

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155621	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/26/2015
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NAME OF PROVIDER OR SUPPLIER PINE HAVEN HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3400 STOCKER DR EVANSVILLE, IN 47720
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F 000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey Dates: May 18, 19, 20, 21, and 26, 2015</p> <p>Facility Number: 000442 Provider Number: 144621 AIM Number: 100266510</p> <p>Census Bed Type: SNF: 21 SNF/NF: 54 Total: 75</p> <p>Census Payor Type: Medicare: 21 Medicaid: 35 Other: 19 Total: 75</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 000	<p>By submitting the Plan of Correction, the facility is not admitting the truth or accuracy of the cited deficiencies or allegations. The facility reserves the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the Plan of Correction be considered our allegation of compliance, effective 062515, to the cited deficiencies of the Re-certification and State Licensure Survey, ID5CAT111, exit date, 052515.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F 241 SS=D Bldg. 00	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation and interview, the facility failed to provide and/or promote dignity and privacy to 1 of 4 residents who were observed receiving personal care, in that, a resident was assisted to the bathroom and no privacy was provided. (Resident #92)</p> <p>Findings include:</p> <p>During an observation on 5/21/15 at 9:55 a.m., CNA #1 was observed to assist Resident #92 to the bathroom. CNA #1 was observed to removed a soiled brief from Resident #92 while in the bathroom and cleansed the resident's perineum. CNA #1 was observed to assist Resident #92 back to her chair. CNA #1 was observed to leave the bedroom and the bathroom doors open while the resident</p>	F 241	<p>Resident # 92 is now receiving all personal care in accordance with facility policy related to resident dignity and privacy. As all residents residing in the facility have been identified as having the potential to be affected by the cited deficient practice, with education provided to all staff. The education included the policy on Resident Rights as related to dignity and privacy. The in-service also included the requirement to treat residents in a manner that maintains privacy when going to the bathroom, and in other activities of personal hygiene such as bathing, dressing, and grooming. This education also included staff interactions with residents, and how to carry out activities that assist the resident to maintain and enhance his/her self-esteem and self-worth. A monitoring tool is being used to ensure personal care is being provided with dignity and respect</p>	06/25/2015

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	<p>was in the bathroom.</p> <p>The clinical record for Resident #92 was reviewed on 5/20/15 at 11:38 a.m. Resident #92 had diagnoses including, but not limited to, anemia, squamous cell cancer of the skin, hyperlipidemia, hypertension, kidney disease, osteoarthritis, chronic back pain, and osteopenia. The quarterly MDS (Minimum Data Set) assessment, dated 2/14/15, indicated Resident #92 had a BIMS (Brief Interview for Mental Status) score of 14, which indicated very slight cognitive impairment.</p> <p>Resident #92 's MDS on 2/14/15 (quarterly) indicated she had occasional incontinence of bowel and bladder.</p> <p>A physician order, dated 5/1/15 through 5/31/15 and signed on 5/12/15, indicated Resident #92 was to be up with assist of 1 person as tolerated with a rolling walker.</p> <p>During an interview on 5/21/15 at 10:07 a.m., CNA #1 indicated she did not believe the resident had a reason to leave the doors opened.</p> <p>During an interview on 5/21/15 at 10:15 a.m., Resident #92 indicated she was upset as she had been incontinent of stool. Resident #92 indicated she had not</p>		<p>for each resident's right to privacy and dignity. The tool will be completed daily 5 times a week, on random shifts, for two weeks, three (3) times weekly for four (4) weeks. Progressing to weekly for one month. Then, monthly for three months and then quarterly for three quarters. This monitoring will conducted by the Director of Nursing/designee. To ensure the deficient practice does not recur, the facility reviewed the policy on Resident Rights related to dignity and privacy. Education has been provided to all staff to ensure a clear understanding of the policy and the facility's expectation to follow the policy. A Quality Assurance Tool has been developed and implemented to monitor the personal care of the residents to ensure that personal care is being provided with dignity and respect of the resident's right to privacy. This tool will be completed by the Social Service Director and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome will be reviewed at the facility's Quality Assurance Performance Improvement (QAPI) meetings to determine if any additional action is warranted.</p>		

