

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155688	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/22/2013
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NAME OF PROVIDER OR SUPPLIER FREELANDVILLE COMMUNITY HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 310 W CARLISLE ST FREELANDVILLE, IN 47535
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: November 18, 19, 20, 21, 22, 2012</p> <p>Facility number: 000355 Provider number: 155688 AIM number: 100273640</p> <p>Survey team: Dorothy Watts, RN TC November 18,19, 22, 2013 Terri Walters, RN November 18,19, 20, 21, 2013 Amy Wininger, RN November 18,19, 20, 21, 2013</p> <p>Census bed type: SNF/NF: 32 Total :32</p> <p>Census payor type: Medicare: 8 Medicaid: 18 Other: 6 Total: 32</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p>	F000000	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve 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 that the plan of correction be considered our allegation of compliance effective December 16, 2013 to the annual licensure survey conducted on November 18, 2013 through November 22, 2013.	

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 completed on November 27, 2013, by Jodi Meyer, RN			

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F000281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.</p> <p>Based on observation, interview, and record review, the facility failed to ensure 1 resident received medications according to acceptable standards of nursing practice, in that a transdermal patch was not rotated and applied as directed by the manufacturer for one of one resident reviewed receiving the patch. Resident #20</p> <p>Findings include:</p> <p>During an interview with LPN #10 on 11/22/13 at 11:49 A.M., LPN #10 indicated there was no documentation on the Medication Administration Record (MAR) as to the placement location for any of the Exelon transdermal patches that had been placed on Resident #20. LPN #10 further indicated that, whenever an old transdermal patch was removed, the new transdermal patch would be placed on the opposite side of the body.</p> <p>The clinical record of Resident #20 was reviewed on 11/22/13 at 12:02 P.M. The record indicated the</p>	F000281	<p>F281It is the practice of this facility to assure that patches are rotated appropriately in accordance with the manufacturer's guidelines. The correction action taken for those residents found to be affected by the deficient practice include:Resident #20 is receiving all medications in accordance with acceptable nursing practice. Other residents that have the potential to be affected have been identified by:All residents have been reviewed. Those with orders for patches are receiving them in a manner in accordance with the manufacturer's guidelines. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:The nurses/QMAs have been in-serviced related to assuring that they are documenting the site applications for patches. The in-service also included that any new orders for patches should automatically have a site rotation included. In addition, the IDT team reviews physician orders each business day. The team will also assure that any new orders related to patches have rotation sites documented on the MAR in</p>	12/16/2013	

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	<p>diagnoses of Resident #20 included, but were not limited to, the following: dementia, depression and atrial fibrillation.</p> <p>The most recent Quarterly MDS (Minimum Data Set Assessment) dated 08/14/13 indicated Resident #20 had severe cognitive impairment.</p> <p>On 11/22/13 at 11:25 A.M., Resident #20 was observed sitting at the dining table eating lunch.</p> <p>The November 2013 Physician's Order read as follows: "Exelon (a medication used to treat mild to moderate dementia) 4.6 mg/24 hr patch. Apply 1 patch daily in the a.m. Remove old patch and apply new patch daily - alternate sites and follow manufacturer's guidelines."</p> <p>The November 2013 Medication Administration Record (MAR) indicated the Exelon patch had been administered daily to Resident #20 from November 1st, 2013, through November 21, 2013. The MAR lacked any documentation related to the placement of the Exelon patch on the body of Resident #20.</p> <p>The Nursing 2013 Drug Handbook 33rd edition page 1203 indicated:</p>		<p>accordance with the manufacturer's recommendations. The corrective action taken to monitor performance to assure compliance through quality assurance is: A Performance Improvement Tool has been initiated that will randomly review 5 residents with orders for patches (if applicable) to assure the documentation identifies rotation of site per manufacturer's guidelines. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any areas identified via the audit will be immediately corrected. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed if the tools show any negative outcomes. The date the systemic changes will be completed: December 16, 2013</p>	

