

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155246	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/08/2013
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NAME OF PROVIDER OR SUPPLIER WATERS OF DUNELAND THE	STREET ADDRESS, CITY, STATE, ZIP CODE 110 BEVERLY DR CHESTERTON, IN 46304
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F000000	<p>This visit was for the Investigation of Complaint IN00137281.</p> <p>Complaint IN00137281-Substantiated. Federal/state deficiencies related to the allegations are cited at F157, F280, and F323.</p> <p>Unrelated deficiencies are cited.</p> <p>Survey dates: October 7 & 8, 2013</p> <p>Facility number: 000150 Provider number: 155246 AIM number: 100267000</p> <p>Survey team: Lara Richards, RN, TC Yolanda Love, RN Jennifer Redlin, RN (10/7/13)</p> <p>Census bed type: SNF/NF: 91 Total: 91</p> <p>Census payor type: Medicare: 13 Medicaid: 67 Other: 11 Total: 91</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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	<p>Sample: 5</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed on October 18, 2013, by Brenda Meredith, R.N.</p>			
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F000157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to ensure the resident's Physician was notified after being lowered to the floor for 1 of 3 residents reviewed for falls. The</p>	F000157	The facility does ensure the residents physician and family's are notified of any changes in condition.I. The actions taken by the facility are as follows:Regarding #B was sent to	10/11/2013			

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	<p>facility also failed to ensure the resident's emergency contact was notified prior to being sent to the hospital for a change in condition for 1 of 5 records reviewed. (Resident #B)</p> <p>Findings include:</p> <p>The record for Resident #B was reviewed on 10/7/13 at 10:25 a.m. The resident's diagnosis included, but was not limited to, osteoporosis. Review of a "Therapy fall/Incident screen" form dated 9/12/13, indicated the resident was performing wheelchair to bed transfers using a sliding board. When the resident was on the bed, she started to slip out due to she was sitting on top of the draw sheet. The resident was lowered to the floor by the writer. The resident was complaining of pain to the left ankle and bilateral shoulders. Ice was applied to the left ankle.</p> <p>Review of the Nursing progress notes for 9/12/13, indicated there was no documentation related to the resident being lowered to the floor by therapy staff. There was also no documentation of Physician notification of the pain and the resident being lowered to the floor by therapy staff.</p>		<p>hospital for evaluation. On 9/23/2013 the hospital nurse called the D.O.N. to tell me the resident had stated she "had fallen a couple weeks ago". An investigation was completed on 9/23/2013. Physician and contact #1 were notified by the hospital nurse.II. The facility's actions to identify other residents are as follows:100% audit was completed over the last 30 days for physician/family notification of falls and proper notification of appropriate family member. No other residents identified.III. The measures put into place by the facility are as follows:The D.O.N. and/or designee will audit the 24 hour board for any falls and proper notification daily. Audits will be reviewed in the monthly QA meeting which will determine when the audits can be stopped. Nursing staff was re-inserviced on physician and family notification on 10/08/2013 and 10/09/2013IV. The facility will monitor actions as follows.The D.O.N. and/or designee will audit the 24 hour board for any falls and proper notification daily. Results of audits will be reviewed in the QA Committee until 100 percent compliance is met. V. Completion date 10/11/2013</p>	

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	<p>Interview with Physical Therapist #1 on 10/7/13 at 3:15 p.m., indicated since the resident was assisted to the floor, Nursing staff did not feel it was a fall.</p> <p>An entry in the Nursing progress notes dated 9/20/13 at 1:15 a.m., indicated the resident was in bed and she was complaining of pain to her left arm. The resident was also complaining of nausea and dizziness and her vitals were unstable. Tremors were noted to the resident's bilateral upper extremities. The Physician was notified and new orders were received to send the resident to the Emergency Room for evaluation. The resident's brother was notified at this time.</p> <p>Review of the resident's face sheet, indicated the resident's Health Care Representative was to be called first if anything happened to the resident and her brother was to be contacted second.</p> <p>Interview with the Director of Nursing on 10/8/13 at 10:45 a.m., indicated a new nurse had sent the resident out and the resident's Health Care Representative should have been notified first rather than the resident's</p>			

