia. She has spent several weeks in Mental Health hospital with many medication adjustments. Goal: The resident will have no evidence of behavior problems by review date." Interventions included but were not limited to, "...Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. ...Resident likes to carry and rummage through her purse, She likes to look for her dog and has a stuff dog in her purse..."<br><br>On 6/29/15 at 3:23 P.M., the Social Service Director (SSD) was interviewed regarding Resident #224's behaviors and monitoring of her behaviors. The SSD indicated the resident had been admitted to the facility on 6/8/15 from a | | | |

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| | psychiatric hospital unit. She indicated the behaviors being monitored at the facility currently and since admission were: 3 behaviors of: wandering, potential to hit at staff, and refusing care. The SSD indicated unit A where Resident #224 resided had a behavior log manual which contained "ALL STAFF BEHAVIOR TRACKING RECORDS." The SSD indicated nurses, CNAs, and all staff were to complete the "All Staff Behavior Tracking Record" for any behavior observed. The tracking record recorded the behavior that occurred, the staff intervention and the effective and ineffective intervention. The tracking record also had a section that indicated, "...DESCRIBE IN DETAIL EXACTLY WHAT OCCURRED. The SSD indicated 1 behavior tracking record had been initiated on 6/22/15 at 7:00 A.M., by a CNA since admission to the facility on 6/8/15. The record indicated, "Other CNA was try to get washcloth out linen closet heard other CNA can I have help (sic) came out of room seeing resident hitting staff, kick CNA. I asked resident to come with me she started shoving me. Hitting at me too."<br><br>On 6/29/15 at 3:30 P.M., the following behaviors documented in the nursing notes of Resident #224 was reviewed with the SSD. | | | |

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| | Nursing note 6/9/15 at 9:30 P.M., indicated, "Resident has had alarms going off on both door, did get out A wing hall door. Was able to get her to come back inside. No happy: Has been [initials of male resident's] room several times and has had to talk c [with] her about this. States this is my rm [room] and I will as I please. Needless to say [male resident's initials] was not happy. Was kicking at other residents: [Female resident's initials] and she pinched her and left bruises on left forearm... ...Has been in and out of resident rms. Thinks she has to take care of them..."<br><br>Nursing note 6/12/15 at 8:00 P.M., indicated, "... Res [resident] was on hands & knees trying to unplug cords behind night stand in another res room..."<br><br>Nursing note 6/15/15 at 2:00 P.M., Resident confused , ambulating all over the unit... ... Resident pulled down pants sat in chair in dining room et urinated in the chair c [with] other residents in the room. Resident also took the shoes off another resident thinking they belong to this resident... ... Another resident touched resident to tell resident to turn around et this resident smacked other resident on the arm..." | | | |

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| | 155042 | | 06/30/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| WILLOW MANOR | 3801 OLD BRUCEVILLE RD BOX 136<br>VINCENNES, IN 47591 |

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| | Nursing note 6/18/15 at 11:30 P.M., Resident awake et walking in hallway attempted to redirect res from other residents rooms. Res resistant to redirection telling staff to 'Leave me alone' et [and] swatting @ [at] staff..."<br><br>Nursing notes on 6/18/15 at 2:00 P.M., indicated, "Res [resident] has been up wandering halls all shift, res wants to mess c [with] electric cords on everything she sees, close supervision required..."<br><br>Nursing notes on 6/20/15 at 3:00 P.M., res [resident] wandered into room [room number ]- male res began yelling get out of my room. Get her out of my room-CNA was walking up the hall heard the yelling ran to intervene. Saw male res pushing res out of his room backwards when resident came out the door fast & backwards landing on the floor on her back..."<br><br>Nursing notes on 6/22/15 at 7:10 A.M., Res[resident] walked up behind another resident who was sitting in chair and started punching him in the back of his head. The nurse got between residents et redirected. This resident was almost unredirectable 1:1 supervision given until calmed.<br><br>Nursing notes dated 6/23/15 at 7:15 | | | |

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| | A.M., indicated, " Resident pinched another resident on L[left] forearm, residents separated. This resident agitated this am, labs et U/A [urinalysis] pending . Will monitor closely to prevent further behaviors..."<br><br>Nursing notes dated 6/24/15 at 9:30 P.M., indicated, "Resident upset et agitated this shift. Would hit staff when tried to redirect resident. Would go in et out of residents room pulling things from closets..."<br><br>The SSD indicated at that time the behaviors documented in the above nursing notes should have been logged on the behavior tracking sheets. SSD indicated she checked the behavior tracking sheets to monitor Resident #224's behaviors.<br><br>On 6/29/15 at 4:01 P.M., the SSD was made aware of the facility behaviors being monitored ( refusing care, potential to hit at staff, and wandering) lacked the monitoring of aggressive behavior toward other residents. The SSD was also made aware the resident's care plan did not address aggressive behavior toward other residents.<br><br>A care plan with an initiation date of 6/29/15 was reviewed on 6/30/15 at 3:18 | | | |

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| | P.M. The care plan addressed the problem of, "The resident is/has potential to demonstrate physical behaviors toward staff and others r/t [related to] Dementia, Poor impulse control." The care plan goals included but were not limited to, "... The resident will not harm self or others through the review date..." Interventions included but were not limited to, "... Monitor (FREQ) [frequently]. Document observed behavior and attempted interventions in behavior log... When the resident becomes agitated: Intervene before agitation escalates..."<br><br>The Policy and Procedure for Social Services provided by the DON (Director of Nursing) on 6/30/15 at 12:45 P.M. indicated, Policy: 2. Medically-related social services is provided to maintain or improve each resident ability to control everyday...mental and psychosocial needs...g. Behavioral problems..."<br><br>3.1-34(a)(1) | | | |
| F 0258<br>SS=D<br>Bldg. 00 | 483.15(h)(7)<br>MAINTENANCE OF COMFORTABLE SOUND LEVELS<br>The facility must provide for the maintenance of comfortable sound levels. | F 0258 | **F 258 What** | 07/30/2015 |

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| | Based on observation and interview, the facility failed to ensure comfortable sound levels were maintained, in that, equipment was noisy and/or construction noise was disturbing for 1 of 1 resident who met the criteria for review of sound levels. (Resident #223)<br><br>1. During an interview on 6/25/15 at 10:20 A.M., Resident #223 indicated the noise of the carts traveling through the hall and the construction noise at random times affected her comfort. During an interview on 6/29/15 at 8:42 A.M., Resident #223 indicated, the equipment was very noisy when staff pushed it through the hall and stated, "...it is disturbing..."<br><br>2. During an observation on 6/30/15 at 9:16 A.M., LPN #2 was observed pushing a barrel through the Unit E hallway. The wheels on the barrel were observed, at that time, to create a loud, high-pitched squeak.<br><br>3. During an observation on 6/29/15 at 11:50 A.M., CNA #22 was observed pushing a barrel through the Unit E hallway. The wheels on the barrel were observed, at that time, to create a loud, high-pitched squeak.<br><br>During an interview on 6/29/15 at 3:15 | | **Correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice:** Maintenance will assess all cart and lubricate the cartsthat are squeaky. Staff will be educated and made aware of acceptable noiselevels. **How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by thisdeficiency. **What measures willbe put into place or what systemic changes will be made to ensure that thedeficient practice does not recur:** The Carts will be placed on a preventative maintenanceschedule. Random interviews with Residents will be conducted to see if thenoise level is acceptable. **How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place:** Squeaky Carts will be placed on a preventativemaintenance schedule for monitoring. Staff will be educated to report noisy orloud carts to maintenance as soon as they are noted to be loud. Observationswill be completed monthly for noisy or loud carts. | |

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| | P.M., the Housekeeping Supervisor indicated no policy could be provided related to excessive noise, but it was the policy of the facility to limit excessive noise.<br><br>3.1-19(f) | | Interviews will be conductedweekly x4 then monthly. All reports will be submitted to the Quality Assuranceteam for review quarterly. Monitoring will be completed on all 3 shifts and will be ongoing **By what date thesystemic changes will be completed:** 7/30/2015 | |
| F 0279<br>SS=D<br>Bldg. 00 | 483.20(d), 483.20(k)(1)<br>DEVELOP COMPREHENSIVE CARE PLANS<br>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.<br><br>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.<br><br>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). | | | |
| | Based on observation, interview, and record review, the facility failed to ensure a resident with a urinary catheter had a care plan to address nursing care and potential adverse effects of urinary catheter use for 1 of 2 residents who met | F 0279 | **F 279 What Correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice:** A plan of care was written for Resident #106 to | 07/30/2015 |

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| | the criteria for catheter review. (Resident #106)<br><br>Findings include:<br><br>On 6/26/15 at 9:45 A.M., Resident #106 was observed in bed and a Foley catheter draining bag was observed uncovered at the bedside.<br><br>On 6/26/15 at 10:42 A.M., Resident #106's clinical record was reviewed. Documentation indicated he had been admitted to the facility on 1/27/15. His current Minimum Data Set assessment (MDS) dated 4/7/15, indicated cognition intact and a indwelling urinary catheter. Diagnoses included, but were not limited to, fistula of intestine, colostomy, and morbid obesity.<br><br>His current routine physician orders of June 2015 included but were not limited to, "CHANGE F/C [Foley catheter] BAG 15TH OF EVERY MONTH [1/27/15]", "... F/C CATH [catheter] EVERY SHIFT [2/27/15]", and "... CHANGE MONTHLY 5TH & AS NEEDED FOR LEAKAGE FR [french]16 10# CC... [3/31/15]"<br><br>On 6/26/15 at 11:11 A.M., during interview with Resident #106's Unit Manager, UM #5, she was made aware of | | addresshis urinary catheter and is in place. **How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken:** All residents with Catheters have the potential to beaffected by the deficient practice. **What measures willbe put into place or what systemic changes will be made to ensure that thedeficient practice does not recur:** All residents with foley catheters charts were reviewedfor plan of care relating to foley catheters. Nursing staff will be eduated toaddress care of a foley catheter and the adverse effects of a foley catheter. **How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place:** Careplans will be monitored monthly x 3 months and thenthey will be evaluated quarterly with each MDS assessment. A careplan audittool will be used to report findings to the Quality Assurance Team quarterly. Monitoring will be completed on all 3 shifts and will be ongoing **By what date thesystemic changes will be completed:** 7/30/2015 | |

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| | documentation lacking of a care plan to address the nursing care of Resident #106's urinary catheter. UM #5 agreed at that time a care plan was lacking for Resident #106's urinary catheter and a care plan was needed.<br><br>On 6/30/15 at 10:47 A.M., UM #5 provided a care plan with an initiation date of 6/29/15, that addressed the care of Resident # 106's urinary catheter. Goal indicated, " The resident will show no s/sx [signs or symptoms] of Urinary infection through review date..."<br><br>A facility policy entitled, "Policy and Procedure for CARE PLANNING (undated) included, "All Residents will have a plan of care addressing the actual problem and potential problems identified through the assessment data on the MDS (Minimum Data Set assessment) and other accompanying assessments..."<br><br>3.1-35(b)(1) | | | |
| F 0280<br>SS=D<br>Bldg. 00 | 483.20(d)(3), 483.10(k)(2)<br>RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or | | | |

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| | changes in care and treatment.<br><br>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.<br><br>Based on observation, interview, and record review, the facility failed to ensure care plans were revised, in that, a fall care plan was not revised with new, immediate, and/or effective interventions after each fall for a cognitively impaired, dependent resident who experienced 12 falls (Resident #8) and/or a cognitively impaired dependent resident who experienced unstageable pressure wounds. (Resident #109) for 2 of 18 residents who met the criteria for review of care plans.<br><br>Findings include:<br><br>1. On 06/25/15 at 9:30 A.M., Resident #8 was observed in a TV lounge sitting in a wheelchair with a cast on the left upper extremity.<br><br>During an interview 6/25/15 at 10:06 A.M., UM #10 indicated Resident #8 | F 0280 | **F 280 What Correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice:** Careplans for resident # 8 (falls) and # 109(pressure) were updated. **How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by thedeficient practice. **What measures willbe put into place or what systemic changes will be made to ensure that thedeficient practice does not recur:** Fall and Pressure areas will be reviewed each morning atthe Change of Condition Meeting to review careplans for revisions andappropriate interventions. Management and nursing staff | 07/30/2015 |

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| | experienced frequent falls.<br><br>The clinical record of Resident #8 was reviewed on 6/29/15 at 9:30 A.M. The record indicated Resident #8 was admitted on 1/29/15 with diagnoses including, but not limited to, left arm fracture.<br><br>A Fall Risk Assessment dated 1/29/15 indicated Resident #8 was a high risk to experience a fall.<br><br>A Care Plan dated 1/31/15 for "Potential for Falls related to...psychotropic med use, confusion..." with interventions of, "assist with toileting every two hours and as needed, encourage resident to be compliant with limitations and to ask for assistance as needed, ensure proper footwear, evaluate all falls for cause and attempt to prevent further falls, innitiate [sic], keep call-light in reach and encourage resident to use it to ask for assistance, notify family and physician of all falls, PT [Physical Therapy/OT [Occupational Therapy] to evaluate and treat as needed, place Dycem [name of anti-slip device] in w/c [wheelchair]"<br><br>The Admission MDS (Minimum Data Set) assessment dated 2/4/15 indicated Resident #8 experienced minimal cognitive impairment, required the | | will be re-educated onthe Skin and Fall Guidelines. Interdisciplinary post fall review will beinitiated by nursing staff and completed by Nursing Management. Change of Condition form will be completed 5xper week to ensure change of condition and new orders are followed through. **How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place:** Falls and pressure will be monitored 5 x weekly with theChange of Condition form during the Change of Condition Meeting. The results of this report will be presentedto the Quality Assurance Team quarterly. Monitoring will be completed on all 3 shifts and will be ongoing **By what date thesystemic changes will be completed:** 7/30/2015 | |

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| | limited assist of one staff for transfers and/or walking, had no history of falls prior to admission and/or had experienced 1 fall since admission to the facility.<br><br>A Quarterly MDS assessment dated 3/28/15 indicated Resident #8 experienced moderate cognitive impairment, required the limited assist of one staff for transfers and/or walking, and had experienced no further falls.<br><br>Fall #1: A Nursing note dated 4/4/15 at 9:15 P.M., indicated Resident #8 experienced a fall from a bed side commode. The note lacked any documentation to indicate a new, immediate, and/or effective intervention was initiated to ensure the safety of Resident #8.<br><br>Fall #2: A Nursing note dated 4/5/15 at 2:30 P.M., indicated, Resident #8 experienced a fall from a wheelchair. The note lacked any documentation to indicate a new, immediate, and/or effective intervention was initiated to ensure the safety of Resident #8.<br><br>Fall #3: A Nursing note dated 4/12/15 at 2:10 P.M., indicated Resident #8 experienced a fall from a wheelchair. The note lacked any documentation to | | | |

