

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155066	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  02/25/2016
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NAME OF PROVIDER OR SUPPLIER  EDGEWATER WOODS	STREET ADDRESS, CITY, STATE, ZIP CODE 1809 N MADISON AVE ANDERSON, IN 46011
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F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaint IN00193476.</p> <p>Complaint IN00193476 - Substantiated. Federal/State deficiencies related to the allegations are cited at F282 and F323.</p> <p>Survey dates: February 25, 2016</p> <p>Facility number: 000026 Provider number: 155066 AIM number: 100274820</p> <p>Census bed type: SNF/NF: 73 Total: 73</p> <p>Census payor type: Medicare: 17 Medicaid: 52 Other: 4 Total: 73</p> <p>Sample: 3</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed on February 29, 2016 by 11474.</p>	F 0000		
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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 0282 SS=D Bldg. 00	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>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 interview and record review, the facility failed to follow the care plan for fall prevention interventions with a cognitively impaired dependent resident. This deficient practice affected 1 of 3 residents reviewed for care plans. (Resident D)</p> <p>Findings include:</p> <p>The closed clinical record for Resident D was reviewed on 2/25/16 at 9:19 a.m. Diagnoses for Resident D included, but were not limited to, depressive disorder, right side hemiplegia, right side hemiparesis and status post nontraumatic subarachoid hemorrhage.</p> <p>The most recent quarterly Minimum Data Set (MDS) assessment, dated 1/1/16, was reviewed on 2/25/16 at 9:19 a.m. The MDS indicated Resident D was moderately cognitively impaired. Resident D received the following Activities of Daily Living (ADL)</p>	F 0282	<p>This provider respectfully requests that the 2567 plan of correction be considered the letter of credible evidence and request a desk review in lieu of post recertification on or after 3/14/2016. In service and identified tools have been attached. F282 - What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident no longer resides at facility. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents have the potential to be affected by this cited deficiency. The Director of Nursing reviewed all resident profiles to ensure that appropriate fall interventions are in place. The nursing supervisors are completing daily observations to ensure that fall interventions are being followed. No other residents were affected. In-service to be completed by 3/14/16 to assure that all staff are</p>	03/14/2016

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	<p>assistance: transfer-extensive assist with 2 person physical assist, dressing bathing and hygiene- extensive assist with 1 person physical assist and extensive assist with 2 person physical assist for toilet use. Resident D was frequently continent of bowel and bladder. Resident D had impairment to range of motion in upper and lower right side extremities.</p> <p>Review of the nursing note, dated 2/8/16 at 6:21 p.m., indicated Resident D was found on the floor in her room lying on her right side close to her wheelchair. Resident D complained of pain in her right elbow and head. Resident D had extensive bruising and swelling to the right side of her face around her eye and cheek. Resident D was assessed and nursing staff assisted her to her bed and called for emergency services. Resident D was transported to the emergency room for evaluation and treatment. The physician, and family were notified. Resident D was admitted to the hospital with a diagnoses of subdural hematoma.</p> <p>The event report, dated 2/8/16, indicated Resident D was not incontinent at the time of the fall, no medication changes within the past 7 days and no environmental factors contributed to the fall. The report also indicated the fall was unwitnessed.</p>		<p>re-educated on residents plan of care, residentprofile, where resident profile is located and how often profile should bereviewed. What measures will be put into place or what systemicchanges will be made to ensure that the deficient practice does not recur? Fall interventions are reviewed by Nurseswith CNA during shift to shift walking rounds. Nurses will sign at the beginning of each shift that they have reviewedfall interventions or changes to resident profile utilizing the profileverification sheet. New fall interventions are reviewed with floorstaff during daily IDT rounds. An in-servicewill be completed by DNS/Designee by 3/14/16 to assure that all staff areeducated on residents plan of care, resident profile, where resident profileis located and how often profile should be reviewed. How the corrective actions will be monitored to ensure hedeficient practice will not recur, i.e., what quality assurance program will beput into place? Fall management CQI tool will be completed by ED/designeedaily for 2 weeks, weekly review for 4 weeks, and monthly for 3 months and quarterlythereafter until compliance is achieved. Results of CQI will be reviewed in Continuous Quality Improvementmeeting which is held monthly and overseen by ED. If a threshold of 100% is not</p>	

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	<p>Review of a current care plan, dated 10/6/15, indicated the following: "Resident is at risk for fall due to: hemiparesis s/p (status post) CVA (cerebral vasuclar accident), and use of antidepressant and hypnotic" The interventions included, but were not limited to, "Res (resident) to stay within site of staff when up in wheelchair...."</p> <p>Review of the Resident Profile, used by the CNAs (Certified Nursing Assistants) for resident care, on 2/25/16 at 3:00 p.m., indicated the intervention to have the resident within site of staff while up in wheelchair was started 1/28/16.</p> <p>During a tour of the facility it was observed that room 107 was not in direct line of site to the nursing station. The room was located middle of the hallway. Resident D had been living in room 107 at the time of the fall.</p> <p>During an interview on 2/25/16 at 1:30 p.m., the Director of Nursing indicated the care plan intervention had not been followed and Resident D should not have been left unattended in her wheelchair. "She should not have been in her room alone while up in the wheelchair." The Director of Nursing indicated staff should have assisted Resident D back to bed if</p>		<p>achieved, anaction plan will be developed. By what date will the systemic changes will be completed? Systemic changes will be in place as of3/14/16.</p>	