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	<p>brother.</p> <p>This Federal tag relates to Complaint IN00137281.</p> <p>3.1-5(a)(2) 3.1-5(a)(3) 3.1-5(a)(4)</p>			

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F000223 SS=A	<p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on record review and interview, the facility failed to ensure each resident had the right to be free from physical abuse for 1 of 1 allegations of physical abuse reviewed. (Resident #G)</p> <p>Findings include:</p> <p>The investigation for an allegation of physical abuse involving Resident #G was reviewed on 10/8/13 at 10:30 a.m. The investigation indicated CNA #1 was observed smacking the resident on the right arm. The CNA was also yelling at the resident to quit pinching her. This incident was witnessed by CNA #2 in the shower room. When CNA #1 left the shower room, CNA #2 asked the resident if she was alright. CNA #2 then proceeded to inform the Director of Nursing of what happened. CNA #1 was instructed to punch out on the time clock, give her statement and then she needed to leave the</p>	F000223	<p>The facility does ensure each resident has the right to be free from physical abuse.I. The actions taken by the facility are as follows:Regarding RG assesment was completed and no injury was identified. Abuse Policy and Procedure were followed for staff member identified.II. The facility's action to identify other residents are as follows:No further residents were identified and no other reportables were identified.III.The measures put into place are as follows:Staff were re-inserviced on Abuse Policy and Procedure and the ISDH Policy and Procedure.IV. All reported allegations of abuse will immediately be reported to ISDH,ISDH policy and procedure will be followed and the facility policy and procedure will be followed. All reportable incidents will be reviewed in the monthly QA meeting.Completion Date 10/11/2013.</p>	10/11/2013			

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	<p>building. The CNA was suspended pending the investigation of the allegation.</p> <p>Based on the results of the investigation, the CNA was terminated due to the substantiated allegation of physical abuse.</p> <p>Interview with the Director of Nursing on 10/8/13 at 10:30 a.m., indicated the allegation of abuse was substantiated and the CNA was terminated.</p> <p>3.1-27(a)(1)</p>			

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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> <p>Based on record review and interview, the facility failed to ensure each resident and/or their responsible party were contacted related to care plan meetings for 1 of 5 records reviewed. (Resident #B)</p> <p>Findings include:</p> <p>The record for Resident #B was reviewed on 10/7/13 at 10:25 a.m. Review of the resident's plan of care, indicated the resident's last care plan meeting was on 8/22/13. Review of the signature page, indicated the resident nor her Health Care</p>	F000280	<p>The facility does ensure each resident and/or their responsible party are contacted of the care plan meeting.I. The action taken by the facility are as follows:Regarding #B on 10/10/2013 Social Services met with the Resident #B to invite to care plan meeting and if Resident #B wanted any family contacted for care plan meeting. Resident #B declined. II. The facility's action taken to identify other residents are as follows: A 30 day 100% audit was completed to ensure residents and legal representative were notified. No further residents identified.III. The measures put into place are as follows:Social services will</p>	10/11/2013			

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	<p>Representative had attended.</p> <p>Interview with the Minimum Data Set (MDS) Coordinator on 10/8/13 at 10:05 a.m., indicated that she knows when the residents' care plans are scheduled and she notifies Social Services and they notify the resident and/or their responsible party.</p> <p>Review of the Social Service progress notes for the month of August 2013, indicated there was no documentation to indicate the resident and/or her Health Care Representative had been notified of the care plan conference.</p> <p>Interview with the Social Service Director on 10/8/13 at 10:05 a.m., indicated that residents were invited to their care plan meetings as she completed their assessments. She indicated families are notified at this time as well. If the resident's responsible party lives out of state, she indicated a phone conference could be arranged. The Social Service Director indicated that she had previously documented when residents and/or their responsible party were notified of the care plan meeting, however, she said recently she had not been doing this.</p> <p>This Federal tag relates to Complaint</p>		<p>document in progress notes when care plan conference is needed, notify, document and invite residents and family. The facility will monitor actions as follows: Social service and/or designee will audit M-F progress notes for care plan conference notification. Results of audits will be reviewed in the QA Committee until 100 percent compliance is met..V. Completion date 10/11/2013</p>		

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	IN00137281. 3.1-35(c)(2)(C)			