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F 282 SS=D Bldg. 00	<p>been assisted to the bathroom quick enough to keep her from being incontinent.</p> <p>A policy, obtained from the Administrator on 5/26/15 at 4:57 p.m., indicated the facility was to uphold the resident's rights to privacy and the facility was also to maintain the resident's dignity through a homelike environment</p> <p>3.1-3(t)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to follow the written plan of care, in that, alarms were not in use, residents were left unassisted in the bathroom, and gait belts were not used for transfers for 3 of 31 residents reviewed in the Stage 2 sample. (Resident #133, Resident #82, Resident #58)</p> <p>Findings include:</p> <p>1. On 5/19/15 at 8:50 a.m., LPN #1 was</p>			F 282	<p>Resident# 133's plan of care has been reviewed by nursing to ensure all interventions are appropriate to meet the resident's needs. The resident's safety interventions are now in place in accordance with the resident's plan of care. Resident# 83's plan of care has been reviewed by nursing to ensure all interventions are appropriate to meet the resident's needs. The resident is now receiving assistance with transfers and ambulation as identified in her plan of care. Resident# 58's plan of care has been reviewed by nursing to</p>		06/25/2015

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	<p>interviewed. LPN #1 indicated Resident #133 had fallen recently and broken her hip but had not had surgery.</p> <p>On 5/19/15 at 2:53 p.m., Resident #133's clinical record was reviewed. Resident #133 was admitted on 4/15/15. Resident #133's diagnoses included, but were not limited to, dementia and aftercare of healing traumatic fracture of upper leg.</p> <p>The Fall Risk Assessment, dated 5/12/15, indicated Resident #133 was a high risk for falls.</p> <p>The progress notes included, but were not limited to: 4/21/15 at 10:31 p.m.: Resident fell at 7:45 p.m. No injuries noted and all parties were notified. Resident was in dining room and attempted to rise from wheelchair. She lost balance and fell. 5/5/15 at 1:30 p.m.: Resident found on floor laying on right side, in front of wheelchair...resident has no complaints of pain, no internal/external rotation noted, no lengthening or shortening noted, staples intact to left hip... 5/5/15 at 8:00 p.m.: Transferred to (Name of Hospital) via (Name of ambulance service) family notified resident fell at 1:30 p.m. out of wheelchair, got orders....for bilateral hip x-ray's which were done and showed new</p>		<p>ensure all interventions are appropriate to meet the resident's needs. The resident is now being transferred/ambulated with the proper use of a gait belt to ensure safe transfers/ambulation. As all residents have the potential to be affected by the cited deficient practice, a house wide audit has been completed to ensure that each resident's plan of care is appropriate to meet the resident's needs. The CNA assignment sheets have been up-dated to reflect the resident's needs, which include level of assistance needed, use of safety alarms and use of gait belts during transfers/ambulation. The corrective measures put into place include in-service education for all nursing staff. The education provided emphasized the importance of following each resident's plan of care as it relates to the use of safety interventions, level of assistance needed and the use of gait belts during transfers/ambulation. The CNAs were also instructed on following the information provided on their assignment sheets as it will contain important components from the resident's plan of care. A monitoring tool was developed and implemented to monitor the application of the resident's plan of care as related to safety interventions, level of assistance needed and the proper use of gait belts during transfers/ambulation. This tool will</p>	

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	<p>fracture in left hip</p> <p>The Clinical Review, dated 5/6/15, indicated: Review of fall. Resident was observed lying on floor in front of wheelchair resting on right side.</p> <p>The Radiology Report, dated 5/5/15, indicated: The visualized osseous (bone) structures demonstrate an acute complete slightly displaced left subcapital hip fracture.</p> <p>The Care Plans included, but were not limited to: Resident has potential for falls related to history of falls, loses balance easily, left hip fracture, dated 4/22/15. The interventions included, but were not limited to, pad alarm to bed and chair due to decreased safety awareness, dated 4/22/15.</p> <p>On 5/19/15 at 3:46 p.m., Resident #133 was observed in the common area watching television. The alarm to the wheelchair was observed in place.</p> <p>On 5/21/15 at 9:52 a.m., LPN #1 indicated Resident #133 had been admitted to the facility and had been discharged to the hospital for removal of orthopedic hardware from a previous surgery. The Resident had returned to</p>		<p>be completed by the Director of Nursing and/or her designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcomes will be reviewed at the facility QAPI meeting to determine if any additional action is warranted.</p>	