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| | indicate a new, immediate, and/or effective intervention was initiated to ensure the safety of Resident #8.<br><br>Fall #4: A Nursing note dated 4/26/15 at 3:05 P.M., indicated Resident #8 experienced a fall. The note lacked any documentation to indicate a new, immediate, and/or effective intervention was initiated to ensure the safety of Resident #8.<br><br>Fall #5: A Nursing note dated 5/7/15 at 10:15 P.M., indicated Resident #8 experienced a fall from the bed. The note lacked any documentation to indicate a new, immediate, and/or effective intervention was initiated to ensure the safety of Resident #8.<br><br>Fall #6: A Nursing note dated 5/15/15 at 3:30 P.M., indicated Resident #8 experienced a fall while independently ambulating with a walker. The note lacked any documentation to indicate a new, immediate, and/or effective intervention was initiated to ensure the safety of Resident #8.<br><br>Fall #7: A Nursing note dated 5/15/15 at 10:00 P.M., indicated Resident #8 experienced an unwitnessed fall in the hallway, a non-functioning bed alarm was observed on the bed and/or an | | | |

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| | immediate intervention of "new alarm" was initiated to ensure the safety of Resident #8. During an interview on 6/29/15 at 11:50 A.M., UM #10 indicated no documentation could be provided to indicate when the bed alarm was initiated. The note lacked any documentation to indicate a new, immediate, and/or effective intervention was initiated to ensure the safety of Resident #8.<br><br>Fall #8: A Nursing note dated 5/18/15 at 3:00 P.M., indicated Resident #8 experienced a fall from a chair in the dining room. The note lacked any documentation to indicate a new, immediate, and/or effective intervention was initiated to ensure the safety of Resident #8.<br><br>Fall #9: A Nursing note dated 5/21/15 at 8:00 P.M., indicated Resident #8 experienced a fall from a chair in the dining room. The note lacked any documentation to indicate a new. immediate, and/or effective intervention was initiated to ensure the safety of Resident #8.<br><br>Fall #10: A Nursing note dated 5/29/15 at 2:50 P.M., indicated Resident #8 experienced a fall from a chair in the dining room. The note lacked any | | | |

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| | documentation to indicate a new. immediate, and/or effective intervention was initiated to ensure the safety of Resident #8.<br><br>Fall #11: A Nursing note dated 5/30/15 at 9:00 A.M., indicated Resident #8 experienced a fall from a sit to stand lift. The note lacked any documentation to indicate a new, immediate, and/or effective intervention was initiated to ensure the safety of Resident #8.<br><br>The most recent MDS assessment dated 6/3/15 indicated Resident #8 experienced moderate cognitive impairment, required the limited assist of one staff for transfers and/or walking, and had experienced 3 additional falls since the previous quarterly assessment.<br><br>A Fall Risk Assessment dated 6/8/15 indicated Resident #8 was at a high risk to experience a fall.<br><br>Fall #12 A Nursing note dated 6/16/15 at 10:00 P.M., indicated Resident #8 experienced a fall from a chair and "fell on left arm...noted indentation to left arm above wrist..." The note lacked any documentation to indicate a new, immediate, and/or effective intervention was initiated to ensure the safety of Resident #8. | | | |

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| | A Care Plan for Falls dated 5/30/15 lacked any documentation a new, immediate, and/or effective intervention was initiated after each fall on 4/4/15, 4/5/15, 4/12/15, 4/26/15, 5/7/15, 5/15/15 (two falls), 5/18/15, 5/21/15, 5/29/15, 5/30/15, 6/16/15.<br><br>During an interview on 6/29/15 at 12:15 P.M., UM #10 indicated no documentation could be provided to indicate new, immediate, and/or effective interventions were initiated after each fall of 12 falls between 4/4/15 and 6/16/15. UM #10 further indicated, at that time, she was not aware new, immediate, and/or effective interventions to ensure the safety of Resident #8 should have been implemented after each fall. UM #10 then indicated, Resident #8 should have been re-assessed after each fall to prevent further falls.<br><br>The Policy and Procedure for Fall Management provided by the DON (Director of Nursing) on 6/30/15 at 10:30 A.M. indicated, "...All residents will be assessed...for significant change...The IDT [Interdisciplinary Team] modifies and implements a Care Plan and treatment approach to minimize repeat falls. The Care plan will be ...revised as indicated...Each facility is responsible for | | | |

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| | implementing individualized interventions related to/for each resident's fall risk.<br><br>2. On 6/29/15 at 8:35 A.M., Resident #109 was observed in the bed on his right side. The right heel was observed, at that time, to have a blue boot on and to be in contact with the surface of the bed. The left heel (medial side) was observed at that time to be in contact with the surface of the bed. A white boot was lying next to his left foot and both heels were not floated.<br><br>During an interview on 6/29/15 at 8:45 A.M., CNA #6 indicated she had turned and repositioned Resident #109 at 8:30 A.M., and that CNA #6 would turn and reposition Resident #109 again at 10:30 A.M.<br><br>On 6/29/15 at 9:40 A.M., Resident #109 was observed in bed on his right side. The right heel was observed, at that time, to have a blue boot on and to be in contact with the surface of the bed. The left heel (medial side) was observed, at that time, to be in contact surface of the bed. A white boot was lying next to his foot and both heels were not floated.<br><br>On 6/29/15 at 10:10 A.M., during an observation of a dressing change, | | | |

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| | Resident #109 was observed in bed on his right side. The right heel was observed, at that time, to have a blue boot on and to be in contact with the surface of the bed. The left heel (medial side) was observed, at that time, to be in contact with the surface of the bed. A white boot was lying next to Resident #109's foot and both heels were not floated. At that time, LPN #12 indicated the boot should have been on his foot, but the two Velcro straps were missing and could not be secured in place. LPN #12 said, "We don't have an abundance of boots here. They are hard to come by." LPN #12 then cleaned and applied sure prep (skin protectant) to a red, non-blanchable area the size of a quarter on the lateral side of left heel, at which time LPN #12 indicated that the area was discovered Friday. LPN #12 then noticed a new unblanchable red area, the size of a nickel, on the medial side of the left heel. The right heel was removed from the boot and two unstageable pressure areas were cleaned and sure prep was applied. At that time, LPN #12 indicated the large, purple pressure area was discovered first, and that a week later the purple area on the inner heel was discovered. LPN #12 indicated Resident #109 had experienced a decline recently and had started developing pressure ulcers. LPN #12 stated, "He just doesn't | | | |

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| | want to get out of bed anymore." LPN #12 exited the room without floating Resident #109's heels or repositioning Resident #109.<br><br>The clinical record of Resident #109 was reviewed on 6/26/15 at 9:30 A.M. The clinical record indicated Resident #109 was admitted to the facility on 12/20/12 with no skin impairment to the right heel and diagnoses including, but not limited to, CVA (stroke), hemiplegia, Parkinson's disease, anxiety and depression.<br><br>The Quarterly MDS (Minimum Data Set) assessment dated 3/30/15 indicated Resident #109 was at risk for the development of a pressure ulcer, experienced mild cognitive impairment, and required the assistance of one staff for bed mobility.<br><br>The last completed Quarterly Nursing Assessment dated 10/5/15 indicated Resident #109 was at risk for the development of a pressure ulcer and had no skin impairment to the right or left heel at that time.<br><br>A Care Plan dated 12/2/11 indicated, "...The resident has potential for impaired skin...r/t [related to]...history of skin breakdown...Interventions...The resident needs assistance to turn/reposition at least | | | |

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| | every 2 hours...Pressure relieving/reducing bed...Administer treatments as ordered...Educate resident...as to causes of skin breakdown...importance of frequent repositioning...6/15/15 sure prep bilat [bilateral heels]...heel protectors while in bed float heels..." The last update to the care plan prior to 6/15/15 was an update on 1/31/14. The care plan lacked documentation Resident #109 had experienced a decline and had become totally dependent for care and bed mobility.<br><br>The Physician's Orders dated 6/15/15 read as follows: "...Sure prep for R (right) heel q [every] shift float heels at all times while in bed..."<br><br>The CNA assignment sheet dated 5/13/15 was provided by UM #1 and reviewed on 6/25/15 at 10:00 A.M., and it read as follows: "...turn and reposition...yes...float heels..."<br><br>A Nurse's note dated 6/1/15 at 1600 (4:00 P.M.) read as follows: "...Res (resident) requiring the assistance of 2 for transfers."<br><br>A Nurse's note dated 6/15/15 at (time not documented) read as follows: "...R [right] heel with 22 soft dark purple UTD | | | |

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| | [unable to determine] nonblanchable area. tender to touch. N.O. [new orders] Sure Prep q [every] shift and float heels at all times while in bed."<br><br>A Nutritional Therapy Quarterly Progress note dated 6/22/15 indicated Resident #109's skin was intact. No supplements were ordered.<br><br>A. A "WEEKLY PRESSURE ULCER RECORD" for the right heel dated 6/15/15 indicated Resident #109 experienced a pressure ulcer to the right heel. The assessment further indicated, "un-stageable...non-removable dressing, slough/eschar, suspected deep tissue injury in evolution...dark purple...soft nonblanching...length...2 [two centimeters]...width...2 [two centimeters]...PREVENTIVE MEASURES...Turned every 2 hours...Pressure Relieving Interventions float heels...6/17/15 heel protectors; Sure prep." The Nutritional/Hydration Status was not completed on the form.<br>A "WEEKLY PRESSURE ULCER RECORD" dated 6/26/15, (eleven days later) indicated the unstageable pressure area to the right heel had increased in size to 3 cm in length to 3 cm in width. A description of the wounds' appearance was not recorded. | | | |

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| | B. A "WEEKLY PRESSURE ULCER RECORD" for the inner right heel dated 6/26/15 indicated Resident #109 experienced a pressure ulcer to the inner right heel. The assessment further indicated, "RISK FACTORS/CAUSE...decline in cond [condition]...un-stageable...non-removabl e dressing, slough/eschar, suspected deep tissue injury in evolution...length...2 [two centimeters]...width...1 cm...Sure prep, foam heel protectors, float heels...PREVENTIVE MEASURES...Turned q [every] 2 hours...Air mattress..." A description of the wounds' appearance was not recorded.<br><br>C. A "WEEKLY PRESSURE ULCER RECORD" for the inner left heel dated 6/29/15 indicated Resident #109 experienced a pressure ulcer to the inner left heel. The assessment further indicated, "...stage 1...intact skin with non-blanchable redness of a localized area usually over a bony prominence...length...2 [two centimeters]...width...1 cm... pink soft non-blanchable to left heel...heel protectors, air mattress, float heels..."<br><br>Documentation was lacking for the pressure area located on the left lateral (outer) aspect of the heel which was | | | |

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| | observed on 6/29/15 at 10:10 A.M. dressing change.<br><br>During an interview on 6/29/15 at 3:15 P.M., the Unit Manager for C and D halls (UM #1) indicated she was unaware of and could provide no documentation that Resident #109 had a pressure ulcer on the outer left heel. UM #1 indicated on 6/1/15 Resident #109 had experienced a decline. UM#1 further indicated Resident #109 was at risk to develop a pressure ulcer prior to his decline, but that Resident #109 was at a higher risk to develop a pressure area once he started the decline and did not want to get out of bed. UM #1 indicated no quarterly nursing assessment for determining Resident #109's Braden Scale (scale to determine risk for developing pressure ulcers) had been completed since 10/2014. UM #1 further indicated a new skin risk assessment and update to the care plan should have been completed when the decline was noticed. UM #1 said, "an order for heel protectors and float heels means to do both, put the heel protectors on at all times and to float the heels off a surface".<br><br>During an interview on 6/29/15 at 11:35 A.M., PT#1 indicated Resident #109 was totally dependent for care and could not reposition himself in the bed. PT #1 | | | |

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| | further indicated Resident #109 was especially weak on his right side.<br><br>During an interview on 6/30/15 at 4:05 P.M., LPN #12 indicated she was not sure if UM #1 knew about the pressure area on Resident #109's left outer heel. LPN #12 said, "It happened on the day we found the two stage 2 pressure ulcers on Resident #109's upper back. There was a lot going on that day, but we have been treating it with sure prep."<br><br>The Policy and Procedure for Skin Management provided by the Director of Nursing on 6/30/15 at 12:00 P.M. indicated, "...Following admission, the Braden Scale - For Predicting Pressure Sore Risk will be completed quarterly, annually, and with a significant change of status...following forms are completed...Weekly Pressure Record...A Care Plan...history of skin impairment or actual impairment..."<br><br>3.1-35(d)(2)(b) | | | |
| F 0282<br>SS=D<br>Bldg. 00 | 483.20(k)(3)(ii)<br>SERVICES BY QUALIFIED PERSONS/PER CARE PLAN<br>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. | F 0282 | **F 282 What** | 07/30/2015 |

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| | Based on observation, interview, and record review, the facility filed to ensure a plan of care was followed, in that a dependent resident was not provided assistance according to the physician's order for 1 of 7 residents who met the criteria for review of accidents. (Resident #10)<br><br>Findings include:<br><br>Resident #10 was observed on 6/24/15 at 10:30 A.M. sitting in a wheelchair in her room watching television in no apparent distress.<br><br>The clinical record of Resident #10 was reviewed on 6/26/15 at 9:43 A.M. The record indicated the diagnoses of Resident #10 included, but were not limited to, left ankle fracture.<br><br>The most recent annual MDS (Minimum Data Set) assessment dated indicated Resident #10 experienced no cognitive impairment and required the extensive assist of two staff for transfers.<br><br>The most recent quarterly MDS assessment dated 1/30/15 indicated Resident #10 experienced minimal cognitive impairment and required the extensive assist of two staff for transfers. | | **Correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice:** Staff was educated to use lifts according to the physician order, the careplan, and the assignments sheet **How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken:** All residents that are transferred with a mechanical lifthave the potential to be affected by the deficient practice. **What measures willbe put into place or what systemic changes will be made to ensure that thedeficient practice does not recur:** All plans of care will be reviewed and updated as needed.Staff will be educated to follow the plan of care as directed involvingmechanical lifts. **How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place:** An audit tool will be used to assess plans of care forresidents requiring the use of a mechanical lift. Observation will be performedto see that the plans of care for residents requiring the use of a mechanicallift are being followed. These audit tools will be completed weekly x4 and thenmonthly. All audits will be | |

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| | The March 2015 Physician's Order Recap included, but was not limited to an order for, "...up with lift and assist X [times] 2...pt [patient] able to use stand up lift..."<br><br>A Care Plan dated 10/14/14 for "Fall Risk Potential for Injury..." included, but was not limited to, an intervention of "...stand up lift for transfers..." The Plan of Care lacked any documentation related to the number of staff required for transfers.<br><br>A Quarterly Nursing Assessment dated 1/30/15 indicated Resident #10 required the use of an "assistive device for all transfers". The assessment lacked any documentation related to number of staff required for transfers.<br><br>A Nursing note dated 4/14/15 at 9:00 A.M. indicated, "...Unit Manager talked to pt. about the incident that occurred Sunday [4/12/15] [with] stand up lift et [and] pt L [left] foot was hurt. pt stated there was only [one] person that assisted her back to bed et [and] she tried to tell her foot was under the pedistal [sic] ..."<br><br>An untimed Interdisciplinary Team Progress note dated 4/14/15 indicated, "...happened 4/12/15 2100 [9:00 P.M.] Pt was being transferred to bed per stand up lift via 1 person that is assist of 2. L foot | | reportedquarterly to the Quality Assurance team. Random audits will be completed todetermine proper technique with utilizing a mechanical lift. Monitoring will be completed on all 3 shifts and will be ongoing **By what date thesystemic changes will be completed:** 7/30/2015 | |

