

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155675	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/28/2013
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NAME OF PROVIDER OR SUPPLIER MORNING BREEZE RETIREMENT COMMUNITY AND HEALTHC	STREET ADDRESS, CITY, STATE, ZIP CODE 950 N LAKEVIEW DR GREENSBURG, IN 47240
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F000000	<p>This visit was for a Post Survey Revisit [PSR] to the Recertification and State Licensure Survey completed on 5-1-13.</p> <p>Dates of survey: June 27, & 28, 2013</p> <p>Facility number: 011039 Provider number: 155675 AIM number: 200299100</p> <p>Survey team: Angel Tomlinson RN Sharon Lasher RN Leslie Parrett RN Barbara Gray RN</p> <p>Census bed type: SNF: 22 SNF/NF: 19 Residential: 18 Total: 59</p> <p>Census payor type: Medicare: 10 Medicaid: 19 Other: 30 Total: 59</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p>	F000000		
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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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	Quality review 7/08/13 by Suzanne Williams, RN				

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F000280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>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 changes in care and treatment.</p> <p>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.</p>	F000280	<p>F280 This facility develops a comprehensive care plan within 7 days after the completion of the comprehensive assessment as determined by the resident needs and participation of the resident, resident's family or legal representative with periodic review after each assessment.</p> <p><u>Action taken for resident's identified</u> Resident #19's care plan was revised and updated to reflect current resident status. (Attachment- A)</p> <p><u>Identification and corrective action for other residents with the potential to be affected:</u> July 1 and 2, 2013 health care facility resident fall risk assessments and</p>	07/14/2013	

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			<p>fall care plans were reviewed, a new care plan was written and implemented for each resident as applicable. The CNA assignment sheet for each resident was reviewed and updated to match the care plan. (Attachment- B)</p> <p><u>Measures to prevent recurrence.</u> The resident care plan and CNA assignment sheet will be reviewed and updated post fall and during the morning managers' meeting, following a fall event , to assure fall interventions are documented . MDS Coordinator will review the resident's fall care plan quarterly or with significant change to assure the care plan is current.</p> <p>Nursing staff education was completed on July 3, 2013 and will be included in new hire orientation. This education included updating the resident care plan and CNA assignment sheet to reflect the resident's current needs, and utilizing the CNA assignment sheet to deliver resident care in conjunction with residents assessed needs and care plan. (Attachment C 1-2)</p> <p><u>How will the facility monitor and who is responsible:</u> The DON/designee will monitor to assure care plans and CNA assignment sheet reflect the resident's current fall prevention</p>		

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	<p>Based on observation, interview, and record review, the facility failed to update a resident's fall care plan interventions to reflect his current status, for 1 of 3 residents sampled for falls. (Resident #19).</p> <p>Findings include:</p> <p>Resident #19's record was reviewed on 6/27/13 at 12:41 P.M. Diagnoses included, but were not limited to, osteoarthritis, chronic obstructive pulmonary disease, late effect cerebral vascular accident (with left sided weakness), chronic pain, and anxiety.</p> <p>Resident #19's quarterly Minimum Data Set (MDS) assessment, dated 6/18/13, indicated Resident #19 understood, and he was understood by others. He scored 7 on his Brief Interview for Mental Status, indicating</p>		<p>interventions and will monitor to assure fall prevention interventions are in place through observation rounds daily times 2 weeks, then weekly times 2 weeks, then monthly times 5 months. The audit results will be presented to the Quality Assurance Committee (QAC) each month for review and further recommendation. (Attachment - D)</p> <p>-</p>				

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	<p>he was severely impaired for cognitive decision making. He did not walk, and required extensive assistance of one person for transfers and toileting. He had a history of falls.</p> <p>A nurses' note for Resident #19, dated 6/25/13 at 1:30 P.M., indicated the following: "Care plan held. Family and resident declined invitation. Care plan updated."</p> <p>Resident #19's fall care plan, updated 6/25/13, indicated the following interventions: Resident #19's scooter would be turned off before he was transferred. His electric scooter would be removed from his access. Non-skid strips would be applied to the floor next to his bed.</p> <p>An interview with MDS Coordinator #1, on 6/27/13 at 2:15 P.M., indicated Resident #19's fall care plan was last reviewed and updated on 6/25/13. She indicated the scooter interventions should not have been on the fall care plan. She indicated he no longer utilized a scooter.</p> <p>An observation and interview with MDS Coordinator #1, on 6/27/13 at 4:14 P.M., indicated Resident #19 did not have non-skid strips on the floor</p>			