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	<p>the facility with five staples. LPN #1 indicated Resident #133 had fallen in the facility and received a hairline fracture to her left leg but surgery was not completed. LPN #1 could not locate documentation which indicated Resident #133's alarm was sounding when the resident fell.</p> <p>2. During the initial tour on 5/18/15 at 11:00 a.m. Resident # 82 was observed to have a large bruise with swelling, bleeding and sutures on left side of head, she also had oozing blood from a pressure stocking on left leg.</p> <p>The clinical record of Resident # 82 was reviewed on 5/19/15 at 1:55 p.m. Resident #82 had diagnoses including, but not limited to, venous stasis syndrome with ulcer, cellulitis of both lower extremities, depression, hypertension, and congestive heart failure.</p> <p>The quarterly MDS (Minimum Data Set), dated 4/17/15, indicated the resident needed supervision with set up for toileting. The BIMS (Brief Interview for Mental Status) assessment indicated Resident #82 had a score of 12 out of 15 possible, which indicated mild cognitive impairment.</p> <p>A care plan, dated 11/11/14, included,</p>			

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	<p>but not limited to: Resident #82 had a potential for fall due to attempts to stand unassisted, loses her balance easily, and had an unsteady gait. The care plan further indicated the resident was to be up with assist of one person and use of an assistive device.</p> <p>A nurses note, dated 5/18/15 at 10:00 a.m., indicated Resident #82 was heard yelling "help" from the bathroom at 5:25 a.m. The note indicated Resident #82 was found lying on the bathroom floor on the left side next to the commode. Resident #82 was observed to have a 3 inch by 5 cm (centimeter) laceration with a hematoma around it and a large amount of bleeding. Neuro checks were completed with the pupils brisk, the grasps strong, and the resident was able to all extremities without pain. The note indicated Resident #82 had a 6 cm by 2 cm abrasion on the left knee which was not bleeding and the nurse was unable to approximate the skin. Resident #82 was transferred to a w/c (wheelchair) with assist of 3 persons and the resident was a total lift. The note further indicated the physician and the resident's brother were notified and the resident was transferred to the hospital at 6:10 a.m.</p> <p>A nurses notes, dated 5/18/15 at 10:30 a.m., indicated Resident #82 returned to</p>			

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	<p>the facility with sutures to the left side of the forehead. New physician's orders were received for ice on hematoma for 30 minutes every shift as needed.</p> <p>A follow-up review of the nurse's notes on 5/20/15 at 10:15 a.m., indicated Resident #82 remained on a follow-up fall assessment. The note further indicated Resident #82 was an extensive assist of one person with transfers due to unsteady gait with surface to surface transfers.</p> <p>The physician's orders indicated Resident #82 was to be up with the assist of one with an assistive device. The initial physician's was dated 1/14/15.</p> <p>The physical therapy notes, dated 3/29/15, indicated the resident was adamant about not trying to stand or bear weight. Resident #82 was discharged from physical therapy. A note also indicated Resident #82 was at a high risk for falls.</p> <p>During an interview on 5/19/15 at 10:50 a.m. RN #2 indicated the resident had been in bathroom alone and fell off of the commode. She indicated resident would use the shower bathroom instead of the room bathroom because it was bigger.</p>			

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	<p>During an interview on 5/20/15 at 11:30 a.m., the DON (Director of Nursing) indicated there were no written reports on incidents except in nurses notes. The DON indicated the fall had not been reported to the Indiana State Department of Health.</p> <p>During an interview on 5/21 at 11:45 a.m., the DON and the Adm (Administrator) indicated Resident #82 would often go into bathroom without assistance. They indicated the toilet seat was loose and when Resident #82 changed positions, the toilet seat slipped and the resident fell off. The Adm indicated the commode seat was to be repaired and/or replaced.</p> <p>During an interview on 5/21/15 at 2:00 p.m., Resident #82 indicated she frequently went to bathroom on her own. Resident #82 further indicated she was alone in bathroom on the morning of her fall. She indicated she had reached down to pick something up from the floor and fell onto the floor.</p> <p>3. The clinical record of Resident #58 was reviewed on 5/20/15 at 9:15 a.m. Resident #58 had diagnoses including, but not limited to, hypertension, arthritis, dementia, diabetes, hyperlipidemia, depression and congestive heart failure.</p>			

