

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155803	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/19/2014
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NAME OF PROVIDER OR SUPPLIER HAMILTON POINTE HEALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 3800 ELI PLACE NEWBURGH, IN 47630
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F000000	<p>This visit was for the Investigation of Complaint IN00158903.</p> <p>Complaint IN00158903 - Substantiated, Federal/State deficiencies related to the allegations are cited at F225, F323, and F514.</p> <p>Survey dates: November 17, 18, and 19, 2014</p> <p>Facility number: 012966 Provider number: 155803 AIM number: 201110390</p> <p>Survey team: Anne Marie Crays RN - TC</p> <p>Census bed type: SNF: 35 SNF/NF: 59 Residential: 48 Total: 142</p> <p>Census payor type: Medicare: 23 Medicaid: 49 Other: 22 Total: 94</p> <p>Sample: 4</p>	F000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F000225 SS=D	<p>These deficiencies reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on November 20, 2014 by Jodi Meyer, RN</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p>			

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	<p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record review, the facility failed to ensure a thorough investigation occurred after a resident alleged a staff member ran over her foot, and failed to report the incident to the Indiana Department of Health, for 1 of 4 residents reviewed for abuse, in a sample of 4. Resident D</p> <p>Findings include:</p> <p>1. On 11/17/14 at 10:50 A.M., the Administrator provided Indiana State Department of Health (ISDH) reportable incidents from the previous 3 months. There was no incident regarding Resident D.</p> <p>The closed clinical record of Resident D was reviewed on 11/17/14 at 2:15 P.M. The resident was admitted to the facility</p>	F000225	<p><i>The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.</i></p> <p>Immediate Actions taken for those residents identified:</p> <ul style="list-style-type: none"> Resident D – Event occurred in the past so unable to complete an immediate, thorough investigation. <p>How the Facility identified other residents:</p> <ul style="list-style-type: none"> Incidents/injuries reported in last 7 days reviewed and reported per protocol. 	12/12/2014

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	<p>with diagnoses including, but not limited to, cerebrovascular disease, general muscle weakness, abnormality of gait, and osteoporosis.</p> <p>An admission Minimum Data Set (MDS) assessment, dated 9/26/14, indicated the resident scored an 11 out of 15 for cognition, with 15 indicating no memory impairment.</p> <p>Progress Notes included the following notations:</p> <p>9/28/14 at 10:00 A.M.: "Needs extensive assist of one staff for transfers. Needs extensive assist of one for bed mobility...Resident is alert. Oriented to person. Oriented to place. Oriented to time. Speech is clear...."</p> <p>9/28/14 at 12:37 P.M.: "Resident has bruise to right [sic] foot. Resident able to move foot and toes. No swelling. Resident reports staff ran over foot with bedside table when given food."</p> <p>A Skin Report, dated 9/28/14, indicated, "Date First Observed, 09/28/2014...Bruise...Description [left blank], Treatment/Recommended Changes, bruise to left foot...Date MD notified 09/28/2014. Date family notified 09/28/2014."</p>		<p>Measures put into Place/System Changes:</p> <ul style="list-style-type: none"> · An inservice was provided for the facility staff regarding facility policy on fall monitoring and reportable criteria. · Staff will be inserviced immediately to report any allegations of alleged abuse or unusual incidents to the Administrator. · An investigation will be initiated and the allegation will be reported as required by state guidelines. · Injuries noted in Clinical Meeting will be reviewed for proper documentation and follow up. · Falls and Injuries will be investigated by facility protocol and recommendations made by IDT. This will be done in Clinical Meeting. <p>How the corrective actions will be monitored:</p> <ul style="list-style-type: none"> · All resident incidents and injuries will be reviewed in Clinical Meeting and documented on audit tool. · Audit tool will be reviewed 				