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	<p>"Exelon...Administration...transdermal s...change the site daily, and don't use the same site within 14 days..."</p> <p>During an interview with the DON on 11/22/13 at 12:15 P.M., the DON indicated that she would consult with the pharmacist about issues of Exelon patch placement and rotation. The DON indicated that a correction to the MAR providing for such documentation would be made on this date.</p> <p>3.1-35(g)(1)</p>			

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F000323 SS=G	<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 observation, interview, and record review, the facility failed to ensure a resident identified as a high risk to fall received adequate supervision and/or failed to ensure interventions were initiated after falls to prevent further falls for 1 of 2 residents reviewed for falls in the sample of 2 residents who met the criteria for review of falls. This practice resulted in Resident #2 experiencing 17 falls and receiving lacerations, skin tears, and a hematoma. Resident #2</p> <p>Findings include:</p> <p>On 11/20/13 at 11:55 A.M., Resident #2 was observed sitting in the main dining room in his wheelchair. The wheelchair had in place an anti-roll back system. The resident also had a alarmed velcro seat belt intact.</p> <p>Resident #2's clinical record was reviewed on 11/18/13 at 2:00 P.M. He was admitted to the facility on 06/06/13. His current diagnoses</p>	F000323	<p>F323It is the practice of this facility to assure that adequate supervision is provided to prevent incidents as well as interventions implemented appropriately if an incident occurs to assist with preventing future incidents. It should be noted that although the documentation did not accurately support all of the interventions attempted with resident #2, that multiple interventions had been attempted and most often unsuccessful or refused by the family. The correction action taken for those residents found to be affected by the deficient practice include:Resident #2 has been thoroughly reviewed by the IDT and proper interventions are in place to assist with the prevention of falls. Documentation will reflect ALL interventions implemented related prevention of falls.Other residents that have the potential to be affected have been identified by:All residents have been reviewed that are identified as being at risk for falls. Each of these residents has appropriate interventions in place to assist with the prevention of fallsThe measures or systematic changes</p>	12/16/2013			

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	<p>included, but were not limited to, major depressive disorder, anxiety state, dementia with lewy bodies, closed fracture of rib, spinal stenosis, and insomnia.</p> <p>The Minimum Data Set Assessment (MDS) dated 06/10/13, indicated a severe cognitive impairment with a score of 5. The assessment indicated supervision and set up help only (1,1) for transfers and to walk in room or corridor. A MDS Assessment dated 08/12/13, indicated independence and no set up or physical help from staff (0,0) for bed mobility, and walk in room and corridor. The assessment also indicated a cognition score of 2 (severe cognitive impairment).</p> <p>Resident #2 had a care plan initiated on 06/07/13 that addressed the resident being a high risk for falls. Goals included to remain as independent as possible and to maintain safety with falls with no injuries or fractures. Interventions included, but were not limited to, "... allow to do for self as able...and call light in reach."</p> <p>On 11/19/13 at 2:40 P.M., the DON (Director of Nursing) was interviewed regarding Resident #2's falls in regard to reviewing Resident #2's fall</p>		<p>that have been put into place to ensure that the deficient practice does not recur include: Residents will be assessed at the time of admission, with a significant change, and quarterly thereafter for fall risk. If a resident is identified as being at risk for falls, the IDT will review to assure there are proper interventions in place for fall prevention including proper supervision. If a fall occurs, the nurse is responsible for the immediate intervention. A fall committee has been established that will review any occurrence of a fall. The fall committee is responsible to assure a thorough investigation was conducted as to possible root cause of the fall with appropriate interventions to assist with the prevention of reoccurrence. Special care will occur to assure that interventions that may have not previously been effective for some reason are again considered as part of the review. The IDT is aware that it is expected that there be a new intervention that correlates with any actual fall. The nurses have been in-serviced related to immediate interventions and proper supervision to assist with the prevention of falls. The corrective action taken to monitor performance to assure compliance through quality assurance is: A Performance Improvement tool has been established that reviews 5 residents (if applicable) related to</p>	