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	<p>next to his bed. She indicated he was moved closer to the nurse's station, on 3/1/13, and it was decided he no longer needed the non-skid strips.</p> <p>An interview with the Director of Nursing (DoN), on 6/28/13 at 10:44 A.M., indicated the Interdisciplinary Team was responsible for making sure resident care plan interventions were appropriate, and the MDS Coordinator was responsible for updating the care plan interventions.</p> <p>The most recent Care Plan policy and procedure, provided by the DoN, on 6/28/13 at 10:50 A.M., indicated the following: "Purpose: Provide an interdisciplinary communication tool for promotion and coordination of individual resident care to meet resident's medical, nursing, mental and psychological needs identified through comprehensive assessment. Procedure: ... 8.) Update resident's care plan as changes occur and notify appropriate persons."</p> <p>This deficiency was cited on 5/01/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-35(d)(2)(B)</p>			

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F000323 SS=D	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.	F000323	F323 This facility supervises residents while toileting based on individual evaluation, provides and implements fall prevention interventions based on individual evaluation and communicates the intervention via the Care Plan and CNA assignment sheet, and provides safe transfers by utilizing gait belts as indicated. <u>Action taken for resident cited as affected</u> . Resident #19 was re-assessed and a new fall care plan was written and implemented to reflect current status and fall prevention interventions are in place according to the resident's individual care plan. (Attachment - A <u>Identification and corrective action for other residents with the potential to be affected:</u> Health care resident fall care plans were reviewed on July 1 and 2, 2013 with new care plan written and implemented. The CNA assignment sheet was reviewed and updated as	07/14/2013

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			<p>needed to match the care plan. Residents at risk for falls were observed to ensure fall interventions were in place. No other residents were identified. "(Attachment- B)</p> <p><u>Measures to prevent recurrence.</u> Nursing staff education was completed on July 3, 2013 and will be included in new hire orientation. The education included updating the resident care plan and CNA assignment sheet to reflect the resident's current needs, and utilizing the CNA assignment sheet to deliver resident care in conjunction with residents assessed needs and care plan. (Attachment- C 1-2) New resident admission fall risk assessment and new fall events will be reviewed by the interdisciplinary team (IDT) in morning managers' meeting to ensure interventions are updated to reflect the current resident status on both the individual resident's care plan and CNA assignment sheet. This IDT review will include observation rounds to validate interventions are in place. Results of this review will be documented on the audit form. Individual resident care plans will be reviewed with MDS assessment and care plan meetings to assure fall prevention care plan remains applicable. (Attachment- E)</p>		

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	<p>Based on observation, interview, and record review, the facility failed to supervise a resident while toileting, who was a high risk for falls, failed to follow his fall care plan interventions, and failed to provide safe transfers by not utilizing a gait belt, for 1 of 3 residents reviewed for falls. (Resident #19)</p> <p>Findings include:</p> <p>Resident #19's record was reviewed, on 6/27/13 at 12:41 P.M. Diagnoses included, but were not limited to, osteoarthritis, chronic obstructive pulmonary disease, late effect cerebral vascular accident (with left sided weakness), chronic pain, and anxiety.</p> <p>Resident #19's quarterly Minimum</p>		<p><u>How will the facility monitor and who is responsible:</u></p> <p>The DON/designee will complete observation rounds daily times 2 weeks, weekly times 2 weeks, then monthly times 5 months to ensure interventions are in place based on care plan and CNA assignment sheets. The audit results will be presented to the QAC each month for review and further recommendation. (Attachment D)</p>		