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	<p>Progress notes continued:</p> <p>9/29/14 at 1:35 P.M.: "[Name of physician] and family notified awaiting orders. DON [Director of Nursing] notified."</p> <p>9/30/14 at 6:56 A.M.: "Called Triage to ask if they ever received a [sic] authorization for an order to x-ray her left foot due to a bruise. [Son] called office to request for a xray...."</p> <p>9/30/14 at 10:00 A.M.: "Needs extensive assist of one staff for transfers...Complains of pain in foot."</p> <p>9/30/14 at 4:35 P.M.: "Received x-ray report...left foot shows fracture to left 5th metatarsal. Notified [name of physician] and received orders to see orthopedic and Tramadol 50 mg every 6 hours as needed for pain. Call placed to [Orthopedic name] and they recommended to send resident to Urgent Care for faster service as there [sic] foot MD is going on vacation. Call placed to son [name] to notify of x-ray results and orders for ortho visit and pain medication. To speak to sister...."</p> <p>The resident was transferred to the ER on 10/2/14 at 9:48 A.M.</p>		<p>monthly x3, and quarterly x1.</p> <ul style="list-style-type: none"> The Administrator/Designee will provide oversight. <p>Date of Compliance:</p> <ul style="list-style-type: none"> December 12, 2014 	

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	<p>A hospital ER note, dated 10/2/14 at 9:51 A.M., indicated, "Chief Complaint:...she is recently [sic] sustained a crush injury to her left foot sustaining a toe fracture at [name of facility]...Final Impression:...3. Recent fracture left foot, sustained at [name of facility]...."</p> <p>An ER note, dated 10/2/14 at 2:46 P.M., indicated, "Walker boot placed on left foot - pt [patient] tolerated...Pt is alert and oriented...."</p> <p>The resident returned to the facility on 10/2/14 at 3:53 P.M.</p> <p>At 11/18/14 at 11:15 A.M., the Administrator was requested to provide further information regarding the resident's bruise and fracture of her left foot. The Administrator indicated she had started as the Administrator on 10/13/14, and was unaware of this incident.</p> <p>On 11/18/14 at 2:30 P.M., the Administrator provided an "Investigation of Skin Tear, Bruises, and Abrasions," undated and signed by the current Director of Nursing (DON). The Administrator indicated the current DON was not the DON during this incident. The document was unsigned by the Administrator. The investigation</p>			

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	<p>indicated, "Exact location of area: Rt [right] [sic] foot cross top of foot...bruise Rt foot...Resident reports when staff brought lunch they rolled her bedside table over her foot. Most likely cause: bruise. Staff Interviews conducted? No. New Intervention implemented, encourage resident to eat at table in room. Reported to Department of Health? No...."</p> <p>On 11/18/14 at 2:40 P.M., during an interview with the Skilled Unit Manager, she indicated she was "working the floor" on 9/28/14. She indicated she had to "rack my brain" to remember what happened to Resident D's foot. She indicated "from what she could remember," the resident complained to her that they ran over her foot with a cart or bedside table or something." She indicated she took off the resident's sock, and noticed bruising over the top of her toes. She indicated she did not know who the staff might have been who caused the bruising.</p> <p>On 11/19/14 at 1:35 P.M., during an interview with the Corporate Administrator, she indicated she was present and was working as the Administrator on 9/28/14 when this incident occurred. She indicated she did not report this incident to the ISDH</p>			

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	<p>because, "We knew what happened and it didn't meet out policy for reportable bruises." She indicated, since the size of the bruising was not documented, that it "was probably the size of her toe." She indicated that she did not think the event "was that unusual. It was an accident." When informed it did not appear to have been investigated until 11/18/14, she indicated she thought that it had been investigated, but did not know where that documentation would be. She was unable to state the name of the employee who ran over the resident's foot.</p> <p>2. On 11/19/14 at 10:55 A.M., Medical Records Staff # 1 provided the current facility policy on "Abuse, Neglect, and Misappropriation of Resident Property," revised 11/2010. The policy included: "...The facility will ensure that all allegations of mistreatment, neglect or abuse, including injuries of unknown source, are reported immediately to the Administrator...The Administrator shall notify ISDH in accordance with ISDH Guidelines...When incidents involving suspected abuse, neglect or mistreatment including [sic] are reported, the facility shall take the following steps:...If resident sustains injury by an employee or employee is a suspected perpetrator: i. Remove the employee immediately. ii. Staff is to notify immediate supervisor</p>			