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	<p>A quarterly MDS (Minimum Data Set) assessment, dated 2/18/15, indicated Resident #58 required extensive assist with ADL's (activities of daily living). The MDS indicated Resident #58 had a BIMS (Brief Interview for Mental Status) assessment score of 4 of possible 15 which indicated severe cognitive impairment.</p> <p>The nurse's notes indicated that on 5/15/15, Resident #58 had been transferred from the wheelchair to the bed by a CNA. The note indicated Resident #58 became weak and was assisted to the floor. The note further indicated the CNA was unable to move the wheelchair out of the way due to the anti-rollback device on the chair. The note indicated the CNA had not used a gait belt when Resident #58 was transferred. The note further indicated interventions including, but not limited to, CNA provided education on importance of utilization of gait belt for all transfers, the resident was assessed, and vital signs were obtained. The note indicated no changes to the plan of care were recommended by the clinical review team.</p> <p>A care plan, dated 11/21/14, indicated Resident #58 had a history of falls or unsteady gait. The care plan further</p>			

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	<p>indicated Resident #58 would be walked a distance of 20 feet daily with a gait belt, rolling walker and staff assist of 1 (one).</p> <p>A cumulative physician's order, dated 5/1/15 through 5/31/15 and signed on 5/20/15, indicated Resident #58 was to be up with assist to the wheelchair as tolerated.</p> <p>During an interview on 5/20/15 at 11:00 a.m., the DON (Director of Nursing) indicated Resident #58 had been lowered to the floor after becoming weak. The DON further indicated the CNA was not using a gait belt during the transfer of the resident back into bed. The DON indicated gait belts were to be used while transferring and/or walking all residents.</p> <p>On 5/26/15 at 5:00 p.m., the Administrator provided the Interdisciplinary Care Plan Policy and Procedure. The policy indicated its purpose was to act as a communication tool that allowed staff members to interact with on another regarding resident care and allow for a constant and consistent approach in the deliver of quality of care.</p> <p>3.1-35(g)(2)</p>			

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F 323 SS=G Bldg. 00	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents were free from accidents, in that, alarms were not in place during a fall, residents were left unassisted in the bathroom, gait belts were not used during transfers for 3 of 5 residents reviewed for accidents and 1 of 4 nursing units. This resulted in Resident #133 receiving a second fracture and Resident #82 requiring sutures. (Resident #133, Resident #82, Resident #58)</p> <p>Findings include:</p> <p>1. On 5/19/15 at 8:50 a.m., LPN #1 was interviewed. LPN #1 indicated Resident #133 had fallen recently and broken her hip but had not had surgery.</p> <p>On 5/19/15 at 2:53 p.m., Resident #133's clinical record was reviewed. Resident #133 was admitted on 4/15/15. Resident #133's diagnoses included, but were not limited to, dementia and aftercare of healing traumatic fracture of upper leg.</p>	F 323	<p>Resident# 133 now has all safety interventions in place and functioning properly in an attempt to prevent future falls. Resident # 82 is now receiving assistance during toileting and is not left unattended in the bathroom. The resident has had no new falls. Resident# 58 is now being transferred with the proper use of a gait belt. The resident has experienced no new falls. No residents were identified during the survey as having been struck by the South Unit bathroom door, however, due to all residents having the potential to be injured by the door opening into the hallway, the facility re-hung the door so that it opens into the shower room area instead of opening into the hallway. The corrective measure consisted of a house wide audit for fall risks to ensure all resident have the appropriate measures in place for fall prevention. Education has been conducted for all staff on the facility's fall prevention program and the importance of ensuring that the resident's safety interventions are being utilized in accordance with the plan of care. The in-service focused on</p>	06/25/2015			