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| | with shoes on got caught under the pedistal [sic]...Intervention inservice staff on use of stand up lift and pt needs assist of 2 @ [at] all times..."<br><br>The Policy and Procedure for Lifting provided by the DON (Director of Nursing) on 6/26/15 at 11:30 A.M. indicated, "...Transfer Activity is performed by nursing personnel based upon the Resident's needs..."<br><br>The Policy and Procedure for Lifting provided by the DON on 6/26/15 at 2:00 P.M. indicated, "...Using a Portable Machine Level of Responsibility...2. To promote comfort and to maintain body alignment while the resident is being moved..." During an interview, at that time, the DON indicated Resident #10 should have been transferred with the required amount of staff.<br><br>3.1-35 (g)(2) | | | |
| F 0309<br>SS=D<br>Bldg. 00 | 483.25<br>PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br>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 | | | |

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| | the comprehensive assessment and plan of care.<br><br>Based on observation, interview, and record review, the facility failed to ensure services were provided, in that, a resident's pain was unrelieved and increased when a pressure relieving device was not utilized as ordered by a physician for 4 of 5 days of the survey, for 1 of 4 residents who met the criteria for skin conditions and/or the fistula of same resident receiving dialysis was not assessed as ordered by the physician for 1 of 4 residents with dialysis. (Resident #182)<br><br>Findings include:<br><br>Resident #182 was observed on 6/24/15 at 4:15 P.M., Resident #182 was observed to have bruising around both eyes and a healing laceration to his forehead. At that time, during an interview, he indicated he had fallen forward from his recliner after falling asleep. He further indicated he had to lean forward and to the side to get off of his sore buttock.<br><br>Resident #182 was observed on 6/26/15 at 11:14 A.M., Resident #182 was observed sitting in a motorized wheel chair. Resident #182 was observed to be | F 0309 | **F 309 What Correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice:** A cushion was offered to resident #182 but he declinedstating that he wanted one his family had ordered. On 7.11.15 his familyarrived with a cushion and he is utilizing it. New orders were received tocheck his dialysis shunt every shunt.<br>**How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken:** All residents who have a risk of pressure or areparticipating in dialysis have a potential to be affected by the deficientpractices.<br>**What measures willbe put into place or what systemic changes will be made to ensure that thedeficient practice does not recur:** An assessment will be completed of all residents who atrisk of a pressure area for a cushion. Cushions will be provided to allresidents who are at risk of pressure or as needed. All residents who participate in dialysis willbe reviewed for orders to check their dialysis shunt. New orders will beacquired as needed. Staff will be educated on providing cushions for Residentsat Risk of Pressure and | 07/30/2015 |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| WILLOW MANOR | 3801 OLD BRUCEVILLE RD BOX 136<br>VINCENNES, IN 47591 |

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| | scooted toward the front edge of the wheel chair seat and lean forward while grimacing. At that time, during an interview, Resident #182 indicated he did that because his buttocks was sore as it had been for a long time. He further indicated his family was getting him a cushion to place in his chair and/or recliner, but it had not come in yet.<br><br>On 6/26/15 at 11:22 A.M., Resident #182's skin was observed with Licensed Practical Nurse (LPN) #2. Resident #182 was observed to have no open areas on his buttock and/or thigh.<br><br>The clinical record for Resident #182 was reviewed on 6/26/15 at 10:24 A.M., diagnoses included, but were not limited to, peripheral vascular disease, neuropathy, end stage renal failure, hemodialysis, and insulin dependent diabetes mellitus.<br><br>A care plan for potential skin impairment was initiated on 10/21/14 it included, but was not limited to, The resident needs, monitoring, reminding and/or assistance to turn and reposition at least every 2 hours, pressure reducing mattress on bed/chair, administer treatment as ordered, follow facility policies protocols for the prevention/treatment of skin breakdown, and monitor document | | assessing Dialysis shunts every shift. **How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place;** An audit will be completed for all residents for properpressure relieving equipment as indicated by the residents' careplan. An audittool will be utilized for all residents receiving dialysis for the properassessment and care of dialysis shunts. These audit tools will be completedweekly x 4 and then monthly. All audits will be reported to the QualityAssurance Team quarterly. Monitoring will be completed on all 3 shifts and will be ongoing **By what date thesystemic changes will be completed:** 7/30/2015 | |

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| | changes in skin status and report to medical doctor as needed.<br><br>A care plan for Resident #182 preference to sleep in a recliner was initiated on 10/22/14 it included, but was not limited to, honor residents preference to sleep in recliner, observed for restful nights sleep, keep pressure reducing cushion in chair.<br><br>A care plan for potential for pain was initiated on 10/21/14. The interventions include, but are not limited to, anticipate the need for pain relief and respond immediately to any complaints, evaluate effectiveness of pain interventions, Observe for and report signs and symptoms of pain to the nurse and report unresolved pain to the Medical Doctor.<br><br>On 6/29/15 at 2:50 P.M., Resident #182 was observed in his recliner with Certified Nursing Assistant #5. At that time, Resident #182 was observed to not have a cushion to his chair. CNA #5 indicated they did not know if Resident #182 should have a cushion in his chair. Resident #182 indicated his buttock was still very sore.<br><br>On 6/29/15 at 3:10 P.M., Resident #182's skin was observed with during care with CNA #5 and CNA #19. Resident #182 was observed to have a pencil eraser | | | |

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| | sized open area on his lower right buttock/thigh area. LPN #2 was notified and assessed the area.<br><br>During an interview with LPN #2 she indicated Resident #182 had had a cushion in his recliner but it had been taken out due to Resident #182 voicing complaints of sweating. She indicated his family had ordered him a new cushion but was unaware of when it would be received. She indicated she was not aware of another cushion being offered, but would ask the therapy department. The clinical record was reviewed. No documentation could be provided, to indicate resident #182 had refused use of a cushion.<br><br>During an interview on 6/29/15 at 3:05 P.M., Physical Therapy Assistant #10 indicated Resident #182 had been seen by therapy periodically in the past. She provided documentation that Resident #182 had received a ROHO (a pressure relief device) cushion for his recliner on 1/17/15 and indicated she did not know when the cushion was removed.<br><br>On 6/30/15 at 3:10 P.M., A Weekly Pressure Ulcer Record dated 6/29/15, indicated Resident #182 had a Stage 2 wound to his right lower buttock and/or upper thigh. The form indicated the area | | | |

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| | measured 0.5 x 0.4 x 0.1 centimeters and/or the resident experienced wound related pain.<br>The same resident, Resident #182 had a diagnosis of hemodialysis. On 6/26/15 at 12:00 P.M., Resident #182 was observed sitting in his recliner in his room.<br><br>The Quarterly Minimum Data Set assessment dated 5/31/15 indicated Resident #182 experienced moderate cognitive impairment and received dialysis services.<br><br>June 2015 routine physician's orders (before resident hospitalization 6/6, 6/7 and 6/8/15) included, but were not limited to, a physician's orders (order date 3/26/15) "...DIALYSIS ON M-W-F PT [patient] TO BE PICKED UP AT FACILITY AT 0500 and CHECK BRUIT AND THRILL TO AV [Arteriovascular Access] SHUNT EVERY SHIFT REPEAT sic (report) ABSENCE OF R/T TO MD (order date 3/1/15)..."<br><br>The June treatment sheet from 6/1/15 thru 6/5/15 (before hospitalization) included documentation by nurses' initials of 7-3, 3-11, and 11-7 shifts indicating monitoring of bruit and thrill of the AV shunt. The June 2015 treatment record dated 6/8/15 - 6/30/15 | | | |

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| | lacked documentation of any monitoring of bruit and thrill of resident's AV shunt.<br><br>On 6/29/15 at 9:55 A.M., Unit Manager #9 was made aware of the clinical record lacking documentation of the monitoring of the resident's dialysis shunt by checking of the bruit and thrill since the resident had been readmitted to the facility on 6/8/15. Unit Manager # 9 indicated at that time Resident #182 had been hospitalized on 6/6/15, 6/7/15, and returned to the facility on 6/8/15. She indicated the readmission orders of 6/8/15 had not included orders for dialysis or monitoring of the resident's A/V shunt. She indicated the nurse had missed it. At that time, Unit Manager #9 did not provide facility documentation indicating Resident #182 A/V shunt had been monitored for complications of hemodialysis, and/or that the bruit/thrill had been checked every shift, Unit Manager #9 indicated Resident #182's dialysis shunt needed to be monitored and she would notify the physician for orders and redo the current treatment documentation to include monitoring of the AV shunt every shift.<br><br>On 6/30/15 at 11:14 A.M., a facility policy entitled, "Monitoring dialysis (AV shunts) LEVEL OF RESPONSIBILITY (policy date 2003) was received and | | | |

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| | reviewed. The policy included but was not limited to, "... OBJECTIVES: to detect Complications of Hemodialysis sites related to infection, occlusions, or cannula separation. Purpose: Patency of access for Dialysis PROCEDURE : ...1. Visually monitor site and /or dressing. Palpate and monitor Bruit and thrill to AV shunt Q (every) shift. (Bruit is present on auscultation. A thrill is palpable)...<br><br>3.1-37(a) | | | |
| F 0312<br>SS=D<br>Bldg. 00 | 483.25(a)(3)<br>ADL CARE PROVIDED FOR DEPENDENT RESIDENTS<br>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.<br><br>Based on observation, interview, and record review, the facility failed to ensure services were provided to a dependent resident, in that, a resident who required assistance with oral care did not receive assistance with oral care for 1 of 3 residents who met the criteria for review of ADL's (Activities of Daily Living). (Resident #149)<br><br>Findings include: | F 0312 | **F 312 What Correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice:** Staff assisted resident #149 with the brushing of his orher teeth. **How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken:** All residents who require assistance | 07/30/2015 |

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| | During an interview on 6/30/15 at 1:30 P.M., Resident #149 indicated she needed assistance for oral care and had not received any assistance with oral care. Resident #149 said, "...it's been awhile..." At that time, mouth care supplies were not present in the resident's room or bathroom.<br><br>During an interview on 6/30/15 at 1:30 P.M., CNA #18 indicated she could not find Resident #149's toothbrush and did not know what had happened to it. CNA #18 indicated Resident #149's morning care was completed before she arrived to work.<br><br>The clinical record of Resident #149 was reviewed on 6/30/14 at 2:00 P.M. The record indicated the diagnosis of Resident #149 included, but were not limited to, Alzheimer's, anxiety, and dementia.<br><br>The Admission MDS (Minimum Data Set) assessment dated 3/24/15 indicated Resident #149 experienced cognitive impairment, required the extensive assistance of two staff for hygiene and/or experienced no episodes of refusing care.<br><br>A Plan of Care dated 10/24/12 for "Self care deficit: all ADL's... related to: | | with the brushing oftheir teeth have the potential of being affected by this deficient practice. **What measures willbe put into place or what systemic changes will be made to ensure that thedeficient practice does not recur:** All residents identified needing assistance with ADL'swill have their plans of care reviewed and updated as needed. C.N.A assignmentssheets will be updated as well. We willensure all residents have tooth brushes and toothpaste. Staff will bere-educated on giving Oral Care. **How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place:** An audit tool will be used to monitor teeth brushing.Observation will be completed weekly x 4 and then monthly. All audits will be submitted to theQuality Assurance Team meeting quarterly. Monitoring will be completed on all 3 shifts and will be ongoing **By what date thesystemic changes will be completed:** 7/30/2015 | |

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| | weakness" included, but was not limited to, interventions of "...extensive assist with ADL's...mouth care daily and prn (as needed)..."<br><br>The Policy and Procedure for oral Hygiene provided by the Director of Nursing (DON) on 6/30/15 at 3:00 P.M. indicated that "...1. A resident should be assisted with brushing his or her teeth based on his or her needs..."<br><br>3.1-38(a)(3)(c) | | | |
| F 0314<br>SS=G<br>Bldg. 00 | 483.25(c)<br>TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES<br>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.<br><br>Based on observation, interview, and record review, the facility failed to ensure care was provided, in that, cognitively impaired, dependent residents admitted without skin impairment developed skin | F 0314 | **F 314 What Correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice:** Resident #182's physician was notified and an order totreat the newly acquired | 07/30/2015 |

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| | impairment (Resident 109, Resident #182) for 2 of 4 residents reviewed who met the criteria.<br>This deficient practice resulted in Resident #109 experiencing two (2) unstageable wounds to the right heel.<br><br>Findings include:<br><br>1. On 6/29/15 at 8:35 A.M., Resident #109 was observed in the bed on his right side. The right heel was observed, at that time, to have a blue boot on and to be in contact with the surface of the bed. The left heel (medial side) was observed at that time to be in contact with the surface of the bed. A white boot was lying next to his left foot and both heels were not floated.<br><br>During an interview on 6/29/15 at 8:45 A.M., CNA #6 indicated she had turned and repositioned Resident #109 at 8:30 A.M., and that CNA #6 would turn and reposition Resident #109 again at 10:30 A.M.<br><br>On 6/29/15 at 9:40 A.M., Resident #109 was observed in bed on his right side. The right heel was observed, at that time, to have a blue boot on and to be in contact with the surface of the bed. The left heel (medial side) was observed, at that time, to be in contact surface of the | | pressure area was obtained. Resident #182 refused afacility cushion. His family did provide a cushion and resident #182 isutilizing it. Resident #109's physician was called and new orders werereceived to treat the pressure area. Bunny Boots are being utilized forpressure relief to his/or her heels. **How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by thisdeficient practice. **What measures willbe put into place or what systemic changes will be made to ensure that thedeficient practice does not recur:** An audit of all Braden scores will be completed to helpidentify residents at risk. Educate staff on reporting new pressure areas tothe physicians and acquiring new orders to treat. Staff will be educated onproper turning and repositioning and the off-loading of bony prominences.Careplans will be reviewed for all residents to ensure proper interventions arein place. C.N.A assignment sheets will be reviewed and updated. An inventory of pressure relieving equipmentwill be taken to ensure an adequate equipment supply is available to staff toutilize. Weekly skin audits will be completed weekly on all residents. **How the** | |

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| | bed. A white boot was lying next to his foot and both heels were not floated.<br><br>On 6/29/15 at 10:10 A.M., during an observation of a dressing change, Resident #109 was observed in bed on his right side. The right heel was observed, at that time, to have a blue boot on and to be in contact with the surface of the bed. The left heel (medial side) was observed, at that time, to be in contact with the surface of the bed. A white boot was lying next to Resident #109's foot and both heels were not floated. At that time, LPN #12 indicated the boot should have been on his foot, but the two Velcro straps were missing and could not be secured in place. LPN #12 said, "We don't have an abundance of boots here. They are hard to come by." LPN #12 then cleaned and applied sure prep (skin protectant) to a red, non-blanchable area the size of a quarter on the lateral side of left heel, at which time LPN #12 indicated that the area was discovered Friday. LPN #12 then noticed a new unblanchable red area, the size of a nickel, on the medial side of the left heel. The right heel was removed from the boot and two unstageable pressure areas were cleaned and sure prep was applied. At that time, LPN #12 indicated the large, purple pressure area was discovered first, and that a week later | | **correctiveaction(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place:** Wounds will be monitored by weekly walking rounds by theUnit Manager, Assistant Director of Nursing, Director of Nursing and the Administrator.The pressure wounds will be documented weekly on pressure sheets to helpidentify trends. An audit tool will be completed to make sure pressurerelieving devices are in place according the plans of care. This will be doneweekly x 4 and then monthly if no problems persist. All audit will be reportedto the Quality Assurance team Quarterly. Monitoring will be completed on all 3 shifts and will be ongoing **By what date thesystemic changes will be completed:** 7/30/2015 | |