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F000323 SS=G	<p>and he or she must conduct interview with employee and resident. iii. Employee must be sent home (suspended) immediately pending outcome of final investigation...11. The facility will keep evidence that all alleged violations are thoroughly investigated...."</p> <p>This Federal tag relates to Complaint IN00158903.</p> <p>3.1-28(d)</p> <p>483.25(h) FREE OF ACCIDENT</p>				

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	<p>HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on interview and record review, the facility failed to properly provide care in that staff ran over a resident's foot with a bedside table, causing a fracture of her left toe, and failed to provide appropriate supervision to prevent falls, for 1 of 3 residents reviewed for accidents, in a sample of 4. Resident D</p> <p>Findings include:</p> <p>1. The closed clinical record of Resident D was reviewed on 11/17/14 at 2:15 P.M. The resident was admitted to the facility with diagnoses including, but not limited to, cerebrovascular disease, general muscle weakness, abnormality of gait, and osteoporosis.</p> <p>A Progress Note, dated 9/20/14 at 11:48 A.M., indicated, "Needs extensive assist of one staff for transfers. Needs extensive [sic] assist of one for ambulation. Needs extensive assist of one for bed mobility...Resident complains of weakness...."</p> <p>A "Fall IDT [interdisciplinary team]</p>	F000323	<p><i>The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.</i></p> <p>Immediate Actions taken for those residents identified:</p> <ul style="list-style-type: none"> Resident D – Event occurred in the past so unable to complete an immediate, thorough investigation. <p>How the Facility identified other residents:</p> <ul style="list-style-type: none"> Incidents/injuries reported in last 7 days reviewed and reported per protocol. <p>Measures put into Place/System Changes:</p> <ul style="list-style-type: none"> An inservice was provided for the facility staff regarding facility policy on fall monitoring and reportable criteria. 	12/12/2014			

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	<p>Note," dated 9/24/14 at 11:39 A.M., indicated, "Summary of the fall: Staff responded to call light, upon entering room, nurse found residency [sic] sitting on the floor on buttocks in front of statinatory [sic] chair in room...Resident stated that she attempted to transfer self from chair. Intervention and care plan updated: Resident encouraged to call for assistance with transfers, pressure alarm placed and [sic] bed and chair."</p> <p>Documentation which indicated on what date or time that the resident actually fell was not found in the clinical record.</p> <p>An admission Minimum Data Set (MDS) assessment, dated 9/26/14, indicated the resident scored an 11 out of 15 for cognition, with 15 indicating no memory impairment. The MDS assessment indicated the resident required limited assistance of one staff for transfer and ambulation. A test of "Balance During Transitions and Walking" indicated "Not steady, only able to stabilize with staff assistance." The resident had fallen one time since admission.</p> <p>Progress Notes included the following notations:</p> <p>9/27/14 at 2:00 P.M.: "This nurse answered call light and found resident</p>		<ul style="list-style-type: none"> · Staff will be inserviced immediately to report any allegations of alleged abuse or unusual incidents to the Administrator. · An investigation will be initiated and the allegation will be reported as required by state guidelines. · Injuries noted in Clinical Meeting will be reviewed for proper documentation and follow up. · Falls and Injuries will be investigated by facility protocol and recommendations made by IDT. This will be done in Clinical Meeting. <p>How the corrective actions will be monitored:</p> <ul style="list-style-type: none"> · All resident incidents and injuries will be reviewed in Clinical Meeting and documented on audit tool. · Audit tool will be reviewed monthly x3, and quarterly x1. · The DON/Designee will provide oversight. <p>Date of Compliance:</p>	