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	<p>The Fall Risk Assessment, dated 5/12/15, indicated Resident #133 was a high risk for falls.</p> <p>The progress notes included, but were not limited to: 4/21/15 at 10:31 p.m.: Resident fell at 7:45 p.m. No injuries noted and all parties were notified. Resident was in dining room and attempted to rise from wheelchair. She lost balance and fell. 5/5/15 at 1:30 p.m.: Resident found on floor laying on right side, in front of wheelchair...resident has no complaints of pain, no internal/external rotation noted, no lengthening or shortening noted, staples intact to left hip... 5/5/15 at 8:00 p.m.: Transferred to (Name of Hospital) via (Name of ambulance service) family notified resident fell at 1:30 p.m. out of wheelchair got orders....for bilateral hip x-ray's which was done and showed new fracture in left hip</p> <p>The Clinical Review, dated 5/6/15, indicated: Review of fall. Resident was observed lying on floor in front of wheelchair resting on right side.</p> <p>The Radiology Report, dated 5/5/15, indicated: The visualized osseous (bone) structures demonstrate an acute complete</p>		<p>ensuring that each resident had the appropriate interventions in place in an attempt to prevent falls. A Quality Assurance Tool was developed and implemented to ensure all appropriate safety interventions are in place and functioning properly. This tool will be completed by the Director of Nursing and/or her designee daily for two (2) weeks, progressing to once weekly for four (4) weeks, then monthly for three (3) months with followup quarterly for three (3) quarters. The outcome of this tool will be reviewed at the facility's QAPI meeting to determine if any additional action is warranted.</p>	

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	<p>slightly displaced left subcapital hip fracture.</p> <p>The Care Plans included, but were not limited to: Resident has potential for falls related to history of falls, loses balance easily, left hip fracture, dated 4/22/15. The interventions included, but were not limited to, Pad alarm to bed and chair due to decreased safety awareness, dated 4/22/15.</p> <p>On 5/19/15 at 3:46 p.m., Resident #133 was observed in the common area watching television. The alarm to the wheelchair was observed in place.</p> <p>On 5/21/15 at 9:52 a.m., LPN #1 indicated Resident #133 had been admitted to the facility and had been discharged to the hospital for removal of orthopedic hardware from a previous surgery. The Resident had returned to the facility with five staples. LPN #1 indicated Resident #133 had fallen in the facility and received a hairline fracture to her left leg but surgery was not completed. LPN #1 could not locate documentation which indicated Resident #133's alarm was sounding when the resident fell.</p> <p>2. During the initial tour on 5/18/15 at</p>			

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	<p>11:00 a.m. Resident # 82 was observed to have a large bruise with swelling, bleeding and sutures on left side of head, she also had oozing blood from a pressure stocking on left leg.</p> <p>The clinical record of Resident # 82 was reviewed on 5/19/15 at 1:55 p.m. Resident #82 had diagnoses including, but not limited to, venous stasis syndrome with ulcer, cellulitis of both lower extremities, depression, hypertension, and congestive heart failure.</p> <p>The quarterly MDS (Minimum Data Set), dated 4/17/15, indicated the resident needed supervision with set up for toileting. The BIMS (Brief Interview for Mental Status) assessment indicated Resident #82 had a score of 12 out of 15 possible, which indicated mild cognitive impairment.</p> <p>A care plan, dated 11/11/14, included, but not limited to: Resident #82 had a potential for fall due to attempts to stand unassisted, loses her balance easily, and had an unsteady gait. The care plan further indicated the resident was to be up with assist of one person and use of an assistive device.</p> <p>The physician's orders indicated Resident #82 was to be up with the assist of one</p>			

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	<p>with an assistive device. The initial physician's was dated 1/14/15.</p> <p>The physical therapy notes indicated the resident was adamant about not trying to stand or bear weight. Resident #82 was discharged from physical therapy. A note also indicated Resident #82 was at a high risk for falls.</p> <p>A nurses note, dated 5/18/15 at 10:00 a.m., indicated Resident #82 was heard yelling "help" from the bathroom at 5:25 a.m. The note indicated Resident #82 was found lying on the bathroom floor on the left side next to the commode. Resident #82 was observed to have a 3 inch by 5 cm (centimeter) laceration with a hematoma around it and a large amount of bleeding. Neuro checks were completed with the pupils brisk, the grasps strong, and the resident was able to all extremities without pain. The note indicated Resident #82 had a 6 cm by 2 cm abrasion on the left knee which was not bleeding and the nurse was unable to approximate the skin. Resident #82 was transferred to a w/c (wheelchair) with assist of 3 persons and the resident was a total lift. The note further indicated the physician and the resident's brother were notified and the resident was transferred to the hospital at 6:10 a.m.</p>			