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	<p>progress notes.</p> <p>A progress note dated 06/07/13 at 12:10 P.M., indicated, "...Resident attempted to get up on own, and fell hitting his head and landing on right shoulder and side..."</p> <p>A progress note dated 06/07/13 at 1:37 P.M., indicated, "Assessed resident's room no environmental hazards in room. Was in regular bed with call light in reach attached to side rail. Resident had been resting all morning unable to arouse gently. Then he got up with sheets wrapped feet and fell in room. Charge nurse (nurse's name) started neuro (neurological) checks and resident denied any pain but very confused. Has altered mental status with dementia. Resident was very high risk for falls but refuses hipsters, helmet, non-skid socks and refuses to ask for assist or use call light. Wife aware of fall risk. Stated, 'he fell 4-5 times a week at home and also would fall upon standing and catch himself on things.' Noted on admission laceration above left eye with sutures and bruising scattered all over body but mostly to head and arms. Admitted yesterday evening with orders for PT to eval (evaluate) and treat as indicated. Received new order for</p>		<p>falls and proper interventions. The tool will specifically observe for new interventions as needed to assist with fall prevention related to the possible root cause. The Director of Nursing, or designee, will complete the tool weekly x3, monthly x3, then quarterly x3. Any issues identified will be immediately addressed. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed based on any negative outcome of the tools. The date the systemic changes will be completed: December 16, 2013</p>	

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	<p>from Dr. (Dr.'s name) for non-skid mat by bed. Placed non-skid mat by bed at this time. Is on scheduled toileting plan and checked every 2 hours and prn (when needed) for incontinence... Resident is in room close to the nurses station for frequent monitoring."</p> <p>A second fall documented in progress note dated 06/22/13 at 7:30 P.M., indicated, "Late entry: CNA reported to this nurse that resident was found on floor by his bed...Res (resident) continues on 15 min (minute) checks and has wanderguard intact."</p> <p>On 11/19/13 at 2:40 P.M., the Director of Nursing indicated the resident had been put on 15 minute checks and a wanderguard had been placed on 06/21/13, after the resident had exited the facility and was found on the facility grounds on 06/21/13 at 3:00 A.M. by staff. Fifteen minute checks remained in place until resident was hospitalized from 07/08/13 to 07/17/13 on a psychiatric unit.</p> <p>A follow up progress note to the 06/22/13 fall dated 06/24/13 at 1:20 P.M., indicated, "... Resident high risk and anticipate falls due to frequent falls, history of multiple falls at home,</p>				

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	<p>weakness, non-compliance with safety, weakness, and episodes of dizziness. Antivert (anti-dizziness medication) 12.5 mg [milligram] changed from prn to routinely TID (3 times a day) x 5 days due to c/o (complaint of) episodic dizziness. Sitting and standing BP (blood pressure) to be recorded twice daily x [times] 5 days to evaluate for orthostatic hypotension. Resident requires assistance for transfers and ambulation however resident non-complaint with assistance and gets up without assist. Safety devices to prevent injury declined per family/POA (Power of Attorney) such as hipsters and helmet. Resident demonstrates impaired balance and gait. Receiving PT 5x wkly (weekly) for therapeutic exercises, gait training, and balance. Resident placed on a low bed with mat at bedside. Resident demonstrates ability to get up from low bed therefore, not considered a restraint. Grab poles in room maintained. Resident on 15 min rounding..."</p> <p>On 11/19/13 at 2:40 P.M., during interview with the DON she indicated Resident #2 had been hospitalized at a psychiatric hospital from 07/08/13 to 07/17/13 and then returned to the facility. The DON indicated after</p>			