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	<p>sitting on the floor. Daughter stated, 'I was assisting mother to the bathroom and had to assist her to the floor on her bottom due to weakness....'</p> <p>9/28/14 at 10:00 A.M.: "Needs extensive assist of one staff for transfers. Needs extensive assist of one for bed mobility...Resident is alert. Oriented to person. Oriented to place. Oriented to time. Speech is clear...."</p> <p>9/28/14 at 12:37 P.M.: "Resident has bruise to right [sic] foot. Resident able to move foot and toes. No swelling. Resident reports staff ran over foot with bedside table when given food."</p> <p>A Skin Report, dated 9/28/14, indicated, "Date First Observed, 09/28/2014...Bruise...Description [left blank], Treatment/Recommended Changes, bruise to left foot...Date MD notified 09/28/2014. Date family notified 09/28/2014."</p> <p>Progress notes continued:</p> <p>9/29/14 at 1:35 P.M.: "[Name of physician] and family notified awaiting orders. DON [Director of Nursing] notified."</p> <p>9/30/14 at 6:56 A.M.: "Called Triage to</p>		December 12, 2014	

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	<p>ask if they ever received a [sic] authorization for an order to x-ray her left foot due to a bruise. [Son] called office to request for a xray...."</p> <p>9/30/14 at 10:00 A.M.: "Needs extensive assist of one staff for transfers...Complains of pain in foot."</p> <p>9/30/14 at 4:35 P.M.: "Received x-ray report...left foot shows fracture to left 5th metatarsal. Notified [name of physician] and received orders to see orthopedic and Tramadol 50 mg every 6 hours as needed for pain. Call placed to [Orthopedic name] and they recommended to send resident to Urgent Care for faster service as there [sic] foot MD is going on vacation. Call placed to son [name] to notify of x-ray results and orders for ortho visit and pain medication. To speak to sister...."</p> <p>A Physical Therapy note, dated 10/1/14 at 2:51 P.M., indicated, "Precautions: Fall risk...Pain-General...Patient verbalized pain level; Does pain limit patient's functional activities? = Yes; Pain limits the following functional activities: Walking and standing with RW [rolling walker], What relieves pain? Sitting down; What exacerbates pain? = Standing...Frequency= Constant; Location: left foot; Pain</p>			

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	<p>Description/Type: left foot sharp pain with weight bearing...Patient very fearful of hurting left foot with movement...."</p> <p>Progress notes continued:</p> <p>10/1/14 at 6:21 P.M.: "When assisting resident to bathroom this evening resident had tremors noted to all extremities. Resident [sic] also very weak and taking extensive assist of 2 to transfer. Spoke with daughter about resident decline over last few days of increased weakness and tremors...."</p> <p>10/1/14 at 6:52 P.M.: "Received call from daughter [name] and she stated that her and her brother agree that she should be sent to ER although they does [sic] not want her to go until the morning...Call placed to [name of physician] at that time and he agreed to send resident for evaluation in the morning."</p> <p>The resident was transferred to the ER on 10/2/14 at 9:48 A.M.</p> <p>A hospital ER note, dated 10/2/14 at 9:51 A.M., indicated, "Chief Complaint:...she is recently [sic] sustained a crush injury to her left foot sustaining a toe fracture at [name of facility]...Final Impression:...3. Recent fracture left foot, sustained at [name of facility]...."</p>			

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NAME OF PROVIDER OR SUPPLIER HAMILTON POINTE HEALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 3800 ELI PLACE NEWBURGH, IN 47630
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	<p>An ER note, dated 10/2/14 at 2:46 P.M., indicated, "Walker boot placed on left foot - pt [patient] tolerated...Pt is alert and oriented...."</p> <p>The resident returned to the facility on 10/2/14 at 3:53 P.M.</p> <p>Progress notes continued:</p> <p>10/2/14 at 9:04 P.M.: "Needs extensive assist of two staff for transfers. Resident did not ambulate today. Needs extensive assist for two staff for bed mobility...Needs extensive assist of two staff for dressing and grooming...."</p> <p>10/4/14 at 10:00 A.M.: "Needs extensive assist of two staff for transfers. Resident did not ambulate today...Needs extensive assist with dressing and grooming...."</p> <p>10/6/14 at 10:20 A.M.: "Fall IDT Note...Summary of the fall: Resident attempting to toilet self fell. Root cause of fall: Poor safety awareness resident attempting to toilet self. Intervention and care plan updated: Assess for toileting program."</p> <p>Documentation which indicated on what date and time that the resident actually fell was not found in the clinical record.</p>			