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	<p>Data Set (MDS) assessment, dated 6/18/13, indicated Resident #19 understood, and he was understood by others. He scored 7 on his Brief Interview for Mental Status, indicating he was severely impaired for his cognitive decision making. He did not walk, and required extensive assistance of one person for transfers and toileting. He had a history of falls.</p> <p>Resident #19's fall care plan, initiated 1/13/12, and last updated 6/25/13, indicated, but was not limited to, the following interventions: Initiated 1/13/12-Resident #19 would wear non-skid footwear when he was up. He would be assisted to the toilet, per his toileting plan. He required 1 person physical assistance for transfers. Added 4/17/12-He would be reminded not to unfasten his pants, until his transfer was complete. He would be reminded to ask for assistance with his transfers, if he felt fatigued. Added 7/8/12-He would wear shoes for transfers. Added 7/20/12-He would be re-educated on the benefits of asking for help with transfers. Added 9/8/12-He would be encouraged to use his call light for all transfers. He would have a visual reminder to call for assistance. Added 12/13/12-He would periodically</p>			
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	<p>be reminded to ask for assistance with any and all transfers. He would be reminded to wear shoes or non-skid socks during all transfers. Added 1/2/13-Non-skid strips would be applied on the floor next to his bed. He would be encouraged to use his call light for assistance with transfers. His bedroom door would be kept open to allow for closer supervision. Added 3/18/13-His bedroom would be changed to promote observation and early detection. Added 4/18/13-He would be re-educated to use his call light for all transfers. Added 6/25/13-The staff would be educated on the importance of remaining with the resident during care.</p> <p>On 5/14/13 and 6/25/13, Resident #18 scored 18 on his Fall Risk assessment, indicating he was a high risk for falls.</p> <p>Nurses' notes for Resident #19, indicated the following: 6/25/13 at 11:45 A.M.-Resident #19 had been found on the floor in his bathroom, holding onto the rail and the toilet seat. He was barely touching the floor. He had no injuries. 6/25/13 at 1:30 P.M.-A care plan meeting had been held for Resident #19. He and his family had declined the invitation.</p>			

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	<p>His care plan had been updated.</p> <p>An Incident/Accident report for Resident #19, dated 6/25/13, indicated the following: Resident #19 had attempted to transfer himself from the toilet, to his wheelchair. He was found holding onto the bar and toilet seat, barely touching the floor. He had no injuries. His bathroom call light was not on. The bathroom call light was checked and was functional. He had been left unattended. Actions taken by the facility indicated staff would be educated to remain with Resident #19 in the bathroom. He was educated to use his call light to have staff help him with transfers.</p> <p>On 6/27/13 at 12:20 P.M., Resident #19 was observed being transferred with the assistance of CNA #4 and CNA #5, and the use of a gait belt. He had non-skid socks on both of his feet. While Resident #19 was lying down, CNA #4 placed rubber sole tennis shoes on Resident #19's bilateral feet, and left them untied. She placed a pair of shorts on his legs up to his knees. He sat up on the side of his bed. He then stood with the assist of both staff and the use of the gait belt. He also held onto a small bed rail, attached to the open side of his bed. His shorts were</p>			

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	<p>pulled up after he stood. While standing, Resident #19 was bent over at the waist, and his bilateral legs were bent at the knees. His legs were shaking as he stood. He showed signs of anxiousness by cursing while he was standing. His bedroom flooring was laminate, designed to look like wood. No skid strips were visible on the floor next to his bed.</p> <p>An interview with MDS Coordinator #1, on 6/27/13 at 2:15 P.M., indicated Resident #19's fall care plan was last reviewed, and updated, on 6/25/13.</p> <p>On 6/27/13 at 2:23 P.M., Resident #19 was observed lying down on his bed, with a visitor in his bedroom. CNA #2 walked into Resident #19's bedroom, to get him out of bed, for an activity he wanted to attend. CNA #2 placed Resident #19's rubber sole tennis shoe on his bilateral feet, and left them untied. He sat up on the side of his bed and held onto the bed rail, attached to the open side of his bed. CNA #2 assisted Resident #19 to stand, by holding onto his right arm. While standing, he was bent over at the waist, and his bilateral legs were bent at the knees. He pivoted and sat down sideways, near the edge of the wheelchair seat. He was then able to scoot back in the</p>			