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| | the purple area on the inner heel was discovered. LPN #12 indicated Resident #109 had experienced a decline recently and had started developing pressure ulcers. LPN #12 stated, "He just doesn't want to get out of bed anymore." LPN #12 exited the room without floating Resident #109's heels or repositioning Resident #109.<br><br>On 6/29/15 at 11:03 A.M., Resident #109 was observed in bed on his right side.<br><br>On 6/29/15 at 12:10 P.M., Resident #109 was observed in bed on his right side.<br><br>On 6/29/15 at 12:28 P.M., CNA #6 was in Resident #109's room and indicated she had just repositioned Resident #109 on his left side. CNA #6 further indicated, she had entered the room to assist Resident #109's roommate when Resident #109 asked her to turn him in bed.<br><br>The clinical record of Resident #109 was reviewed on 6/26/15 at 9:30 A.M. The clinical record indicated Resident #109 was admitted to the facility on 12/20/12 with no skin impairment to the right heel and diagnoses including, but not limited to, CVA (stroke), hemiplegia, Parkinson's disease, anxiety and depression. | | | |

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| | The Quarterly MDS (Minimum Data Set) assessment dated 3/30/15 indicated Resident #109 was at risk for the development of a pressure ulcer, experienced mild cognitive impairment, and required the assistance of one staff for bed mobility.<br><br>The last completed Quarterly Nursing Assessment dated 10/5/15 indicated Resident #109 was at risk for the development of a pressure ulcer and had no skin impairment to the right or left heel at that time.<br><br>A Care Plan dated 12/2/11 indicated, "...The resident has potential for impaired skin...r/t [related to]...history of skin breakdown...Interventions...The resident needs assistance to turn/reposition at least every 2 hours...Pressure relieving/reducing bed...Administer treatments as ordered...Educate resident...as to causes of skin breakdown...importance of frequent repositioning...6/15/15 sure prep bilat [bilateral heels]...heel protectors while in bed float heels..." The last update to the care plan prior to 6/15/15 was an update on 1/31/14.<br><br>The Physician's Orders dated 6/15/15 read as follows: "...Sure prep for R (right) heel q [every] shift float heels at | | | |

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| NAME OF PROVIDER OR SUPPLIER WILLOW MANOR | | STREET ADDRESS, CITY, STATE, ZIP CODE 3801 OLD BRUCEVILLE RD BOX 136 VINCENNES, IN 47591 | |

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| | all times while in bed..."<br><br>The CNA assignment sheet dated 5/13/15 was provided by UM #1 and reviewed on 6/25/15 at 10:00 A.M., and it read as follows: "...turn and reposition...yes...float heels..."<br><br>A Nurse's note dated 6/1/15 at 1600 (4:00 P.M.) read as follows: "...Res (resident) requiring the assistance of 2 for transfers."<br><br>A Nurse's note dated 6/15/15 at (time not documented) read as follows: "...R [right] heel with 2 x 2 soft dark purple UTD [unable to determine] nonblanchable area. tender to touch. N.O. [new orders] Sure Prep q [every] shift and float heels at all times while in bed."<br><br>A Nutritional Therapy Quarterly Progress note dated 6/22/15 indicated Resident # 109's skin was intact. No supplements were ordered.<br><br>A "WEEKLY PRESSURE ULCER RECORD" for the right heel dated 6/15/15 indicated Resident #109 experienced a pressure ulcer to the right heel. The assessment further indicated, "un-stageable...non-removable dressing, slough/eschar, suspected deep tissue injury in evolution...dark purple...soft | | | |

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| | nonblanching...length...2 [two centimeters]...width...2 [two centimeters]...PREVENTIVE MEASURES...Turned every 2 hours...Pressure Relieving Interventions float heels...6/17/15 heel protectors; Sure prep." The Nutritional/Hydration Status was not completed on the form.<br>A "WEEKLY PRESSURE ULCER RECORD" dated 6/26/15, (eleven days later) indicated the unstageable pressure area to the right heel had increased in size to 3 cm in length to 3 cm in width. A description of the wounds' appearance was not recorded.<br><br>A "WEEKLY PRESSURE ULCER RECORD" for the inner right heel dated 6/26/15 indicated Resident #109 experienced a pressure ulcer to the inner right heel. The assessment further indicated, "RISK FACTORS/CAUSE...decline in cond [condition]...un-stageable...non-removabl e dressing, slough/eschar, suspected deep tissue injury in evolution...length...2 [two centimeters]...width...1 cm...Sure prep, foam heel protectors, float heels...PREVENTIVE MEASURES...Turned q [every] 2 hours...Air mattress..." A description of the wounds' appearance was not recorded. | | | |

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| | A "WEEKLY PRESSURE ULCER RECORD" for the inner left heel dated 6/29/15 indicated Resident #109 experienced a pressure ulcer to the inner left heel. The assessment further indicated, "...stage 1...intact skin with non-blanchable redness of a localized area usually over a bony prominence...length...2 [two centimeters]...width...1 cm... pink soft non-blanchable to left heel...heel protectors, air mattress, float heels..."<br><br>Documentation was lacking for the pressure area located on the left lateral (outer) aspect of the heel which was observed on 6/29/15 at 10:10 A.M. dressing change.<br><br>A Medication Administration Record (MAR) for 6/15/15 through 6/30/15 was reviewed on 6/29/15 at 4:01 P.M.<br><br>An order dated 6/15/15 read as follows: "float heels while in bed"<br>Documentation was lacking that Resident #109's heels were floated for 13 of the 14 nights during the 7:00 P.M. to 7:00 A.M. shift.<br><br>An order dated 6/17/15 read as follows: sure prep bilat (bilateral) heels q (every) shift. Documentation was lacking Resident #109's sure prep had been | | | |

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| | applied to his heels for 9 of the 12 nights on the 7:00 P.M. to 7:00 A.M. shift.<br><br>An order dated 6/17/15 read as follows: "heel protectors while in bed" Documentation was lacking that Resident #109's heel protector had been applied to his heels for 9 of the 12 nights for the 7:00 P.M. to 7:00 A.M. shift.<br>During an interview with the UM#1, at the time of the MAR review, the UM#1 indicated she did not know if the treatments had been done because they were not signed off on the treatment sheet.<br><br>During an interview on 6/29/15 at 3:15 P.M., the Unit Manager for C and D halls (UM #1) indicated she was unaware of and could provide no documentation that Resident #109 had a pressure ulcer on the outer left heel. UM #1 indicated on 6/1/15 Resident #109 had experienced a decline. UM#1 further indicated, Resident #109 was at risk to develop a pressure ulcer prior to his decline, but that Resident #109 was at a higher risk to develop a pressure area once he started the decline and did not want to get out of bed. UM #1 indicated no quarterly nursing assessment for determining Resident #109's Braden Scale (scale to determine risk for developing pressure ulcers) had been completed since | | | |

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| | 10/2014. UM #1 further indicated a new skin risk assessment and revision to the care plan should have been completed when the decline was noticed. UM #1 said, "an order for heel protectors and float heels means to do both, put the heel protectors on at all times and to float the heels off a surface".<br><br>During an interview on 6/29/15 at 11:35 A.M., PT#1 indicated Resident #109 was totally dependent for care and could not reposition himself in the bed. PT #1 further indicated Resident #109 was especially weak on his right side.<br><br>During an interview on 6/30/15 at 4:05 P.M., LPN #12 indicated she was not sure if UM #1 knew about the pressure area on Resident #109's left outer heel. LPN #12 said, "It happened on the day we found the two stage 2 pressure ulcers on Resident #109's upper back. There was a lot going on that day, but we have been treating it with sure prep."<br><br>The Policy and Procedure for Skin Management provided by the Director of Nursing on 6/30/15 at 12:00 P.M. indicated, "...Following admission, the Braden Scale - For Predicting Pressure Sore Risk will be completed quarterly, annually, and with a significant change of status...following forms are | | | |

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| | completed...Weekly Pressure Record...A Care Plan...history of skin impairment or actual impairment...Wounds are tracked as acquired and are assessed and documented on the Weekly Pressure Ulcer Record...Licensed Nurse will document daily monitoring of all pressure ulcers on the Treatment Administration Record...A Registered Dietician will assess all residents identified with skin impairments for nutritional status in a timely manner...Pressure ulcers are measured and staged weekly in accordance with the Practice Guidelines..."<br>2. Resident #182 was observed on 6/24/15 at 4:15 P.M., Resident #182 was observed to have bruising around both eyes and a healing laceration to his forehead. At that time during an interview he indicated he had fallen forward from his recliner after falling asleep. He further indicated he had to lean forward and to his side to get off of his sore buttock.<br><br>Resident #182 was observed on 6/26/15 at 11:14 A.M., Resident #182 was observed sitting in a motorized wheel chair. Resident #182 was observed to be scooted toward the front edge of the wheel chair seat and lean forward while grimacing. At that time during an interview Resident #182 indicated he did | | | |

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| | this because his buttocks was sore and had been for a long time. He further indicated his family was getting him a cushion to place in his chair and/or recliner but it had not come in yet.<br><br>On 6/26/15 at 11:22 A.M., Resident #182's skin was observed with Licensed Practical Nurse #2. Resident #182 was observed to have no open areas on his buttock and/or thigh.<br><br>The clinical record for Resident #182 was reviewed on 6/26/15 at 10:24 A.M., diagnoses included, but were not limited to, peripheral vascular disease, neuropathy, and diabetes.<br>The Quarterly Minimum Data Set assessment dated 5/31/15 indicated Resident #182 experienced moderate cognitive impairment.<br><br>A care plan for potential skin impairment was initiated on 10/21/14 it included, but was not limited to, The resident needs, monitoring, reminding and/or assistance to turn and reposition at least every 2 hours, pressure reducing mattress on bed/chair, administer treatment as ordered, follow facility policies protocols for the prevention/treatment of skin breakdown, and monitor document changes in skin status and report to medical doctor as needed. | | | |

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| | A care plan for skin impairment initiated 2/17/15 indicated resident #182 experienced chronic excoriation, to his buttock, and scrotum. Interventions included, but were not limited to, turn and reposition every two hour.<br><br>A care plan for resident #182 preference to sleep in a recliner was initiated on 10/22/14 it included, but was not limited to, honor residents preference to sleep in recliner, observe for restful nights sleep, keep pressure reducing cushion in chair.<br><br>A care plan for potential for pain was initiated on 10/21/14. The interventions include, but were not limited to, anticipate the need for pain relief and respond immediately to any complaints, evaluate effectiveness of pain interventions, Observe for and report signs and symptoms of pain to the nurse and report unresolved pain to the medical doctor.<br><br>On 6/29/15 at 2:50 P.M., Resident #182 was observed in his recliner with Certified Nursing Assistant #5. At that time Resident #182 was observed to not have a cushion to his chair. CNA #5 indicated they did not know if Resident #182 should have a cushion in his chair. Resident #182 indicated his buttock was | | | |

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| | still very sore.<br><br>On 6/29/15 at 3:10 P.M., Resident #182's skin was observed with during care with CNA #5 and CNA #19. Resident #182 was observed to have a pencil eraser sized open area on his lower right buttock/thigh area. LPN #2 was notified and assessed the area.<br><br>During an interview with LPN #2 she indicated Resident #182 had had a cushion in his recliner but it had been taken out due to Resident #182 voicing complaints of sweating. She indicated his family had ordered him a new cushion but was unaware of when it would be received. She indicated she was not aware of another cushion being offered but would ask the therapy department. The clinical record was reviewed. No documentation could be provided, to indicate resident #182 had refused use of a cushion.<br><br>During an interview on 6/29/15 at 3:05 P.M., Physical therapy assistant #10 indicated Resident #182 had been seen by therapy periodically in the past. She provided documentation that Resident #182 had received a ROHO (type of pressure relief cushion) cushion for his recliner on 1/17/15 and indicated she did not know when the cushion was | | | |

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| | removed.<br><br>On 6/30/15 at 3:10 P.M., A Weekly Pressure Ulcer Record dated 6/29/15, it indicated Resident #182 had a Stage 2 wound to his right lower buttock and/or upper thigh area measuring 0.5 x 0.4 x 0.1 centimeters with pain present at the wound.<br><br>3.1-40(a)(1)<br>3.1-40(a)(2) | | | |
| F 0323<br>SS=G<br>Bldg. 00 | 483.25(h)<br>FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br>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.<br><br>Based on observation, interview, and record review, the facility failed to ensure effective services were provided to prevent accidents, in that, care was not provided as ordered by the physician (Resident #19), effective interventions were not implemented and/or supervision was not provided (Resident # 8, #74, #182, #137) for 5 of 7 residents who met the criteria for review of accidents. This deficient practice resulted in Resident #10 experiencing a left ankle | F 0323 | **F 323 What Correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice:** For Residents # 8, #74 and #137 Fall interventions wereimplemented. On Resident #10 all staff member was educated on the use of themechanical lift requiring the assistance 2 people. For Resident #182 interventions were implemented **How otherresidents having the potential to be affected by the** | 07/30/2015 |

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| | fracture, Resident #8 experiencing a left arm fracture, Resident #74 experiencing a right ankle fracture.<br><br>Findings include:<br><br>1. Resident #10 was observed on 6/24/15 at 10:30 A.M., sitting in a wheelchair in her room watching television in no apparent distress.<br><br>The clinical record of Resident #10 was reviewed on 6/26/15 at 9:43 A.M. The record indicated the diagnoses of Resident #10 included, but were not limited to, DJD (Degenerative Joint Disease)<br><br>The most recent annual MDS (Minimum Data Set) assessment dated indicated Resident #10 experienced no cognitive impairment and required the extensive assist of two staff for transfers.<br><br>The most recent quarterly MDS assessment dated 1/30/15 indicated Resident #10 experienced minimal cognitive impairment and required the extensive assist of two staff for transfers.<br><br>The March 2015 Physician's Order Recap included, but was not limited to an order for, "...up with lift and assist X [times] 2...pt [patient] able to use stand up lift..." | | **same deficient practicewill be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by thedeficient practice. **What measures willbe put into place or what systemic changes will be made to ensure that thedeficient practice does not recur:** Staff education on supervising residents, the use ofmechanical lifts, and following careplans and implementing interventions. **How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place:** Falls will be monitored after the daily morning meetingfor proper interventions. The fall careplans will be reviewed and updated witheach meeting. Observations of staff using mechanical lifts will be conductedfor proper usage. An audit tool will be used to monitor falls, careplans,interventions, and mechanical lift use. Audits will be conducted weekly x 4 andthen monthly if the problem resolves. All audits will be reported to theQuality Assurance Team quarterly. Monitoring will be completed on all 3 shifts and will be ongoing **By what date thesystemic changes will be completed:** 7/30/2015 | |

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| | A Care Plan dated 10/14/14 for "Fall Risk Potential for Injury..." included, but was not limited to, an intervention of "...stand up lift for transfers..." The Plan of Care lacked any documentation related to the number of staff required for transfers.<br><br>A Quarterly Nursing Assessment dated 1/30/15 indicated Resident #10 required the use of an "assistive device for all transfers". The assessment lacked any documentation related to number of staff required for transfers.<br><br>A Nursing note dated 4/14/15 at 9:00 A.M. indicated, "...Unit Manager talked to pt. about the incident that occurred Sunday [4/12/15] [with] stand up lift et [and] pt L [left] foot was hurt. pt stated there was only [one] person that assisted her back to bed et she tried to tell her foot was under the pedistal [sic] ..."<br><br>An untimed Interdisciplinary Team Progress note dated 4/14/15 indicated, "...happened 4/12/15 2100 [9:00 P.M.] Pt was being transferred to bed per stand up lift via 1 person that is assist of 2. L foot with shoes on got caught under the pedistal [sic]...Intervention inservice staff on use of stand up lift and pt needs assist of 2 @ [at] all times..." | | | |