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	<p>Documentation which indicated if the resident's alarm was sounding was not found in the clinical record.</p> <p>Progress notes continued:</p> <p>10/9/14 at 8:42 P.M.: "Needs extensive assist of two staff for transfers. Resident did not ambulate today...Resident is alert. Oriented to person...Gait is unsteady. Has impaired balance while standing...."</p> <p>10/14/14 at 3:51 P.M.: "Fall IDT Note. Summary of the fall: IDT reviewed fall documentation. No injury or pain noted. Resident feel [sic] out of wheelchair...Resident was in wheelchair trying to reach papers on table and fell. Intervention and care plan updated: Resident not to be left in room in wheelchair unattended."</p> <p>Documentation of what date and time the resident actually fell was not found in the clinical record. Documentation regarding if the alarm was sounding or not was not found in the clinical record.</p> <p>At 11/18/14 at 11:15 A.M., the Administrator was requested to provide further information regarding the resident's bruise and fracture of her left foot, and of her falls.</p>			

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	<p>At 11/18/14 at 1:30 P.M., the Administrator and Director of Nursing (DON) provided "Fall Investigation Worksheets" for falls on 9/22/14, 9/27/14, 10/4/14, and 10/11/14. The Administrator also provided electronic fall worksheets regarding the falls. She indicated these documents were not a part of the clinical record. She indicated the staff were supposed to transfer the information to the progress notes. The DON indicated an IDT note was usually documented 1-2 days after a fall, in addition to the progress note.</p> <p>A Falls Investigation Worksheet, dated 9/22/14, included: "Number of falls in the last 30 days? [Left blank], Locations of this fall: Resident Room, Time of this fall: [Left blank]...what was resident trying to do? Transfer on own...Unwitnessed fall...What recommendations/interventions were put in place at time of fall? Pressure alarm to bed and chair...."</p> <p>A Falls Investigation Worksheet, dated 10/4/14, included: "...Behavior at the time of this fall: Restless...[increased] confusion R/T [related to] UTI [urinary tract infection], Number of Falls in the past 31-180 days: ?, Location of this fall? Resident Room, Time of this fall: 2030 [8:30 P.M.]... What were the</p>			

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	<p>recommendations/interventions in place at the time of the fall? Walker, pressure alarm to bed and wheelchair. What recommendations/interventions were put in place at time of fall? Toileting schedule. Conclusion...Resident attempting to transfer self to toilet."</p> <p>A Falls Investigation Worksheet, dated 10/11/14, included: "...Number of Falls in the past 31-180 days [a check mark was documented], Location of this fall: Resident Room, Time of this fall: 1637 [4:37 P.M.]...what was resident attempting to do? pick up papers...require supervision? Yes; Resident at nurses station; not to be left in room while up in w/c [wheelchair]...Was the resident injured? No...What were the recommendations/interventions in place at the time of the fall? Pressure alarm to bed and chair...Encourage resident to use call light when assistance is needed. What recommendations/interventions were put in place at time of fall? Resident taken to nurses station. Resident is not to be left in room when up in wheelchair. Conclusion...Resident found on floor on left side in front of wheelchair. Resident stated that she was 'trying to get papers on table.'"</p> <p>On 11/18/14 at 2:30 P.M., the Administrator provided an "Investigation</p>			

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	<p>of Skin Tear, Bruises, and Abrasions," undated and signed by the current Director of Nursing. The Administrator indicated the current DON was not the DON during this incident. The document was unsigned by the Administrator. The Investigation indicated, "Exact location of area: Rt [right] [sic] foot cross top of foot...bruise Rt foot...Resident reports when staff brought lunch they rolled her bedside table over her foot. Most likely cause: bruise. Staff Interviews conducted? No. New Intervention implemented, encourage resident to eat at table in room. Reported to Department of Health? No...."</p> <p>On 11/18/14 at 2:40 P.M., during an interview with the Skilled Unit Manager, she indicated she was "working the floor" on 9/28/14. She indicated she had to "rack my brain" to remember what happened to Resident D's foot. She indicated "from what she could remember," the resident complained to her that they ran over her foot with a cart or bedside table or something." She indicated she took off the resident's sock, and noticed bruising over the top of her toes. She indicated she did not know who the staff might have been who caused the bruising.</p> <p>At that time, the Rehab Unit Manager</p>			