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	<p>A nurses notes, dated 5/18/15 at 10:30 a.m., indicated Resident #82 returned to the facility with sutures to the left side of the forehead. New physician's orders were received for ice on hematoma for 30 minutes every shift as needed.</p> <p>A follow-up review of the nurse's notes on 5/20/15 at 10:15 a.m., indicated Resident #82 remained on a follow-up fall assessment. The note further indicated Resident #82 was an extensive assist of one person with transfers due to unsteady gait with surface to surface transfers.</p> <p>During an interview on 5/19/15 at 10:50 a.m. RN #2 indicated the resident had been in bathroom alone and fell off of the commode. She indicated resident would use the shower bathroom instead of the room bathroom because it was bigger.</p> <p>During an interview on 5/20/15 at 11:30 a.m., the DON (Director of Nursing) indicated there were no written reports on incidents except in nurses notes. The DON indicated the fall had not been reported to the Indiana State Department of Health.</p> <p>During an interview on 5/21 at 11:45 a.m., the DON and the Adm (Administrator) indicated Resident #82</p>			

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	<p>would often go into bathroom without assistance. They indicated the toilet seat was loose and when Resident #82 changed positions, the toilet seat slipped and the resident fell off. The Adm indicated the commode seat was to be repaired and/or replaced.</p> <p>During an interview on 5/21/15 at 2:00 p.m., Resident #82 indicated she frequently went to bathroom on her own. Resident #82 further indicated she was alone in bathroom on the morning of her fall. She indicated she had reached down to pick something up from the floor and fell onto the floor.</p> <p>3. The clinical record of Resident #58 was reviewed on 5/20/15 at 9:15 a.m. Resident #58 had diagnoses including, but not limited to, hypertension, arthritis, dementia, diabetes, hyperlipidemia, depression and congestive heart failure.</p> <p>During a review on 5/20/15 at 9:15 a.m., the nurse's notes indicated that on 5/15/15, Resident #58 had been transferred from the wheelchair to the bed by a CNA. The note indicated Resident #58 became weak and was assisted to the floor. The note further indicated the CNA was unable to move the wheelchair out of the way due to the anti-rollback device on the chair. The</p>			

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	<p>note indicated the CNA had not used a gait belt when Resident #58 was transferred. The note further indicated interventions including, but not limited to, CNA provided education on importance of utilization of gait belt for all transfers, the resident was assessed, and vital signs were obtained. The note indicated no changes to the plan of care were recommended by the clinical review team.</p> <p>A care plan, dated 11/21/14, indicated Resident #58 had a history of falls or unsteady gait. The care plan further indicated Resident #58 would be walked a distance of 20 feet daily with a gait belt, rolling walker and staff assist of 1 (one). A quarterly MDS (Minimum Data Set) assessment, dated 2/18/15, indicated Resident #58 required extensive assist with ADL's (activities of daily living). The MDS indicated Resident #58 had a BIMS (Brief Interview for Mental Status) assessment score of 4 of possible 15 which indicated severe cognitive impairment.</p> <p>A cumulative physician's order, dated 5/1/15 through 5/31/15 and signed on 5/20/15, indicated Resident #58 was to be up with assist to the wheelchair as tolerated.</p>			