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| | A Radiology report dated 4/13/15 at 3:12 P.M. indicated, "...Impression: Acute fracture lateral margin of the talus [ankle]..."<br><br>The Policy and Procedure for Lifting provided by the DON (Director of Nursing) on 6/26/15 at 11:30 A.M. indicated, "...Transfer Activity is performed by nursing personnel based upon the Resident's needs..."<br><br>The Policy and Procedure for Lifting provided by the DON on 6/26/15 at 2:00 P.M. indicated, "...Using a Portable Machine Level of Responsibility...2. To promote comfort and to maintain body alignment while the resident is being moved..." During an interview, at that time, the DON indicated Resident #10 should have been transferred with the required amount of staff.<br><br>2. On 06/25/15 at 9:30 A.M., Resident #8 was observed in a TV lounge sitting in a wheelchair with a cast on the left upper extremity.<br><br>During an interview 6/25/15 at 10:06 A.M., UM #10 indicated Resident #8 experienced a fall on 6/16/15 and received a fractured left arm. | | | |

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| | The clinical record of Resident #8 was reviewed on 6/29/15 at 9:30 A.M. The record indicated Resident #8 was admitted on 1/29/15 with diagnoses including, but not limited to, major depressive disorder with psychotic features, dementia, anxiety, difficulty walking, lack of coordination, and/or cognitive communication deficit.<br><br>A Fall Risk Assessment dated 1/29/15 indicated Resident #8 was a high risk to experience a fall.<br><br>A Care Plan dated 1/31/15 for "Potential for Falls related to...psychotropic med use, confusion..." with interventions of, "assist with toileting every two hours and as needed, encourage resident to be compliant with limitations and to ask for assistance as needed, ensure proper footwear, evaluate all falls for cause and attempt to prevent further falls, innitiate [sic], keep call-light in reach and encourage resident to use it to ask for assistance, notify family and physician of all falls, PT [Physical Therapy/OT [Occupational Therapy] to evaluate and treat as needed, place Dycem [name of anti-slip device] in w/c [wheel chair]"<br><br>The Admission MDS (Minimum Data Set) assessment dated 2/4/15 indicated Resident #8 experienced minimal | | | |

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| | cognitive impairment, required the limited assist of one staff for transfers and/or walking, had no history of falls prior to admission and/or had experienced 1 fall since admission to the facility.<br><br>A Quarterly MDS assessment dated 3/28/15 indicated Resident #8 experienced moderate cognitive impairment, required the limited assist of one staff for transfers and/or walking, and had experienced no further falls.<br><br>Fall #1: A Nursing note dated 4/4/15 at 9:15 P.M., indicated Resident #8 experienced a fall from a bed side commode. The note lacked any documentation related to safety equipment in use, adequate supervision was provided, and/or a new, immediate, and/or effective intervention was initiated to ensure the safety of Resident #8.<br><br>Fall #2: A Nursing note dated 4/5/15 at 2:30 P.M., indicated, Resident #8 experienced a fall from a wheelchair. The note lacked any documentation related to safety equipment in use, adequate supervision was provided, and/or a new, immediate, and/or effective intervention was initiated to ensure the safety of Resident #8. | | | |

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| | Fall #3: A Nursing note dated 4/12/15 at 2:10 P.M., indicated Resident #8 experienced a fall from a wheelchair. The note lacked any documentation related to safety equipment in use, adequate supervision was provided, and/or a new, immediate, and/or effective intervention was initiated to ensure the safety of Resident #8.<br><br>Fall #4: A Nursing note dated 4/26/15 at 3:05 P.M., indicated Resident #8 experienced a fall. The note lacked any documentation related to the resident's location at the time of the fall. The note further lacked any documentation related to safety equipment in use, adequate supervision was provided, and/or a new, immediate, and/or effective intervention was initiated to ensure the safety of Resident #8.<br><br>Fall #5: A Nursing note dated 5/7/15 at 10:15 P.M., indicated Resident #8 experienced a fall from the bed and received a bruise to the left hip. The note lacked any documentation related to safety equipment in use, adequate supervision was provided, and/or a new, immediate, and/or effective intervention was initiated to ensure the safety of Resident #8.<br><br>Fall #6: A Nursing note dated 5/15/15 at | | | |

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| | 3:30 P.M., indicated Resident #8 experienced a fall while independently ambulating with a walker. The note lacked any documentation adequate supervision was provided, and/or a new, immediate, and/or effective intervention was initiated to ensure the safety of Resident #8.<br><br>Fall #7: A Nursing note dated 5/15/15 at 10:00 P.M., indicated Resident #8 experienced an unwitnessed fall in the hallway, a non-functioning bed alarm was observed on the bed and/or an immediate intervention of "new alarm" was initiated to ensure the safety of Resident #8. During an interview on 6/29/15 at 11:50 A.M., UM #10 indicated no documentation could be provided to indicate when the bed alarm was initiated.<br><br>Fall #8: A Nursing note dated 5/18/15 at 3:00 P.M., indicated Resident #8 experienced a fall from a chair in the dining room. The note lacked any documentation related to safety equipment in use, adequate supervision was provided, and/or a new, immediate, and/or effective intervention was initiated to ensure the safety of Resident #8.<br><br>Fall #9: A Nursing note dated 5/21/15 at 8:00 P.M., indicated Resident #8 | | | |

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| | experienced a fall from a chair in the dining room. The note lacked any documentation related to safety equipment in use, adequate supervision was provided, and/or a new. immediate, and/or effective intervention was initiated to ensure the safety of Resident #8.<br><br>Fall #10: A Nursing note dated 5/29/15 at 2:50 P.M., indicated Resident #8 experienced a fall from a chair in the dining room. The note lacked any documentation related to safety equipment in use, adequate supervision was provided, and/or a new. immediate, and/or effective intervention was initiated to ensure the safety of Resident #8.<br><br>Fall #11: A Nursing note dated 5/30/15 at 9:00 A.M., indicated Resident #8 experienced a fall from a sit to stand lift. The note lacked any documentation related to the safety equipment in use, adequate supervision was provided, and/or a new, immediate, and/or effective intervention was initiated to ensure the safety of Resident #8.<br><br>The most recent Quarterly MDS assessment dated 6/3/15 indicated Resident #8 experienced moderate cognitive impairment, required the limited assist of one staff for transfers and/or walking, and had experienced 3 | | | |

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| | additional falls since the previous quarterly assessment.<br><br>A Fall Risk Assessment dated 6/8/15 indicated Resident #8 was at a high risk to experience a fall.<br><br>Fall #12 A Nursing note dated 6/16/15 at 10:00 P.M., indicated Resident #8 experienced a fall from a chair and "fell on left arm...noted indentation to left arm above wrist..." The note lacked any documentation to related safety equipment in use, adequate supervision was provided, and/or a new, immediate, and/or effective intervention was initiated to ensure the safety of Resident #8.<br><br>A Care Plan for Falls dated 5/30/15 lacked any documentation a new, immediate, and/or effective intervention was initiated after each fall and/or adequate supervision was provided at the time of the falls on 4/4/15, 4/5/15, 4/12/15, 4/26/15, 5/7/15, 5/15/15 (two falls), 5/18/15, 5/21/15, 5/29/15, 5/30/15, 6/16/15.<br><br>An X-ray report dated 6/16/15 at 11:59 P.M. indicated, "...Impression: Displaced impaction fracture of the distal radius [large bone in the forearm]. Ulnar styloid [area the secondary bone in the forearm] fracture is also seen..." | | | |

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| | During an interview on 6/29/15 at 12:15 P.M., UM #10 indicated no documentation could be provided to indicate new, immediate, and/or effective interventions were initiated after each fall and/or adequate supervision was provided to prevent the 12 falls between 4/4/15 and 6/16/15. UM #10 further indicated, at that time, she was not aware new, immediate, and/or effective interventions to ensure the safety of Resident #8 should have been implemented after each fall. UM #10 then indicated, Resident #8 should have received adequate supervision and/or been re-assessed after each fall to prevent further falls.<br><br>3. On 6/26/15 at 9:32 A.M., Resident # 74 was observed on secured unit A asleep in a recliner with a black boot device on his right foot. No distress or behaviors were noted.<br><br>On 6/25/15 at 2:50 P.M., Resident #74's clinical record was reviewed. Diagnoses included but not limited to, anxiety, dementia with behavioral disturbances, and delusional disorder. He was admitted to the facility on 8/6/14. His quarterly Minimum Data Set assessment (MDS) dated 6/3/15, indicated a severe cognitive impairment | | | |

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| | and the limited assistance of 1 staff for transfers, bed mobility, and ambulation in room and corridor. A MDS annual assessment dated 3/10/15, indicated a severe cognition impairment and independence in transfers and bed mobility. The assistance of 1 staff had been needed for ambulating in room and corridor.<br><br>Resident #74's current fall care plan had been initiated on 11/9/13, and addressed the problem of, "The resident has potential for falls r/t [related to] Unaware of safety needs and history of heart block with pacemaker placement."<br>Goal was " The resident will be free of falls through the review date..."<br>Interventions included but were not limited to, reminder sign (4/27/15), pull tab alarm in bed and a motion detector by bed (4/29/15), discontinue tab alarm and start pressure alarm when in bed (6/1/15), and last intervention dated 6/10/15 was to use of a pressure alarm at all times.<br><br>On 6/29/14 at 4:09 P.M., Nurse Manager #10 of the A and B unit of the secured units of the facility was interviewed in regard to Resident #74's (who resided in the A unit) falls. The following nursing notes were reviewed with Resident #74's Nurse Manager at that time: | | | |

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| | Nursing note dated 4/27/15 at 12:15 A.M., indicated,"Resident was walking up hallway from room and fell against door hitting back of head. Large knot and laceration noted to back of head. Large amt [amount] of blood present pressure dsg [dressing] applied to back of head and cool cloths applied..."<br><br>Nursing note dated 4/27/15 at 12:30 A.M., indicated, "Dr. [physician's name] on call for Dr. [ physician's name] notified of fall MN [new]/O[order] rec'vd [received] to send to ER [emergency room] for eval [evaluation]. Weekend Manager notified of fall. Agree c [with] Dr. to send to ER."<br><br>Nursing Note 4/27/15 at 3:00 A.M., indicated, " Report rec'd [received] from [hospital name] ER. CT Scan of head was negative. Res [resident] ambulatory, 3 staples to back of head. Res to be returned to facility."<br><br>During interview with the Nurse Manager #10 at that time (6/29/15 at 4:09 P.M.) she indicated before the 4/27/15 fall, Resident #74 had been up ad lib with his walker with a pressure alarm on at night. Nurse Manager #10 also indicated the resident had been walking in the hall and hit his head. The intervention after the fall had been a reminder sign to call for | | | |

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| | assistance with transfers.<br><br>Nursing notes dated 4/29/15 at 9:30 P.M., indicated, "Res.[resident] alarm sounding in room. Responded-found Res lying on floor beside bed. States he is not sure why he was getting up..."<br><br>Nurse Manager #10 indicated at that time the alarm had sounded and the resident was found on the floor. Nurse Manager #10 indicated a motion sensor alarm and a pull tab alarm in bed was initiated after the 4/29/15 fall and the pressure alarm when in bed was then discontinued.<br><br>Nursing note dated 5/29/15 at 10:45 P.M., indicated, 'Resident was attempting to get out of bed. Got tangled in blankets slid to floor..."<br><br>Nurse Manager #10 indicated at that time, after the 5/29/15 fall the resident's tab alarm was discontinued due to the resident taking it off and a pressure alarm was again initiated in bed.<br><br>Nursing note dated 6/9/15 at 11:45 P.M., indicated, "CNA called for this nurse to come to room 4. Res [resident] was on floor. Res. alarm was in place c [with] alarm box in drawer of bedside table. Alarm was not sounding. Upon assessment of res noted two reddened | | | |

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| | areas on back et [and] res c/o [complaint] pain to R [right] ankle/foot. Noted edema but no discoloration..."<br><br>Nursing note dated 6/10/15 at 3:00 A.M., indicated, "Call received from [name of staff] @ [hospital name] ER to update on res condition. Res [resident] fractured R[right] ankle, OCL[orthopedic casting lab splint] cast in place. Non- weight bearing..."<br><br>Interview with Nurse Manager #10 at that time indicated, Resident 74's alarm should not have been in the drawer. The Nurse Manager also indicated she thought the resident had turned off his alarm. She indicated the intervention after the fall had been to discontinue the low bed. She indicated the resident now needed the assistance of 2 for transfers and was non weight bearing.<br><br>Nursing note dated 6/15/15 at 8:00 A.M., indicated, "This nurse was in med [medication] room when the CNA came and said resident was on the floor. When I got down to the room, the resident was laying on his right side. Resident stated that he was not having any pain. V/S [vital signs] were obtained... Resident was helped up off the floor et placed in chair c [with] alarm. Et at approximately 0815 [8:15 A.M.] the CNA again comes | | | |

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| | to me et said the resident is once again on the floor, when I arrived to the room the resident was again on his right side and sustained [zero] injuries..."<br><br>Nurse Manager #10 indicated after the 6/15/15 fall, a recliner was used for the resident due to the resident frequently asked to go to bed and can't remember he can't walk. The Nurse Manager indicated the recliner as an intervention had not been added to the care plan yet.<br><br>Nursing notes dated 6/17/15 at 6:30 P.M., indicated, "Resident sitting in dayroom in recliner this nurse walked in et resident slid off bottom of recliner, alarm behind head buttocks et legs on floor assisted back to chair c [with] help of staff no injuries noted..."<br><br>Nurse Manger #10 indicated after the 6/17/15 fall, the pressure alarm was added for all times not just in bed.<br><br>Nursing notes dated 6/28/15 at 7:15 A.M., indicated, "Summoned to res. [resident] room by CNA Res. was down on his knees next to his bed. 0 [zero] c/o [complaint] pain/disc. [discomfort] @ this time voiced by res. ROM [range of motion] WNL [within normal limits] 0 [zero] injuries... | | | |

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| | Nurse Manager #10 indicated she had added a pull tab alarm at all times after the 6/28/15 fall. She also indicated she was going to get the resident up early around 7:00 A.M., so he wouldn't be so restless.<br><br>On 6/29/15 at 4:38 P.M., Nurse Manager #10 was made aware of the problem of a lack of supervision in regard to preventing falls for Resident #74. Nurse Manager #10 agreed there had been a lack of supervision to prevent Resident #74's falls.<br><br>4. Resident #182 was observed on 6/24/15 at 4:15 P.M., Resident #182 was observed to have bruising around both eyes and a healing laceration to his forehead. At that time, during an interview he indicated he had fallen forward from his recliner after falling asleep. He further indicated he had to lean forward and to his side to get off of his sore buttock. During this observation no pull tab alarm, no Dycem (a no slip surface) and no mat to floor in front of recliner was observed.<br><br>Resident #182 was observed on 6/26/15 at 11:14 A.M., Resident #182 was observed to be scooted toward the front edge of the wheel chair and lean forward while grimacing. At that time, during an | | | |