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	<p>indicated Resident D "would try to get up by herself, so we moved her closer to the nurses station."</p> <p>On 11/18/14 at 3:00 P.M., the Administrator indicated staff had spoken to the nurses who filled out the incident sheets regarding the falls on 10/4/14 and 10/11/14. She indicated LPN # 1, who was working on 10/4/14, thought she remembered the resident's alarm sounding. She indicated RN # 2, who was working on 10/11/14, could not remember if an alarm was sounding or not.</p> <p>2. On 11/19/14 at 1:30 P.M., the Administrator provided the current facility policy on "Fall Evaluation and Investigation," revised 8/2013. The policy included: "Purpose: 1. To detect root cause of falls to extent possible and to identify supportive aides to prevent falls. 2. To identify high-risk residents and implement interventions to reduce falls and the consequences of falls..."</p> <p>This Federal tag relates to Complaint IN00158903.</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p>			

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F000514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically			

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	<p>organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on interview and record review, the facility failed to ensure documentation was complete regarding residents who had fallen, for 2 of 3 residents reviewed for falls, in a sample of 4. Residents D and C</p> <p>Findings include:</p> <p>1. The closed clinical record of Resident D was reviewed on 11/17/14 at 2:15 P.M. The resident was admitted to the facility with diagnoses including, but not limited to, cerebrovascular disease, general muscle weakness, abnormality of gait, and osteoporosis.</p> <p>A "Fall IDT [interdisciplinary team] Note," dated 9/24/14 at 11:39 A.M., indicated, "Summary of the fall: Staff responded to call light, upon entering room, nurse found residency [sic] sitting on the floor on buttocks in front of statinonary [sic] chair in room...Resident stated that she attempted to transfer self from chair. Intervention and care plan updated: Resident encouraged to call for</p>	F000514	<p><i>The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.</i></p> <p>Immediate Actions taken for those residents identified:</p> <ul style="list-style-type: none"> Resident D is no longer in facility. <p>How the Facility identified other residents:</p> <ul style="list-style-type: none"> Resident Progress Notes and related documentation is reviewed in Clinical Meeting for completeness with a 24 or 72 hour look back report. <p>Measures put into Place/System Changes:</p> <ul style="list-style-type: none"> An inservice was provided for the facility staff regarding facility 	12/12/2014			

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	<p>assistance with transfers, pressure alarm placed and [sic] bed and chair."</p> <p>Documentation which indicated on what date or time that the resident actually fell was not found in the clinical record.</p> <p>Progress Notes included the following notations:</p> <p>10/6/14 at 10:20 A.M.: "Fall IDT Note...Summary of the fall: Resident attempting to toilet self fell. Root cause of fall: Poor safety awareness resident attempting to toilet self. Intervention and care plan updated: Assess for toileting program."</p> <p>Documentation which indicated on what date and time that the resident actually fell was not found in the clinical record. Documentenation which indicated if the resident's alarm was sounding was not found in the clinical record.</p> <p>Progress notes continued:</p> <p>10/14/14 at 3:51 P.M.: "Fall IDT Note. Summary of the fall: IDT reviewed fall documentation. No injury or pain noted. Resident feel [sic] out of wheelchair...Resident was in wheelchair trying to reach papers on table and fell. Intervention and care plan updated:</p>		<p>policy on fall monitoring and reportable criteria.</p> <ul style="list-style-type: none"> · Staff will be inserviced immediately to report any allegations of alleged abuse or unusual incidents to the Administrator. · An investigation will be initiated and the allegation will be reported as required by state guidelines. · Injuries noted in Clinical Meeting will be reviewed for proper documentation and follow up. · Falls and Injuries will be investigated by facility protocol and recommendations made by IDT. This will be done in Clinical Meeting. <p>How the corrective actions will be monitored:</p> <ul style="list-style-type: none"> · All resident incidents and injuries will be reviewed in Clinical Meeting and documented on audit tool. · Record review will be done on all related injuries/incidents/falls for complete and thorough documentation per protocol. · Audit tool will be reviewed monthly x3, and quarterly x1. 	