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	<p>hospitalization the Psychiatrist had recommended to staff that Resident #2 needed to keep his normal routine. The Psychiatrist indicated that staff intervention may increase his behaviors.</p> <p>A progress note dated 07/22/13, late entry for 5:15 A.M., indicated, "Found res on floor next to his bed on right side..."</p> <p>A progress note dated 07/23/13 at 10:27 A.M., indicated, "Follow up to resident found lying on floor next to bed... Resident is up ad lib in room/facility. Toilets self as is changed per nursing staff PRN due to occasional incontinence. Resident has grab poles (initiated 06/11/13) in room to aid in transfers/ambulation. Non-skid mat at bedside. Resident has 1/2 side rails on bed for enablers and demonstrates safe use. Resident is on 30 minute checks. POA/Family has declined use of low bed, helmet, or hipsters... Resident non-complaint with use of call light for assist. Continues to receive physical therapy 5 x weekly..." "...15 min checks re-implemented..."</p> <p>A progress note dated 07/25/13 at 10:00 P.M., indicated, "Resident</p>			

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	<p>found on floor beside bed by nurse..."</p> <p>A progress note dated 07/27/13 at 2:19 P.M., indicated, "Motion sensor alarm to bed-on when in bed. Resident refuses to have sensor alarm. Resident threw alarm."</p> <p>A progress note dated 07/28/13 at 11:45 P.M., indicated, "... CNA reported to this nurse that res was on the floor..."</p> <p>A progress noted dated 07/29/13 at 3:42 P.M., "... Resident severely cognitively impaired. Up ad lib in facility/room with walker. Resident high risk for falls and falls are anticipated related to history of falls and non-compliance with safety measures. Resident declines use of call light for assist. 1/2 SR (side rail) to bed for enablers. Grab poles in room. Non-skid mat to bedside. Family/POA declines hipsters, helmet, and low bed. Motion sensor alarm to bed attempted as resident took alarm off bed and threw it in hallway. Resident on 15 min checks. Toilet self and change prn per nursing staff for occasional incontinence...</p> <p>Documentation was lacking of a new intervention initiated after the 07/28/13 fall. During interview with</p>			

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	<p>the DON on 11/19/13 at 2:40 P.M., she indicated the motion sensor alarm initiated after the 07/25/13 fall had been discontinued on 07/30/13. The DON indicated at that time no new intervention had been initiated after the 07/28/13 fall.</p> <p>A progress note dated 08/11/13 at 3:30 A.M., indicated, "CNA, (CNA's name) heard noise in resident's room. (CNA's name) found resident on the floor next to chair, and bedside commode was flipped over...Resident was bleeding from right anterior forehead and right two knuckles on right hand...Resident has approximate 5 inch hematoma with a one inch laceration on the anterior right side of forehead...Resident also received an abrasion to right knee with no bleeding noted..."</p> <p>A progress note dated 08/12/2013 at 3:12 P.M., addressed the 08/11/13 fall. The documentation indicated the resident was up ad lib in facility with his walker. He was receiving physical therapy and 15 minute checks continued. Interventions that remained were: grab poles x 2, non-skid mat beside bed, 1/2 side rails as enablers. A low bed had been attempted with family refusal. Resident had removed alarms and</p>			