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| | interview Resident #182 indicated he did this because his buttock was sore and had been for a long time. He further indicated his family was getting him a cushion to place in his chair and/or recliner but it had not come in yet. During this observation no pull tab alarm, no Dycem (a no slip surface) and no mat to floor was observed in place.<br><br>On 6/26/15 at 2:50 P.M., Resident #182 was observed in his recliner with CNA #5 at that time, Resident #182 did not have a cushion to his chair, no tab alarm in place and no mat to the floor. During an interview with CNA #5 they indicated they were unaware of what interventions for safety were to be in place for Resident #182. A mat was observed folded up behind a bedside commode in the room.<br><br>The clinical record for Resident #182 was reviewed on 6/26/15 at 10:24 A.M., diagnoses included, but were not limited to, peripheral vascular disease, neuropathy, and diabetes mellitus.<br>The Quarterly Minimum Data Set assessment dated 5/31/15 indicated Resident #182 experienced moderate cognitive impairment.<br><br>The nurses notes were reviewed and included, but were not limited to, 2/19/15 at 0125 (1:25 A.M.) " CNA responded to | | | |

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| | call light upon entering room -[sic] found resident flat on face on floor..." The note indicated Resident #182 had bit his tongue, and sustained multiple bruises, abrasions and hematomas. Resident #182 was sent to the emergency room for evaluation and upon return a pull tab alarm was added as an intervention.<br><br>An Interdisciplinary Team (IDT) Progress note dated 2/19/15 at 11:00 A.M., was reviewed and included, but was not limited to, "while sitting upright resident he fell asleep et [and] fell out of chair." A pull tab alarm was added as an intervention.<br><br>A nurse note dated 3/8/15 at 8:35 A.M. included, but was not limited to, "This nurse heard yelling from down the hall. This nurse proceeds down the hallway to find res. [resident] on floor." Resident #182 received no injuries from this fall.<br><br>An IDT progress note dated 3/9/15 at 10:00 A.M., included, " Resident yelling out from room for help nurse entered room to find res [resident] lying on right side....Res. was assisted back into recliner. Dycem placed to seat et [and] Res. educated to ask staff for assist into wheel chair for offloading from buttocks." | | | |

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| | 155042 | | 06/30/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| WILLOW MANOR | 3801 OLD BRUCEVILLE RD BOX 136<br>VINCENNES, IN 47591 |

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| | A nurses note dated 6/22/15 at 2230 (11:30 P.M.) was reviewed it included, but was not limited to, "...CNA's made this nurse aware Res on floor in room face down and has blood pooling by nose...,...Has laceration on forehead 1.5 centimeters [cm] x [by] 3 cm . Under L [left] eye 1 cm x 3 cm laceration...., Res 0 [no] acute stress. Res stated he fell asleep and fell out of chair... Resident #182 was sent to the hospital for evaluation and returned with stitches to both lacerations. No immediate interventions related to the safety of resident #182 were listed in the nurse ' s notes.<br><br>A fall care plan initiated 10/21/14 was reviewed, interventions included, but were not limited to, "...Evaluate all falls for cause and attempt to prevent further falls, innitiate [sic] appropriate interventions,... PT/OT [physical therapy and ocupational therapy] evaluate and treat as needed...,... (2/19/15) pull tab alarm to recliner @ [at] all x's [times] initiated...,...(3/19/15) apply Velcro to recliner, provide res [resident] education re: not scooting to end of recliner which then [sic] then causes pt. [patient] to slide out of recliner.<br><br>During an interview with UM #9 on 6/30/15 at 3:30 P.M., she indicated | | | |

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| | Resident #182 should have a mat in front of his recliner, a pull tab alarm and dycem to the recliner.<br>5. During a random observation on 6/29/15 at 3:00 P.M. through 3:10 P.M., Resident #137 was observed in the Unit A dining room, sitting in chair within the confines of a stand up lift.<br>During the random observation, AA (Activity Assistant) #10 was observed at a neighboring table, conducting an activity and nursing staff were observed to not be in the dining room.<br>During an interview, at that time, AA #10 indicated NA (Nursing Assistant) #11 placed Resident #137 in the stand up lift and left the dining room.<br><br>During an interview on 6/29/15 at 3:10 P.M., NA #11 indicated Resident #137 had been left unattended within the confines of the lift to help another staff member for about 3 minutes.<br>During an interview on 6/29/15 at 3:13 P.M., CNA #12 indicated residents should never be left unattended after being placed in a lift. During an interview on 6/29/15 at 3:15 P.M., the UM #1 indicated Resident #137 should not have been left unattended in the dining room after being placed in a lift.<br><br>The Policy and Procedure for Fall | | | |

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| | Management provided by the DON (Director of Nursing) on 6/30/15 at 10:30 A.M. indicated, "...All residents will be assessed...for significant change...The IDT [Interdisciplinary Team] modifies and implements a Care Plan and treatment approach to minimize repeat falls. The Care plan will be ...revised as indicated...Each facility is responsible for implementing individualized interventions related to/for each resident's fall risk.<br><br>The Policy and Procedure for Lifting: Using a Portable Machine provided by the DON on 6/30/15 at 12:45 P.M., lacked any documentation related to the use of a stand up lift.<br><br>During an interview on 6/30/15 at 11:00 A.M. the DON indicated no specific policy for fall prevention could be provided, but it was the usual practice of the facility to provide adequate supervision to prevent falls.<br><br>3.1-45(a)(2) | | | |
| F 0332<br>SS=D<br>Bldg. 00 | 483.25(m)(1)<br>FREE OF MEDICATION ERROR RATES OF 5% OR MORE<br>The facility must ensure that it is free of medication error rates of five percent or greater. | | | |

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| | Based on observation, interview, and record review, the facility failed to ensure it was free of a medication error rate greater than 5%, in that, the facility had 3 medication errors out of 28 opportunities for error, resulting in a 10.7 % error rate. This affected 3 of 9 residents observed during the medication pass (Resident #54, Resident #165, Resident #188), and 3 of 5 nurses observed to pass medications. (RN #6, RN #9, RN #15)<br><br>Findings include:<br><br>During observation of the medication pass on 6/24/15 the following was observed:<br><br>1. At 11:20 A.M., Registered Nurses (RN) # 9 was observed administering medications for Resident #54. RN #9 was observed administering the Spiriva 18 mcg 1 inhalation to resident #54 and Advair 250/50 mg 1 inhalation concurrently without waiting at least a minute in between inhalations. At that time, during an interview RN #9 indicated she did not know of a waiting time in between inhalations.<br><br>During an interview with LPN #22, on 6/26/15 at 10:15 P.M., she indicated she waited at least 3 minutes in between administration of different inhalers. | F 0332 | **F 332 What Correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice:** No adverse outcomes were noted to Resident # 54, #165,and #188. **How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by thedeficient practice. **What measures willbe put into place or what systemic changes will be made to ensure that thedeficient practice does not recur:** Nurse involved in the med errors for residents # 54, 165and 188 were all educated on their med errors. RN # 6 and RN #15 were educatedon reading medication orders verifying the orders 3 times prior to administering.Medication Administration inservice for all licensed nurses was given.Observation of nurses doing medication administration was completed. **How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place:** By observation of Medication Administration. An audittool will be utilized during the | 07/30/2015 |

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| | 2. At 11:53 A.M., RN #6 was observed preparing to administer medications to Resident #165. She indicated, at that time, Resident #165 would receive Depakote (an antiseizure medication) 1500 milligrams (mg) for a seizure disorder. Upon opening the drawer she indicated he did not have his medication at this time. She indicated she would check the medication room and Emergency drug kit (EDK) for the medication after passing her other medications and continued with her medication pass.<br><br>At 1:15 P.M., RN #6 was interviewed, at that time, she indicated she had forgotten about the missed medication and would check the medication storage room. She indicated, at that time, Resident #165 did not have any Depakote and the facility EDK only contained Depakote Sprinkles and they were not the same thing. She indicated, at that time, she would need to call the pharmacy.<br><br>On 6/24/15 at 4:34 P.M., RN #6 was observed administering Depakote ER 500 mg 3 tabs to Resident #165. The clinical record for Resident #165 was reviewed on 6/24/15 at 4:15 P.M., diagnoses included, but were not limited to, epilepsy (seizure disorder). | | observation periods. This will be done weeklyx4 and then monthly. All audits will goto the Quality Assurance Team quarterly. Monitoring will be completed on all 3 shifts and will be ongoing<br>**By what date thesystemic changes will be completed:** 7/30/2015 | |

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| | The Physicians Order Recap dated 6/1/15 included, but was not limited to, " ...Depakote 1500 mg at 0600 (6:00 A.M.) and 1200 (12:00 P.M.) ... "<br><br>The nurses notes included, but were not limited to, 6/24/15 at 1540 (3:40 P.M.) " ... [Name of pharmacy] notified in between 1300 et [and] 1330 (1:00 and 1:30 P.M.) to get this medication sent over ... "<br><br>During an interview on 6/26/15 at 9:30 A.M., with UM #5 she indicated she was aware of the Depakote for Resident #165 on 6/24/15. She further indicated the medication had been delivered from the pharmacy at 4:30 P.M. that day and administered as soon as it had arrived. She further indicated nurses have a one hour time frame prior to and following scheduled times of administration to administer the medications.<br><br>3. During Medication administration observations on 6/29/15 at 4:08 P.M., RN #15 was observed preparing medications for Resident #188. RN #15 was observed to prepare, Flomax 0.4 mg 1 tab, Plavix 75 mg 1 tab, Tizadine HCl 4 mg 1 tablet, Ritalin 5 mg 1 tablet, Colace 100 mg 1 gelcap, Neurontin 400 mg 1 capsule, Urecholine 25 mg 1 tablet. | | | |

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| | The clinical record for Resident #188 was reviewed on 6/29/15 at 4:15 P.M., diagnoses include, but were not limited to, peripheral neuropathy, depression and hypertension.<br><br>The Physicians Order Recap dated 6/1/15 included, but was not limited to, " Neurontin 400 mg take 2 capsules by mouth 3 times daily. "<br><br>On 6/29/15 at 4:14 P.M., the orders were reviewed with RN #15. She indicated she had only administered 1 Neurontin 400 mg capsule to Resident #188 and the order called for 2.<br><br>A policy titled "Administering Medications" was provided on 6/26/15 at 10:50 A.M., by the Director of Nursing. It included, but was not limited to, " ...3. Medications must be administered in accordance with orders, including any required time frame ...., ...6. Medications may not be prepared in advance and must be administered within one (1) hour of their prescribed time ... " , and " ...7. The individual administering the medication must verify the right medication, right dosage, right time and right method of administration (e.g., review of the drug label, physician's orders, etc.) before giving the medications. " | | | |

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| | 3.1-25(b)(9)<br>3.1-48(c)(1) | | | |
| F 0353<br>SS=E<br>Bldg. 00 | 483.30(a)<br>SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS<br>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.<br><br>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:<br><br>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.<br><br>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.<br><br>Based on observation, interview, and record review, the facility failed to ensure sufficient nursing staff was available, in that, a cognitively impaired dependent resident was left unattended in a | F 0353 | **F 353 What Correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice:** Resident # 137 had no injury related to being unattendedwhile staff member | 07/30/2015 |

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| | mechanical lift (Resident #137), staff was observed to feed more than 2 residents at a time (Resident 225, Resident #183, Resident #86, Resident #118, Resident #60), 8 of 13 residents interviewed indicated care was delayed due to lack of staff, 2 of 3 families interviewed indicated staffing was frequently insufficient, and 4 of 4 resident council minutes reviewed indicated staff was lacking.<br><br>Findings include:<br><br>1. During a random observation on 6/29/15 at 3:00 P.M., Resident #137 was observed in the Unit A dining room, sitting in chair within the confines of a stand up lift. No nursing staff was observed in the dining room, at that time. AA (Activity Aide) #10 was observed at a neighboring table, conducting an activity and indicated CNA (Certified Nurses Assistant) #11 placed Resident #137 in the stand up lift and had left Resident #137 to help another staff member.<br>During an interview on 6/29/15 at 3:10 P.M. CNA #11 indicated he/she had left Resident #137 unattended within the confines of the lift to help another staff member for about 3 minutes. During an interview on 6/29/15 at 3:13 P.M. CNA #12, indicated residents should never be | | attended to another resident. Resident #225 had no adverse outcomes related to Resident#183 drinking from her glass. Resident #183 stood up and a family member assisted herback to her chair with no injury noted. Resident #118, #60, and #86 were assisted by one staffmember during lunch with no adverse outcomes Resident # 500, 501, 503, 504, 505, 506, and 509 had noadverse affects related to call lights not being answered **How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by thedeficient practices. **What measures willbe put into place or what systemic changes will be made to ensure that thedeficient practice does not recur:** #1 Willow Manor is currently running newspaper and onlineads to attract C.N.A's and Nurses. We are offering a $1000 sign on bonus forC.N.A's and a $500 sign on bonus for licensed nurses. #2 Department Heads will be assigned Daily QualityAssurance rounds. # 3 Administrative staff have been assigned dining room dutyfor morning and lunch. #4 A nursing manager will be assigned a day to work 11am to 7 pm. #5 Willow has hired Environmental aides that will assist theC.N.A's but will | |

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| | left unattended when within a lift. During an interview on 6/29/15 at 3:15 P.M. the UM(Unit Manager) #1 indicated Resident #137 should not have been left alone in the dining room while in a lift.<br><br>2. On 6/24/15 at 12:18 P.M., CNA #16 was observed to place the tray for Resident #225 on a table in back of the E and F dining room. Resident #183 unsupervised in a Broda chair moved himself/herself to Resident #225's table and took him/her drink. LPN #19 took Resident #183 back to him/her table.<br><br>On 6/24/15 at 12:23 P.M., Resident #183 moved from him/her table back to Resident #225's table and started putting him/her feet on the table and bumping into another resident. A family member of Resident #187 got up and stopped Resident #183 from kicking.<br><br>On 6/24/15 at 12:25 P.M., LPN #19 assisted Resident #183 back to his/her table and locked his/her Broda chair. Resident #183 became agitated and stood up from his/her chair.<br><br>On 6/24/15 at 12:31 P.M., Resident #183 moved himself/herself to a table and locked his/her chair and stood up. A family member of Resident #187 had to | | not complete hands on patient care. They will pass ice, makebeds, transport residents, and answer call lights, etc. All staff will bereeducated on answering call lights. **How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place:** This tag will be monitored by reviewing the Grievance logand answering timely. We will review the Resident council notes from theirmonthly meetings. Willow will do random resident interviews to help determine if care is being provided more promptly weekly x 4 then monthly. All reportswill be submitted to the Quality Assurance Team quarterly. Monitoring will be completed on all 3 shifts and will be ongoing **By what date thesystemic changes will be completed:** 7/30/2015 | |