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F000323 SS=D	<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 record review and interview, the facility failed to ensure a resident was assessed and monitored after being lowered to the floor for 1 of 3 residents reviewed for falls. (Resident #B)</p> <p>Findings include:</p> <p>The record for Resident #B was reviewed on 10/7/13 at 10:25 a.m. The resident's diagnosis included, but was not limited to, osteoporosis. Review of a "Therapy fall/Incident screen" form dated 9/12/13, indicated the resident was performing wheelchair to bed transfers using a sliding board. When the resident was on the bed, she started to slip out due to she was sitting on top of the draw sheet. The resident was lowered to the floor by the writer. The resident was complaining of pain to the left ankle and bilateral shoulders. Ice was applied to the left ankle.</p> <p>Review of the Nursing progress notes for 9/12/13, indicated there was no</p>	F000323	<p>It is the intent of this facility to ensure that the resident's environment remain as free of accident hazards as is possible and that each resident receive adequate supervision and assistance to prevent accidents. I. Resident #B was transferred to the Emergency Room on 9/20/2013. Resident #B was re-admitted to this facility 9/27/2013 with admission assessments to include but not be limited to Fall Risk assessment coompleted at that time.. II. The facilitys' action to identify other residents are as follows: A 30 day 100% look back was conducted of any resident who had a fall for proper assessment and monitoring. No further residents identified. III. The measures put into place are as follows: Licensed Nursing Staff were re-inserviced on definition of a fall assessment and monitoring. IV. The D.O.N. and/or designee will monitor and audit the 24 hour board for any falls and proper documentation until 100 percent compliance is met. Completion Date 10/11/2013.</p>	10/11/2013			

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	<p>documentation related to the resident being lowered to the floor by therapy staff. There was also no documentation of Physician notification of the pain and the resident being lowered to the floor by therapy staff.</p> <p>Interview with Physical Therapist #1 on 10/7/13 at 3:15 p.m., indicated since the resident was assisted to the floor, Nursing staff did not feel it was a fall.</p> <p>There was no documentation in the Nursing progress notes between the dates of 9/12/13 and 9/18/13.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment dated 8/13/13, indicated the resident was dependent on staff for transfers and that she had no falls since her prior assessment.</p> <p>An entry in the Nursing progress notes dated 9/20/13 at 1:15 a.m., indicated the resident was complaining of pain to the left arm as well as nausea and dizziness. The resident's vital signs were unstable and she had tremors to the bilateral upper extremities. The resident's Physician was notified and orders were obtained to send the resident to</p>			

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	<p>the Emergency Room for evaluation.</p> <p>Review of the hospital history and physical dated 9/20/13, indicated the resident was found to have a possible acute fracture including left iliac bone, left lateral superior pubic ramus and left acetabulum.</p> <p>Interview with the Director of Nursing on 10/8/13 at 10:45 a.m., indicated when the hospital notified her of the resident's fractures, she began an investigation. She indicated there was no documentation completed on and after 9/12/13, in the Nursing progress notes related to the resident being lowered to the floor.</p> <p>Review of the fall investigation completed by the Director of Nursing indicated, the resident had told the hospital she had fallen when she had learned of the x-ray results. Upon investigation with Nursing and Therapy staff, the resident was lowered to the floor by Physical Therapy by the way of the sliding board. Physical Therapy had a note in the record related to lowering. The Director of Nursing did not consider that a fall due to the documentation. The resident had no complaints to the areas that had the fractures. The resident also had not stated to the</p>						

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	<p>Nurse prior to hospital admission that she had a fall. Therapy indicated it was not a fall, she was assisted to prevent a fall.</p> <p>Review of the Physician progress note dated 9/28/13, indicated the resident was found to have a pelvic fracture and that he felt it was pathological based on her current diagnoses and long term Prednisone (a steroid) use.</p> <p>Review of the Minimum Data Set (MDS) 3.0 definition of a fall indicated the following: "An intercepted fall occurs when the resident would have fallen if he or she had not caught him or herself, or had not been intercepted by another person-this is still considered a fall."</p> <p>This Federal tag relates to Complaint IN00137281.</p> <p>3.1-45(a)(2)</p>			