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	<p>Resident not to be left in room in wheelchair unattended."</p> <p>Documentation of what date and time the resident actually fell was not found in the clinical record. Documentation regarding if the alarm was sounding or not was not found in the clinical record.</p> <p>At 11/18/14 at 1:30 P.M., the Administrator and Director of Nursing (DON) provided "Fall Investigation Worksheets" for falls on 9/22/14, 9/27/14, 10/4/14, and 10/11/14. The Administrator also provided electronic fall worksheets regarding the falls. She indicated these documents were not a part of the clinical record. She indicated the staff were supposed to transfer the information on the fall worksheets to the progress notes. The DON indicated an IDT note was usually documented 1-2 days after a fall, in addition to the progress note.</p> <p>A Fall Investigation Worksheet, dated 9/22/14, indicated, "...Number of Falls in the past 31-180 days? [Left blank], Location of this fall: Resident Room, Time of this fall: [Left blank]...Unwitnessed Fall...What recommendations/interventions were put in place at time of fall? Pressure alarm to bed and chair..."</p>		<ul style="list-style-type: none"> The DON/Medical Records/Designee will provide oversight. <p>Date of Compliance:</p> <ul style="list-style-type: none"> December 12, 2014 	

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	<p>A Falls Investigation Worksheet, dated 10/4/14, included: "...Behavior at the time of this fall: Restless...[increased] confusion R/T [related to] UTI [urinary tract infection], Number of Falls in the past 31-180 days: ?, Resident Room Time of this fall: 2030 [8:30 P.M.]..."</p> <p>A Falls Investigation Worksheet, dated 10/11/14, included: "...Number of Falls in the past 31-180 days [a check mark was documented], Resident Room, Time of this fall: 1637 [4:37 P.M.]..."</p> <p>On 11/18/14 at 3:00 P.M., the Administrator indicated staff had spoken to the nurses who filled out the incident sheets regarding the falls on 10/4/14 and 10/11/14. She indicated LPN # 1, who was working on 10/4/14, thought she remembered the resident's alarm sounding. She indicated RN # 2, who was working on 10/11/14, could not remember if an alarm was sounding or not.</p> <p>2. On 11/17/14 at 10:30 A.M., the Rehab Unit Manager indicated Resident C had fallen recently.</p> <p>The clinical record of Resident C was reviewed on 11/19/14 at 8:45 A.M.</p>			

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	<p>Progress notes included the following notations:</p> <p>11/17/14 at 1:34 P.M.: "Fall IDT Note, Summary of the fall: Nurse walked by resident room & observed resident sitting on floor back against bed. Resident stated that she was tring [sic] to clean up water off the floor...Intervention and care plan updated: Resident to use reacher with wash cloth to clean spill off of floor."</p> <p>Documentation of when the fall actually occurred was lacking in the clinical record.</p> <p>On 11/19/14 at 10:55 A.M., Medical Records Staff # 1 provided an incident report for Resident C. The report, dated 11/14/14 at 11:20 P.M., indicated, "This nurse walking by resident's room and observed resident sitting on floor...."</p> <p>On 11/19/14 at 11:45 A.M., during interview with the Administrator, she indicated she was aware of documentation issues regarding the resident's fall.</p> <p>3. On 11/19/14 at 1:30 P.M., the Administrator provided the current facility policy on "Fall Evaluation and Investigation," revised 8/2013. The policy included: "...When you find a</p>			

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	<p>resident has fallen...Document findings in a fall progress note template...Complete IDT Fall Note...."</p> <p>This Federal tag relates to Complaint IN00158903.</p> <p>3.1-50(a)(1)</p>			

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

PRINTED: 12/10/2014

FORM APPROVED

OMB NO. 0938-0391

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