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| | intervene, and then RN #6 entered the dining room from the G-H-I hall and assisted Resident #183 back down in him/his/her chair.<br><br>On 6/24/15 at 12:39 P.M., CNA #22 removed Resident #183 from the dining room. During interview at that time, CNA #22 indicated staff in the dining room were responsible for supervision and service to all residents in the dining room not just the ones that resided on the E and F units were he/she was working.<br><br>3. On 6/24/15 at 1:03 P.M., in the dining room for the C and D hall, 6 residents in the restorative area were at the restorative table and had their noon lunch trays. One CNA, CNA #8 was observed to assist Residents #86, #118 and #60 to eat, by walking around the table giving the three residents each a bite or a drink and then repeated the process. CNA #8 was observed to stand while assisting the residents with eating until 8 minutes later when Restorative CNA #20 from the D unit came and sat down to assist in feeding Resident #86 and Resident #60 and CNA #8 then sat down and began to feed Resident #118.<br><br>4. On 6/30/15 at 2:18 P.M., during interview with the Director of Nursing (DON) the DON was made aware of | | | |

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| | residents waiting to be assisted to eat at the noon meal on 6/24/15 due to 1 staff assisting in the restorative dining area of the C and D dining room. The DON indicated at that time more than 1 nursing staff was needed to assist residents to eat in the restorative dining room.<br><br>5. During 8 of 13 confidential resident interviews, residents indicated they frequently had to wait extended periods of time for call lights to be answered.<br><br>Their comments included :<br><br>During a confidential interview with Resident #500 on the H hall, Resident #500 indicated at times when he/she turns on call light he/she has had to wait and has urinated on himself/herself. He/he/she indicated that happens once in a while.<br><br>During a confidential interview with Resident #501 on the F hall, Resident #501 indicated he/she was told staff were told they can't toilet him/her except for every 2 hours. Staff refuses to take him/her and he/she then he/she has to toilet himself/herself.<br><br>During a confidential interview with Resident #502 on the F hall, Resident #502 indicated there was a CNA who | | | |

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| NAME OF PROVIDER OR SUPPLIER WILLOW MANOR | | STREET ADDRESS, CITY, STATE, ZIP CODE 3801 OLD BRUCEVILLE RD BOX 136 VINCENNES, IN 47591 | |

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| | answers his call light and says he/she will come right back and never comes back. Resident #502 indicated he was unable transfer himself to toilet and has had an incontinent accident due to waiting.<br><br>During a confidential interview with Resident #503 on the G hall, Resident #503 indicated, on the 3rd shift due to not enough staff, he gets himself up and goes to the bathroom instead of calling for assistance from staff. He indicated it takes too long for staff to come and assist him.<br><br>During a confidential interview with Resident #504 on the I hall, Resident #504 indicated at times on the evening shift he has to wait up to 25 minutes to receive help. Resident #504 indicated the facility simply does not have enough help.<br><br>During a confidential interview with Resident #505 on the F hall, Resident #505 indicated he/she had to wait a long time for help. Resident #505 indicated he/she had been incontinent at times waiting for staff assistance.<br><br>During a confidential interview with Resident #506 on the F hall, Resident #506 indicated there was never enough staff. | | | |

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| | During a confidential interview Resident #507 indicated it was a usual practice for one nurse and one CNA to be assigned to provide care for two units after 10:00 P.M. Resident #507 further indicated a wait time of 30 minutes or more for care was frequently experienced.<br><br>6. During a confidential family interview with a family member of Resident #58, the family member of Resident #508 indicated during the evening hours it was very difficult to find a nurse or a CNA for help. The family member of Resident #508 indicated you could look for a long time and still not find them. The resident call lights would ring for a long time in the evening as well.<br>The family member of Resident #508 indicated during a visit at 7:30 P.M., on a Saturday evening Resident #508's tray was on the bedside table untouched. Resident #508 needed assistance with eating. Resident #508 indicated he/she was hungry, so the family member of Resident #508 fed him/her the cold food.<br><br>Later the family member of Resident #508 went to the nurse and told him/her how much of the dinner Resident #508 had eaten and requested Resident #508 pain medication. The nurse responded I'll get to it when I can and turned away and | | | |

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| | continued working.<br>The family member of Resident #508 indicated they went to the facility one evening and told the nurse I wanted to see the pressure ulcer Resident #508 had developed . The nurse indicated he/she did not have a pressure ulcer. When I insisted we looked and it was on him/his/her buttock. The nurse was surprised and said he/she wasn't aware Resident #508 had developed a pressure ulcer. The family member of Resident #508 indicted how could they have been turning him/her and repositioning him/her when they weren't not even aware of the pressure ulcer.<br><br>7. During a confidential family interview with Resident #509's family member on the F hall, Resident #509's family member indicated a lot of residents at the facility needed assistance and there was not enough staff.<br><br>8. The 3/24/15 Resident Council Minutes indicated, "...call light not in reach for resident use to call for help [Resident #45]...light not answered in a timely fashion, [Resident #188] says there isn't enough CNA's..."<br><br>9. The 4/28/15 Resident Council Minutes indicated, "...[Resident #151] said nursing staff didn't check on him all night | | | |

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| | after 10:00 P.M....call light not in his reach also call light on all halls not answered, having to wait a long time, staff rude turns off light tells us to wait they will get to us when they can they are short on help..."<br><br>10. The 5/26/15 Resident Council Minutes indicated, "...hard to find a CNA to take us out...nurses state we can't pull them off the hall [Resident #188] states...believes they know when smoke breaks are and they should have it covered.<br><br>11. The 6/23/15 Resident Council Minutes indicated, "...delayed on answering call lights..."<br><br>12.During an interview on 6/30/15 at 12:54 P.M. the Staffing Coordinator indicated the facility census was 143 residents and provided an "as-worked" nursing schedule from June 1-June 30, 2015. The staffing schedule indicated the facility routinely staffed 2.5-4.0 nurses and 5-7 CNA's on the night shift, 3-10 nurses and 8-15 CNA's on the day shift, and 2-4 nurses and 8-12 CNA's on the evening shift for 9 nursing halls during the same time period.<br><br>13. The CNA assignment sheets provided by the DON on 6/30/25 at 2:00 | | | |

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| | P.M., indicated the following:<br><br>Hall A-(Total of 16 residents):<br>Need assist of (2) staff: 3 residents<br>High traffic area: 1 resident<br>Fall risk:10 residents<br>Sit/stand lift: 1 resident<br>Assist with ADL'S (Activities of Daily Living): 16 residents<br>Assist with turning and repositioning: 3 residents<br>Incontinent and/or toilet schedule: 14 residents<br><br>Hall B-(Total of 16 residents):<br>Need assist (2) staff: 1 residents<br>Fall risk: 3 residents<br>Use walker: 3 residents<br>Assist with ADL's: 16 residents<br>Assist with turning and repositioning: 4 residents<br><br>Hall C-(Total of 23 residents)<br>Assist of (2) staff- including with Hoyer (mechanical) lift: 12 residents<br>Risk for falls: 5 residents<br>Assist with toileting, incontintent, program: 17 residents<br><br>Hall D- (Total of 26 residents)<br>Assist of (2) staff including Hoyer lift: 16 residents<br>Fall risk: 14 residents<br>Assist for toileting: 18 residents | | | |

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| | Assist with turning and repositioning: 17 residents<br><br>Hall E- (Total of 22 residents)<br>Assist of (2) staff including lifts/hoyer: 13 residents<br>Fall risk: 14 residents<br>Incontintent, toileting program assist: 17 residents<br>Turn/reposition-assist: 19 residents<br><br>Hall F- (total of 24 residents)<br>Assist of (2) staff: 11 residents<br>Use of hoyer lift: 5+ residents<br>Residents with Broda chair, wheelchair: 22 residents<br>Fall risk: 13 residents<br>Assist with toileting, incontinent, toileting program with assist: 19 residents<br>Assist with turning and repositioning: 21 residents<br><br>Hall G - (Total of 5 residents)<br>Assist of (2) staff: 2 residents<br>Fall risk: 1 resident<br>Incontinent: 3 residents<br>Assist with turning and repositioning: 4 residents<br>High traffic area: 1 resident<br>Seizure Precaution/Aspiration Precautions: 2 residents<br><br>Hall H- (Total of 9 residents)<br>Assist of (2) staff: 4 residents | | | |

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| | Fall risk: 2 residents<br>Incontinent: 3 residents<br>Aspiration Precautions: 1 resident<br><br>Hall I- (Total of 6 residents)<br>Assist of (2) staff: 1 resident<br>Incontinent/Foley (urinary catheter): 2 residents<br>Fall risk: 1 resident<br><br>On 6/30/15 at 2:32 P.M., the DON and Administrator were interviewed regarding staffing concerns. They indicated they were using agency nurses currently at the facility. They also indicated they had hired environment aides to assist with transporting residents and retrieving items to assist Nurses and CNAs in caring for the residents. They also indicated they currently had a newspaper ad for hiring CNAs.<br><br>3.1-17(a)<br>3.1-17(b) | | | |
| F 0371<br>SS=F<br>Bldg. 00 | 483.35(i)<br>FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions<br>Based on observation, interview, and | F 0371 | **F 371 What** | 07/30/2015 |

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| | record review, the facility failed to ensure food contact solution was the appropriate strength, facial hair restraints were utilized appropriately, food items were dated, and floors were sanitary for 2 of 5 survey days observed. This had the potential to affect 133 of 143 residents who resided in the facility.<br><br>Findings include:<br><br>The following observations were observed on 6/24/15 in the kitchens for the (A, B, C, D) units/upper, and the (E, F, G, H, & I) units/lower:<br><br>1. On 6/24/15 at 10:23 A.M., during the initial tour with the Food Service Manager (FSM) in the upper kitchen area, the interior top portion of the microwave was observed to be soiled with a yellow food substance.<br><br>2. On 6/24/15 at 10:23 A.M., in the upper kitchen the reach in refrigerator contained a pitcher of lemonade that was undated. In the freezer, 3 frozen chicken patties were stored in a zip lock bag undated. The FSM removed the chicken patties from the freezer at that time.<br><br>4. During the 6/24/15 at 10:23 A.M., tour in the upper kitchen, the FSM checked the red bucket container of the | | **Correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice:** The soiled microwave was cleaned immediately. The chickenpatties not dated were thrown in the trash. The three bags of Chicken not dated werediscarded. The food contact solution was discarded and new was made. Covers areprovided for beards and mustaches and the staff have been educated. The floorsin both kitchens have been cleaned. Staff have been educated on what is properto touch during serving and what is not. Storage totes have been replaced withproper fitting lids. Food was removedfrom the freezer that was not holding a temp of 0 degrees. **How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken:** All Residents have the potential of being affected by thedeficient practices. **What measures willbe put into place or what systemic changes will be made to ensure that thedeficient practice does not recur:** Staff have been educated on proper cleaning techniques,dating food, the strength of the food contact solution, covers for beards andmustaches, what is proper to touch before you are required to wash your hands,and proper | |

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| | food contact solution with a Hydrion solution strip. The solution measured 150. The FSM indicated at that time the solution should measure between 200 and 400. The FSM instructed staff to make up new food contact solution.<br><br>5. During the 6/24/15 at 10:23 A.M., during tour in the upper kitchen, a male dietary staff member, Dietary Staff #1, was preparing a potato food item for the noon meal with the facial hair of a beard and mustache exposed (without a hair restraint for his mustache and beard).<br><br>6. On 6/24/15 at 10:40 A.M., the kitchen area for the E,F,G, H, and I units/ lower kitchen was toured with the FSM. The floor under kitchen equipment was observed to have black soiling, dried food particles and dust when a hand swipe was performed.<br><br>7. On 6/24/15 at 10:50 A.M., in the kitchen for the A,B, C, & D halls/upper kitchen at 10:50 A.M., the FSM was made aware of the floor underneath the appliances and equipment had black soiling when a hand swipe was performed. The corner of the kitchen by the refrigerator and shelving unit had dust particles, a dried cereal particle and black soiling when a hand swipe was performed. | | storage for food. **How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place:** Sanitation rounds will be completed 5x per week. A monthlylog will be kept to summarize the repeat concerns noted on the sanitationrounds. This will be presented to the Quality Assurance Team Quarterly. Monitoring will be completed on all 3 shifts and will be ongoing **By what date thesystemic changes will be completed:** 7/30/2015 | |

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| | 8. On 6/24/15 at 12:48 P.M., Dietary Staff #1, the cook (for units: A, B, C, and D) was observed preparing the food for the trays without a hair restraint for his mustache and beard with facial hair exposed.<br><br>9. On 6/24/15 at 12:52 P.M., Dietary Staff #2, (for units A,B, C, and D) was observed placing drinks of tea and grape drink unto resident trays holding the top of the rim of the glasses.<br><br>The following observations were observed on 6/29/15 in the kitchens for the (A, B, C, D) units/upper, and the (E, F, G, H, & I) units/lower:<br><br>10. On 6/29/15 at 10:24 A.M., the downstairs food storage room was toured with the Assistant Food Service Manager (AFSM). Two large plastic containers containing graham cracker crumbs and flour were observed to have lids soiled with food particles and the lids of the containers fitted loosely. The AFSM indicated she needed to get new containers due to lids fitting loosely. Three bags (not original bags) of frozen chicken pieces were in the freezer undated. The AFSM indicated she would discard due to bags not dated. | | | |

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| | 11. On 6/29/15 at 10:37 A.M., Dietary Staff #1 was observed preparing the pureed foods. His beard was in a beard restrain,t but his mustache was not. During an interview, at that time, Dietary Staff #1 indicated he thought his mustache should be covered, but staff had told him he didn't need to cover his mustache. Dietary Staff #1 was made aware at that time that facial hair needed to be covered for food preparation.<br><br>12. On 6/29/15 at 12:00 P.M., Dietary Staff #1 was observed to be serving food onto resident plates with his mustache/facial hair exposed. During interview at that time the AFSM and Dietary Staff #1 indicated dietary staff had cleaned floors in the kitchens till 9:00 P.M., after the 1st survey day 6/24/15 when the floors were observed soiled. They indicated the cleaning had made a big difference with the kitchen floors being clean at present.<br><br>13. On 6/29/15 at 2:52 P.M., Maintenance Staff #1 was observed in the kitchen with mustache/facial hair exposed.<br><br>14. On 6/29/15 at 11:58 A.M., during tour with AFSM of the downstairs kitchen (for units E, F, G, H, and I) the temperature of the upright freezer was | | | |

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| | checked and the thermometer measured 30 degrees F(Fahrenheit) . The AFSM indicated that maybe the freezer was in defrost. On 6/29/15 at 2:15 P.M., the upright freezer temperature was checked again and measured 20 degrees F and the AFSM indicated the food was being moved to another freezer.<br><br>15. On 6/29/15 at 2:52 P.M., the AFSM was made aware of problems with the elevated freezer temperature downstairs , food contact sanitizing solution, lack of food dates, and soiling of the kitchen floors.<br><br>16. On 6/30/15 at 9:30 A.M., the AFSM provided the following dietary polices:<br><br>The policy entitled "FOOD STORAGE (undated)" The policy included but was not limited to, "...FROZEN MEAT/POULTRY and FOOD: page 35, 3. Storage: Store items promptly at 0 degrees F. or below. Foods should be stored in their original containers if designed for freezing. Foods to be frozen should be stored in airtight containers or wrapped in heavy aluminum foil or special laminated papers. Label and date all food items..."<br><br>Food Labeling and Dating (undated) policy: p. 33 "All leftover food or foods | | | |