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	<p>wheelchair and correct his position. No gait belt was utilized during the transfer.</p> <p>On 6/27/13 at 3:41 P.M., Resident #19 stated his last fall "was in the bathroom." He indicated he had not hurt himself. He indicated the facility staff have reminded him to use his call light, but he never did use it, because he always forgot to.</p> <p>An interview with MDS Coordinator #1, on 6/27/13 at 4:14 P.M., indicated Resident #19 did not have non-skid strips on the floor next to his bed. She indicated he had non-skid strips on the floor next to his bed, when he was in another room. She indicated he was moved closer to the nurse's station, on 3/1/13, because he was a fall risk, and kept attempting to get up by himself. She indicated, after he changed bedrooms, it was decided he no longer needed the non-skid strips. She indicated he wore non-skid shoes. She indicated the non-skid strip intervention did not get removed from his care plan.</p> <p>On 6/28/13 at 8:52 A.M., CNA# 3 was observed assisting Resident #19 into his bed. CNA #3 held Resident #19's right arm as he held onto the bed rail, attached to the open side of his bed.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155675	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/28/2013
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NAME OF PROVIDER OR SUPPLIER MORNING BREEZE RETIREMENT COMMUNITY AND HEALTHC	STREET ADDRESS, CITY, STATE, ZIP CODE 950 N LAKEVIEW DR GREENSBURG, IN 47240
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	<p>He stood, pivoted, and sat down sideways on the edge of his bed. While standing, he was bent over at the waist, and his bilateral legs were bent at the knees. Resident #19 was then able to scoot back away from the edge of the mattress and position himself to lay down. His legs were lifted into the bed by CNA #3. No gait belt was utilized by CNA #3. At that time, an interview, with CNA #3, indicated, when she entered Resident #19's bedroom, he was already transferring himself to the toilet. She indicated that is why he utilized an alarm on his wheelchair and bed. She indicated he did not like a gait belt around his waist, while pulling his pants up, because he felt like the belt, was in his way. She indicated, he got agitated if he had a gait belt around his waist, when staff pulled his pants up. She indicated, he would allow staff to place the gait belt on him, to transfer him to bed, if staff could get him to wait long enough to, "actually put it on." She indicated, often when staff wheeled him close to the bed rail, he would grab the rail and stand, without waiting for staff to place the gait belt. She indicated, she had asked Resident #19 if he would wear the gait belt to transfer to bed, but he was already trying to stand. She stated "I asked if he would wear the</p>			

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	<p>belt as you knocked on the door." CNA #3 indicated her understanding of the facility's policy and procedure on gait belt use, was to use a gait belt on all resident transfers, and ambulation.</p> <p>An interview with the Director of Nursing (Don) on 6/28/13 at 9:37 A.M., indicated staff left Resident #19, unsupervised on the toilet, when he fell on 6/25/13. She indicated he was supposed to use his pull cord, but did not.</p> <p>An interview with the DoN, on 6/28/13 at 9:56 A.M., indicated the visual reminder to call for assistance, on Resident #19's fall care plan, was a white laminated sign with red letters, that should be hanging on the wall beside his bed. No visual reminder sign was observed hanging on any of Resident #19's walls. The DoN indicated the sign was not hanging on any of Resident #19's walls.</p> <p>An interview with the DoN, on 6/28/13 at 10:44 A.M., indicated staff determined what residents could be left unattended on the toilet by many different factors, including if they were alert and oriented, call cord appropriate, used alarms, and were at high risk for falls. She indicated staff</p>			

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	<p>were trained to use a gait belt on any resident who was an assist of 1 or more, unless the use of a gait belt was contraindicated.</p> <p>The Gait Belt policy and procedure, provided by the DoN, on 6/28/13 at 9:31 A.M., indicated the following: "Purpose: Provide safety while transferring and ambulating by enabling staff to assist resident regain balance or lower to the floor. Provide an additional sense of security for resident. Procedure: 1.) Prior to the use of gait belt, check resident's care plan or CNA communication form to assure gait belt is not contraindicated (i.e. gait belt may be contraindicated if resident has diagnosis of abdominal aneurysm)...."</p> <p>This deficiency was cited on 5/01/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-45(a)(2)</p>				