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	<p>During an interview on 5/20/15 at 11:00 a.m., the DON (Director of Nursing) indicated Resident #58 had been lowered to the floor after becoming weak. The DON further indicated the CNA was not using a gait belt during the transfer of the resident back into bed. The DON indicated gait belts are to be used while transferring and/or walking all residents.</p> <p>On 5/26/15 at 5:00 p.m., the Administrator provided the Interdisciplinary Care Plan Policy and Procedure. The policy indicated its purpose was to act as a communication tool that allowed staff members to interact with on another regarding resident care and allow for a constant and consistent approach in the deliver of quality of care.</p> <p>During an interview on 5/26/15 at 5:00 p.m., the Administrator provided the "Falls Prevention Program Policy". The policy indicated the facility was to ensure the resident's environment remained free of accident hazards and that each resident received adequate supervision and assistance devices to prevent accidents.</p> <p>4. During an observation on 5/20/15 from 9:00 a.m. - 10:00 a.m., the common shower/bathroom door on the South unit, across from the nurses station, was</p>			

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F 329 SS=D Bldg. 00	<p>observed to be swung out by staff into the hallway, striking three unidentified residents. No injuries were observed.</p> <p>During an observation on 5/21/15 at 10:00 a.m., the common shower/bathroom door was observed to be swung out by staff into the hallway, striking an unidentified resident.</p> <p>During an interview on 5/26/15 at 3:00 p.m., the DON (Director of Nursing) indicated she was not aware of anyone being hit by the common bathroom/shower room door. An interview with CNA # 2 indicated she was not aware of anyone being hit by the door.</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any</p>			

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	<p>combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents were free from unnecessary medications, in that, gradual dose reductions were not attempted and there were inadequate indications for psychoactive medication use for 2 of 5 residents reviewed for unnecessary medications. (Resident #65, Resident #106)</p> <p>Findings include:</p> <p>1. On 5/19/15 at 3:47 p.m., Resident #65 was observed sleeping in his room.</p> <p>On 5/20/15 at 9:05 a.m., Resident #65's clinical record was reviewed. Resident #65's diagnoses included, but were not limited to, dementia.</p> <p>The most recent signed physician's</p>	F 329	<p>Resident# 65 has been reviewed by the interdisciplinary team and a request has been submitted to the physician for a reduction in the dosage of the resident's psychoactive medication. Resident# 106 has been reviewed by the interdisciplinary team and a request has been submitted to the physician for a reduction in the dosage of the resident's psychoactive medication. All residents currently on psychoactive medications have been reviewed by the interdisciplinary team. In accordance with the regulations, the physicians have been notified of those residents who are due to be considered for a gradual dose reduction and/or those residents who are in need of an appropriate indication for the use of those medications. An in-service for the interdisciplinary team on the requirements for the use of psychoactive medications was provided. The in-service included</p>	06/25/2015

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	<p>recapitulation orders, signed 4/14/15 included, but were not limited to, Risperdal (an antipsychotic medication) 0.5 mg (milligrams), by mouth, every evening, for agitation with behaviors, ordered on 3/25/14.</p> <p>The care plans included, but were not limited to: Psychotropic drug use places resident at risk for potential drug related symptoms. The interventions included, but were not limited to, work with physician to provide lowest therapeutic dose.</p> <p>The clinical record lacked an attempted gradual dose reduction recommendation.</p> <p>On 5/20/15 at 3:53 p.m., SS #1 indicated Resident #65 was a hospice patient and therefore the pharmacist would not make recommendations for gradual dose reductions. SS #1 further indicated they had only seen Resident #65 exhibit behaviors when he had contracted a urinary tract infection.</p> <p>On 5/26/15 at 10:00 a.m., the Administrator and DON indicated they were unable to locate a gradual dose reduction for Resident #65.</p> <p>On 5/26/15 at 10:55 a.m., Resident #65 was observed sleeping in his wheelchair</p>		<p>the need for appropriate diagnosis to support the use of the medications along with information on the required gradual dose reductions in accordance with the specific classification of those medications. The facility has developed and implemented a tracking tool that will be completed on all residents on psychoactive medications. This tool will be reviewed by the interdisciplinary team at the monthly behavior/psychoactive drug meeting to ensure that all residents have the appropriate diagnosis and/or indications for use along with timely request for gradual dose reductions. The outcome of this tracking tool will be reviewed at the facility QAPI meeting to determine if any additional action is warranted.</p>	