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F 0323 SS=D Bldg. 00	<p>the resident was going to be in her room unattended.</p> <p>During an interview on 2/25/16 at 3:44 p.m., RN #4 indicated he was informed by the CNA that Resident D had been found on the floor and immediately assessed the resident. He called 911 for emergency transport to the hospital. RN #4 indicated he had been unaware Resident D had been left up in her wheelchair prior to the fall.</p> <p>This federal tag relates to Complaints IN00193476.</p> <p>3.1-35 (g)(2)</p> <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. Based on interview and record review, the facility failed to provide supervision for a cognitively impaired dependent resident leaving the resident in a wheelchair unattended which resulted in a fall. This deficient practice affected 1 of 3 residents reviewed for falls. (Resident D)</p>	F 0323	<p>F323 - What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident no longer resides at the facility. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be</p>	03/14/2016

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	<p>Findings include:</p> <p>The closed clinical record for Resident D as reviewed on 2/25/16 at 9:19 a.m. Diagnoses for Resident D included, but were not limited to, depressive disorder, right side hemiplegia, right side hemiparesis and status post nontraumatic subarachoid hemorrhage.</p> <p>The most recent quarterly Minimum Data Set (MDS) assessment, dated 1/1/16, was reviewed on 2/25/16 at 9:19 a.m. The MDS indicated Resident D was moderately cognitively impaired. Resident D received the following Activities of Daily Living (ADL) assistance: transfer-extensive assist with 2 person physical assist, dressing bathing and hygiene- extensive assist with 1 person physical assist and extensive assist with 2 person physical assist for toilet use. Resident D was frequently continent of bowel and bladder. Resident D had impairment to range of motion in upper and lower right side extremities.</p> <p>Review of the nursing note, dated 2/8/16 at 6:21 p.m., indicated Resident D was found on the floor in her room lying on her right side close to her wheelchair. Resident D complained of pain in her right elbow and head. Resident D had</p>		<p>taken? All residents have thepotential to be affected by this cited deficiency. Director of Nursing reviewed all residentprofiles to ensure that appropriate fall interventions are in place. The nursing supervisors are completing dailyobservations to ensure that fall interventions are being followed. An in-service will be completed by3/14/16 to assure that all staff are re-educated on fall prevention andresident supervision. What measures will be put into place or what systemicchanges will be made to ensure that he deficient practice does not recur? An in-service will be completed byDNS/Designee by 3/14/16 to assure that all staff are re-educated on fallprevention and resident supervision. Newfall interventions are reviewed with floor staff during daily IDT rounds. Hall nurse to complete walking rounds oftheir unit to ensure fall interventions are being followed and signing fallmanagement checklist. How the corrective actions will be monitored to ensure thedeficient practice will not recur, i.e., what quality assurance program will beput into place? Fall Management CQI toolwill be completed by ED/designee daily for 2 weeks, weekly review for 4 weeks,and monthly for 3 months and quarterly thereafter until compliance isachieved. Results of CQI will bereviewed in Continuous quality</p>	

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	<p>extensive bruising and swelling to the right side of her face around her eye and cheek. Resident D was assessed and nursing staff assisted her to her bed and called for emergency services. Resident D was transported to the emergency room for evaluation and treatment.</p> <p>The event report, dated 2/8/16, indicated Resident D was not incontinent at the time of the fall, no medication changes within the past 7 days and no environmental factors contributed to the fall. The report also indicated the fall was unwitnessed.</p> <p>Review of a current care plan, dated 10/6/15, indicated the following: "Resident is at risk for fall due to: hemiparesis s/p (status post) CVA (cerebral vasuclar accident), and use of antidepressant and hypnotic." The interventions included, but were not limited to, "Res (resident) to stay within site of staff when up in wheelchair..."</p> <p>Review of the Resident Profile, used by the CNAs (Certified Nursing Assistants) for resident care, on 2/25/16 at 3:00 p.m., indicated the intervention to have the resident within site of staff while up in wheelchair was started 1/28/16.</p> <p>During an interview on 2/25/16 at 1:30</p>		<p>Improvement meeting which is held monthly and overseen by ED. If a threshold of 100% is not achieved, an action plan will be developed.</p> <p>By what date will the systemic changes will be completed? Corrective actions are complete effective 3/14/16.</p>	

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	<p>p.m., the Director of Nursing indicated the care plan intervention had not been followed and Resident D should not have been left unattended in her wheelchair. "She should not have been in her room alone while up in the wheelchair." The Director of Nursing indicated staff should have assisted Resident D back to bed if she was going to be in her room unattended.</p> <p>During an interview on 2/25/16 at 3:44 p.m., RN #4 indicated he was informed by the CNA that Resident D had been found on the floor and immediately assessed the resident. He called 911 for emergency transport to the hospital. RN #4 indicated he had been unaware Resident D had been left up in the wheelchair prior to the fall.</p> <p>This Federal tag relates to Complaint IN00194376.</p> <p>3.1-45(a)(2)</p>			