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| | removed from their original containers require proper labeling when stored. 8. b. At the time food is being removed from its original container and placed in another container, DATE IT..."<br><br>Policy for Head Covering worn (undated) p. 25, "a. All hair is to be covered properly with a hairnet. Facial hair is to be removed or covered with a beard restraint..."<br><br>FLOORS (undated) policy: SANITATION: p. 186, "... 12. Mop an area 9 x 12 feet at a time. 13. Dip the second mop in the clean water. 14. Wring the mop out and rinse the floor previously mopped with the cleansing solution. 15. Allow the floor to dry. Then mop and rinse the other half or other areas that have not been mopped..."<br><br>3.1-21(i)(2)<br>3.1-21(i)(3) | | | |
| F 0431<br>SS=D<br>Bldg. 00 | 483.60(b), (d), (e)<br>DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS<br>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of | | | |

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| | all controlled drugs is maintained and periodically reconciled.<br><br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. | | | |
| | Based on observation, interview, and record review, the facility failed to ensure medications were stored and/or disposed of properly, in that, medication with a high incidence of abuse were not stored under double-lock and/or discontinued medications were not disposed in a timely manner in 2 of 4 medication storage rooms.(C, D unit medication storage room, G, H, I, unit medication storage room) | F 0431 | **F 431 What Correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice:** The refrigerator in the locked medication room was lockedimmediately. The expired flu vaccine syringes were destroyed per facilitypolicy **How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken:** All | 07/30/2015 |

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| | 155042 | | 06/30/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| WILLOW MANOR | 3801 OLD BRUCEVILLE RD BOX 136<br>VINCENNES, IN 47591 |

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| | Findings include:<br><br>1. The medication storage room was observed on 6/24/15 at 10:25 A.M. with Unit Manager #1 (UM #1). During the observation, the refrigerator was observed to be unlocked, and it contained a black metal box without a lock which held two 30 ml (milliliter) 2 milligram (mg) vials of sublingual Ativan (antianxiety medication).<br>Located on the top shelf of the refrigerator were three 30 ml vials of 2 mg/ml Ativan and one 26 ml vial of 2 mg/ml of Ativan.<br><br>During an interview on 6/24/15 at 10:25 A.M., UM #1 indicated the refrigerator need to be locked.<br><br>A policy "Controlled Substance" was provided by the facility on 6/24/15 at 11:01 A.M., it read as follows: "...The facility shall comply with all laws, regulation and other requirements related to handling, storage...of scheduled 2 and other controlled substances..."<br><br>A policy "Storage of Medications" was provided by the facility on 6/29/15 at 11:05 A.M., and read as follows: "...Compartments (including, but not limited to, drawers, cabinets, rooms, | | Residents have the potential to be affected by thisdeficient practice. **What measures willbe put into place or what systemic changes will be made to ensure that thedeficient practice does not recur:** A lock will be utilized at all times on the medicationroom refrigerator. Charge nurses will be responsible to check all medicationsin the refrigerator for expiration dates. If expired medications they will bedestroyed per facility policy. Staff havebeen educated on the policy for medication storage and expired medications. **How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place:** An audit tool will be used to monitor the medication roomrefrigerator for storage of controlled substances and expired medications. MedRoom audit will be completed weekly to ensure proper storage weekly x 4 then monthly. All audits will be submitted to the Quality Assurance Team quarterly. Monitoring will be completed on all 3 shifts and will be ongoing **By what date thesystemic changes will be completed:** 7/30/2015 | |

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| | refrigerators....shall be locked when not in use."<br>2. On 6/29/15 at 10:50 A.M. the GHI unit medication storage room was observed with LPN #28. During an observation a large bag containing 40 prefilled Influenza Vaccine [afluria] syringes with an expiration date of 5/29/15 (30 days) were observed stored in the medication refrigerator. At the same time during an interview LPN #28 indicated she was unsure how long the facility had to dispose of expired and/or discontinued medications.<br><br>During an interview on 6/29/15 at 2:00 P.M., Unit Manager (UM) #5 indicated she had disposed of the medications. She further indicated the facility policy was to dispose of all expired and/or discontinued medications within 7 days.<br><br>A policy for the storage of medications dated 4/2007 was provided by the Healthcare Facility Administrator on 6/29/15 at 11:05 A.M. The policy included but was not limited to, "4. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed."<br><br>3.1-25(r) | | | |

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| F 0441<br>SS=D<br>Bldg. 00 | 483.65<br>INFECTION CONTROL, PREVENT SPREAD, LINENS<br>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.<br>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection. | | | |

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| | Based on interview, and record review, the facility failed to ensure employees were screened and/or evaluated for communicable disease upon employment for 5 of 10 employees reviewed. (CNA #17, Agency LPN #23, LPN # 6, LPN #5, RN #2)<br><br>Findings include:<br><br>The Employee Files were reviewed on 6/30/15 at 10:30 A.M., and the following was noted:<br><br>1. CNA #17: The Employee Health Exam completed on 10/8/14 lacked a health risk assessment statement.<br><br>2. Agency LPN #23 : The Employee Health Exam completed on 4/29/15 lacked a health risk assessment statement.<br><br>3. LPN #6: The Employee Health Exam completed on 11/3/14 lacked a health risk assessment statement.<br><br>4. LPN #5: The Employee Health Exam completed on 10/16/14 lacked a health risk assessment statement.<br><br>5. RN #2: The Employee Health Exam completed on 10/9/14 lacked a health risk assessment statement. | F 0441 | **F 441 What Correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice:** No Residents were affected by this finding **How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by thisdeficient practice. **What measures willbe put into place or what systemic changes will be made to ensure that thedeficient practice does not recur:** The Human Resources Manager was inserviced on the HealthRisk Assessment Documentation required for all new employees. **How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place:** An audit tool will be utilized to monitor that the HealthRisk Assessment is being completed. All new hire files will be reviewed weeklyx 4 then monthly. Reports will be submitted to the Quality Assurance team quarterly. Monitoring will be done on day shift and will be ongoing **By what date thesystemic changes will be completed:** 7/30/2015 | 07/30/2015 |

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| | A Policy and Procedure for "Tuberculosis Screening Employees" provided by the HR (Human Resources) #1 on 6/30/15 at 3:20 P.M., lacked any documentation related to screening new employees for communicable disease prior to employment.<br><br>A Policy and Procedure for "Health Requirements" provided by the HR #1 on 6/30/15 at 3:20 P.M. lacked any documentation related to screening new employees for communicable disease prior to employment.<br><br>During an interview on 6/30/15 at 3:25 P.M., HR #1 indicated it was her understanding an employee was free of communicable disease if the tuberculosis testing was negative.<br><br>3.1-14(t)(3)<br>3.1-18(b)(1) | | | |
| F 0465<br>SS=E<br>Bldg. 00 | 483.70(h)<br>SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON<br>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.<br>Based on observation and interview the facility failed to ensure the environment | F 0465 | **F 465 What Correctiveaction(s) will be** | 07/30/2015 |

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| | was free of odors, in that, resident rooms had a pervasive odor of urine and/or bowel movement for 7 of 7 residents rooms that met the criteria for review of odors. (Resident #184, Resident #33, Resident #35, Resident #223, Resident #102, Resident #172, Resident #137)<br><br>Findings include:<br><br>1. On 6/24/15 at 4:01 P.M. the room of Resident #184 was observed to have a pervasive urine odor.<br>On 6/29/15 at 8:35 A.M., the room of Resident #184 was observed to have a pervasive odor of urine.<br><br>2. On 6/24/15 at 4:06 P.M., the room of Resident #33 was observed to have a pervasive urine odor.<br>On 6/29/15 at 8:36 A.M., the room of Resident #33 was observed to have a pervasive odor of urine.<br><br>3. On 6/25/15 at 9:32 A.M., the room of Resident #35 was observed to have a pervasive odor of BM (bowel movement). The bathroom of Resident #35 was observed, at that time, to have BM on the floor. During an interview on 6/25/15 at 9:33 A.M. Unit Manager #10 indicated Resident #35 had been incontinent of BM in the bathroom.<br>On 6/29/15 at 8:20 A.M., the room of | | **accomplished for those residents found to have been affectedby the deficient practice:** All Areas affected by the urine odor were deep cleanedfor all residents affected. In resident # 35 and # 184 the tile floor in thebathroom was pulled up and Linoleum was laid down for Flooring. Resident #35had BM on the floor and it was cleaned up immediately. **How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by thedeficient practice. **What measures willbe put into place or what systemic changes will be made to ensure that thedeficient practice does not recur:** Staff have been educated on how to investigate urineodors to find out the root cause of the odor and to address that odor. Staffhave been educated on cleaning up BM as soon as it is detected. **How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place:** These practices will be monitored by Daily Quality Assurance rounds completed by the Department Heads daily with all problem areas being addressed immediately. | |

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| | Resident #35 was observed to have a pervasive odor of urine.<br><br>4. On 6/25/15 at 9:50 A.M. the bathroom of Resident #223 was observed to have a pervasive odor of urine.<br><br>5. On 6/25/15 at 3:25 P.M. the room of Resident #102 was observed to have a pervasive odor of urine.<br><br>6. On 6/25/15 at 3:30 P.M. the room of Resident #172 was observed to have a pervasive odor of urine.<br><br>7. On 6/25/15 at 3:32 P.M., the room of Resident #137 was observed to have a pervasive odor of urine.<br>On 6/29/15 at 8:21 A.M., the room of Resident #137 was observed to have a pervasive odor of urine.<br><br>During an interview on 6/29/15 at 3:00 P.M. the Housekeeping Supervisor indicated pervasive urine and BM odors were a problem on the unit because male residents urinated and/or defecated in areas other than the bathroom and/or urinated on the floors. The Housekeeping Supervisor then indicated the facility had no specific policy related to containing odors, but it was the usual facility practice to spot clean each room daily and deep clean monthly. | | Monitoring will be completed on all 3 shifts and will be ongoing<br>**By what date thesystemic changes will be completed:** 7/30/2015 | |

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| | 3.1-19(f) | | | |
| F 0514 SS=D Bldg. 00 | 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE 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.<br><br>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.<br><br>Based on observation, interview, and record review, the facility failed to ensure a clinical record was complete, in that, the documentation was not complete in regards to falls for 1 of 7 residents who met the criteria for review of falls. (Resident #8)<br><br>Findings include:<br><br>On 06/25/15 at 9:30 A.M., Resident #8 | F 0514 | **F 514 What Correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice:** After survey was completed, an intervention was locatedon an incident report. **How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by thedeficient practice. | 07/30/2015 |

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| | was observed in a TV lounge sitting in a wheelchair with a cast on the left upper extremity.<br><br>The clinical record of Resident #8 was reviewed on 6/29/15 at 9:30 A.M. The record indicated Resident #8 was admitted on 1/29/15 with diagnoses including, but not limited to, dementia, anxiety, difficulty walking, lack of coordination, and/or cognitive communication deficit.<br><br>A Nursing note dated 4/4/15 at 9:15 P.M., indicated Resident #8 experienced a fall from a bed side commode. The note lacked any documentation related to safety equipment in use, adequate supervision was provided, and/or a new, immediate, and/or effective intervention was initiated to ensure the safety of Resident #8.<br><br>A Nursing note dated 4/5/15 at 2:30 P.M., indicated, Resident #8 experienced a fall from a wheelchair. The note lacked any documentation related to safety equipment in use, adequate supervision was provided, and/or a new, immediate, and/or effective intervention was initiated to ensure the safety of Resident #8.<br><br>A Nursing note dated 4/12/15 at 2:10 P.M., indicated Resident #8 experienced | | **What measures willbe put into place or what systemic changes will be made to ensure that thedeficient practice does not recur:** The Interdisciplinary post fall review will be completedby nurses and nursing management to include new interventions **How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place:** An audit tool will be used to review interventions anddocumentation are in place with each fall meeting. Staff will be provideddocumentation education as needed. Deficiencies will be reported to the Quality Assurance Team Quarterly. Changeof Condition report will be completed 5 x per week to ensure follow through is accurate and complete ongoing with any fall or change of condition. Monitoring will be done on all 3 shifts and will be ongoing. **By what date thesystemic changes will be completed:** 7/30/2015 | |

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| | a fall from a wheelchair. The note lacked any documentation related to safety equipment in use, adequate supervision was provided, and/or a new, immediate, and/or effective intervention was initiated to ensure the safety of Resident #8.<br><br>A Nursing note dated 4/26/15 at 3:05 P.M., indicated Resident #8 experienced a fall. The note lacked any documentation related to the resident's location at the time of the fall. The note further lacked any documentation related to safety equipment in use, adequate supervision was provided, and/or a new, immediate, and/or effective intervention was initiated to ensure the safety of Resident #8.<br><br>A Nursing note dated 5/7/15 at 10:15 P.M., indicated Resident #8 experienced a fall from the bed and received a bruise to the left hip. The note lacked any documentation related to safety equipment in use, adequate supervision was provided, and/or a new, immediate, and/or effective intervention was initiated to ensure the safety of Resident #8.<br><br>A Nursing note dated 5/15/15 at 3:30 P.M., indicated Resident #8 experienced a fall while independently ambulating with a walker. The note lacked any documentation adequate supervision was | | | |

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| | provided, and/or a new, immediate, and/or effective intervention was initiated to ensure the safety of Resident #8.<br><br>A Nursing note dated 5/15/15 at 10:00 P.M., indicated Resident #8 experienced an unwitnessed fall in the hallway, a non-functioning bed alarm was observed on the bed and/or an immediate intervention of "new alarm" was initiated to ensure the safety of Resident #8. During an interview on 6/29/15 at 11:50 A.M., UM #10 indicated no documentation could be provided to indicate when the bed alarm was initiated.<br><br>A Nursing note dated 5/18/15 at 3:00 P.M., indicated Resident #8 experienced a fall from a chair in the dining room. The note lacked any documentation related to safety equipment in use, adequate supervision was provided, and/or a new, immediate, and/or effective intervention was initiated to ensure the safety of Resident #8.<br><br>A Nursing note dated 5/21/15 at 8:00 P.M., indicated Resident #8 experienced a fall from a chair in the dining room. The note lacked any documentation related to safety equipment in use, adequate supervision was provided, and/or a new. immediate, and/or effective | | | |

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| | intervention was initiated to ensure the safety of Resident #8.<br><br>A Nursing note dated 5/29/15 at 2:50 P.M., indicated Resident #8 experienced a fall from a chair in the dining room. The note lacked any documentation related to safety equipment in use, adequate supervision was provided, and/or a new. immediate, and/or effective intervention was initiated to ensure the safety of Resident #8.<br><br>A Nursing note dated 5/30/15 at 9:00 A.M., indicated Resident #8 experienced a fall from a sit to stand lift. The note lacked any documentation related to the safety equipment in use, adequate supervision was provided, and/or a new, immediate, and/or effective intervention was initiated to ensure the safety of Resident #8.<br><br>A Nursing note dated 6/16/15 at 10:00 P.M., indicated Resident #8 experienced a fall from a chair and "fell on left arm...noted indentation to left arm above wrist..." The note lacked any documentation to related safety equipment in use, adequate supervision was provided, and/or a new, immediate, and/or effective intervention was initiated to ensure the safety of Resident #8. | | | |

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| NAME OF PROVIDER OR SUPPLIER WILLOW MANOR | | STREET ADDRESS, CITY, STATE, ZIP CODE 3801 OLD BRUCEVILLE RD BOX 136 VINCENNES, IN 47591 | |

| (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 |
|---|---|---|---|---|
| | During an interview on 6/29/15 at 12:15 P.M., UM #10 indicated the clinical record should be complete. The policy and procedure for clinical records was requested, at that time, and was not provided.<br><br>3.1-45(a)(2) | | | |