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	<p>in the common area, no behaviors were observed.</p> <p>2. On 5/20/15 at 10:20 a.m., Resident #106 was observed sleeping in bed.</p> <p>On 5/20/15 at 10:22 a.m., Resident #106's clinical record was reviewed. Resident #106 was admitted on 12/11/14. Resident #106's diagnoses included, but were not limited to, anxiety.</p> <p>The most recent signed physician's recapitulation orders, signed 5/12/15, included but were not limited to: Buspar (an antianxiety medication), 10 mg (milligrams), give one half a tablet, orally twice a day, ordered on 12/11/14.</p> <p>On 5/20/15 at 11:41 a.m., Resident #106 was observed sleeping in the dining room.</p> <p>On 5/20/15 at 3:39 p.m., SS #1 indicated a meeting is held once a month in which the staff discussed how residents on psychoactive medications are. SS #1 indicated based on those discussions the pharmacist made recommendations for gradual dose reductions.</p> <p>On 5/21/15 at 10:14 a.m., RN #1 indicated Resident #106 had not exhibited anxious behaviors.</p>			

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F 465 SS=D Bldg. 00	<p>On 5/21/15 at 1:06 p.m., Resident #106 was observed sleeping in the common area.</p> <p>On 5/26/15 at 5:00 p.m., the Administrator provided the Medication Review Policy. The policy indicated medication regimes were monitored for excessive does, for excessive length of treatment, drugs without adequate monitoring, drugs without a diagnosis or reason for the drug, drug interactions and contraindications.</p> <p>3.1-48(a)(1) 3.1-48(a)(4)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to provide a safe, sanitary, and comfortable environment for 4 of 31 rooms reviewed, in that, rooms had unlabeled personal items in them, a sink had an area broken with a sharp protrusion present, and a folding door was splintered. (Rooms 202, Room 204,</p>	F 465	The urinary collection container, bar of soap and unlabeled toothbrush that were found on the back of the commode in the bathroom of Rooms 202 and 204 have been removed. The residents in those rooms have been provided with new personal care items and containers to ensure proper labeling and storage. The sink in room 206 has been repaired and is free of	06/25/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155621		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 05/26/2015	
NAME OF PROVIDER OR SUPPLIER PINE HAVEN HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3400 STOCKER DR EVANSVILLE, IN 47720			
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	<p>Room 206, Room 210)</p> <p>Findings include:</p> <p>During the Stage 1 observation on 5/18/15 at 11:58 a.m. through 3:30 p.m., the following were observed:</p> <ol style="list-style-type: none"> 1. In Rooms 202 and 204, a urinary collection container, a bar of soap, and an unlabeled toothbrush in a container located on the back of the commode were observed. 2. In Room 206, a device in the sink, which controls holding water and drainage was missing, which resulted in a sharp metal protrusion between the hot and cold water handles. 3. In Room 210, vinyl or plastic folding door was hanging in place of a regular wood door to the bathroom. The folding door was loose and splintered at the bottom. 4. During an observation on 5/20/15 at 10:00 a.m., the same was observed of the above rooms. <p>During an interview on 5/21/15 at 2:00 p.m., Maintenance Supervisor indicated the door in room 210 was requested by the residents, but he would check the</p>		<p>any sharp protruding parts. The folding door in room 210 has been replaced. As all residents have the potential to be affected by the cited deficient practice, a house wide audit was completed in all resident areas to ensure the environment is safe, sanitary and comfortable. Any areas of concern were corrected. In addition a house wide audit has been completed related to the proper labeling and storage of personal care items and equipment. All personal care items have been labeled and properly stored. An in-service has been provided for all staff on the facility's practices in providing a safe, sanitary and comfortable environment for the residents. The staff has also been instructed on the proper labeling and storage of personal care items and equipment. A Quality Assurance Tool has been developed and implemented to monitor the resident's environment to ensure that it is safe, sanitary and comfortable. This tool monitors for any broken or damaged furniture/equipment, as well as the proper labeling and storage of personal care items. This tool will be completed by the Administrator and/or their designee daily five (5) times a week, on random shifts, weekly for four (4) weeks, progressing to monthly for three (3) months, and quarterly for three quarters. The</p>				

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	splintered bottom. 3.1-19(f)		outcome of this tool will be reviewed at the facility QAPI meeting to determine if any additional action is warranted.		