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	<p>had thrown alarm.</p> <p>Documentation was lacking of a new intervention initiated to prevent falls after the 08/11/13 fall. On 11/19/13 at 2:40 P.M., during interview the DON indicated no new intervention had been initiated after the 8/11/13 fall.</p> <p>A progress note dated 08/15/13 at 4:15 A.M., indicated, "resident walked into the living room using walker and had bleeding from the back of head. Resident has approximate one inch laceration to the back of head. Resident stated he had fallen in his room..."</p> <p>A progress note dated 08/15/13 at 1:03 P.M., indicated Resident #2 had been sent to a hospital emergency room and had returned to the facility with 4 staples to laceration of his head. An environmental check of his room was done without concerns noted. Current interventions continued with 15 minute checks, non-skid mat, grab poles and 1/2 side rails. Documentation was lacking of a new intervention initiated.</p> <p>A progress note dated 09/04/13 at 6:42 A.M., indicated, "Found resident on floor with dining table on top of</p>			
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	<p>resident. Assisted resident up and to toilet. Resident c/o (complained) left shoulder pain with tenderness with extension of elbow. Call placed to Dr. (physician's name) with order to send to (hospital name) ER for eval and tx (treatment)."</p> <p>A progress note dated 09/04/13 at 12:59 A.M., indicated, the resident was found on floor under table in his room. He had been sent to hospital emergency room and returned to facility without fracture. The resident had sustained bilateral skin tears from the fall. Interventions continued with grab poles, side rails, and 15 minute checks. Documentation indicated the resident remained up ad lib with walker at the facility.</p> <p>Documentation was lacking of a new intervention initiated after the 09/04/13 fall to prevent further falls. On 11/19/13 at 2:40 P.M., the DON indicated the facility had tried a sleeve device to prevent skin tears.</p> <p>A progress noted dated 09/25/13 at 8:45 A.M., indicated, "Resident in the dining room for breakfast, resident stood up from table, attempted to turn around, lost balance and fell, hitting back of head on floor...." A physician's order was received for an</p>						

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	<p>alarm sensor pad to chair when in dining room.</p> <p>A progress noted dated 09/28/13 at 3:15 A.M., indicated, "A loud noise came from resident's room and resident was found on floor next to recliner. Resident was lying on ground on left shoulder and left hip..."</p> <p>A progress note dated 09/30/13 at 6:38 A.M., indicated, "Late entry for 09/29/13 2210 [10:10 P.M.]... CNA came to this nurse, reported that res [resident] was sitting on floor in own room. Went to assess res, found res sitting on floor next to recliner..."</p> <p>A progress note dated 9/30/13 at 3:17 P.M., indicated, "Occurrence follow up from falls 09/28/13 and 09/29/13. Resident alert with severely impaired cognition. Resident has history of several falls. Resident up ad lib with walker. Frequent reminders for resident to use walker are given per staff. Re-educated resident and family regarding risks and consequences with falls. Resident and family continue to decline safety devices such as low bed, alarms in room, helmet, or hipsters. Resident non-complaint with safety measures. Resident continues on 15 min checks and neuro (neurological) checks post</p>				

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	<p>fall. Resident is not consistent with alerting staff for assist. Resident toilets self with staff assist at times for occasional incontinence..." "... Will continue 15 -min checks and continue to re-educate resident and family regarding falls as necessary. Continue current plan on care." Documentation was lacking of new interventions initiated after falls of 09/28/13 and 09/29/13.</p> <p>A progress note dated 10/3/13 at 11:56 P.M., indicated , "... CNA came to this nurse and reported that res was on the floor next to bed. Went to assess res, CNA #2 is with res sitting on floor next to bed. CNA #2 states res was faced down on floor. Res is alert, asking to get up. MAE (Moves all extremities) w/o (without) difficulty. Skin above left eyebrow and right eye pink slightly swollen...15 min checks cont.(continue)."</p> <p>A progress note dated 10/04/13 at 3:51 P.M., indicated, "Follow up from resident fall. Upon investigation, resident attempted to get up from bed and fell...Resident continues on 15 min checks. Re-educated resident and family regarding risks and consequences regarding falls. Continue to decline low bed, alarms in room, hipsters, or helmet. Grab</p>			

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	<p>poles remain in room. 1/2 SR (side rails) used as enablers. Will continue to re-educate resident and family regarding falls as necessary. Continue current plan of care." Documentation was lacking of a new intervention initiated to prevent falls.</p> <p>A progress note dated 10/08/13 at 12:07 A.M., indicated, " Resident's sensor alarm sounded. CNA (CNA's name) and I both arrived to resident's room and upon entering room, resident fell onto the floor. Resident was attempting to turn off his sensor alarm (alarm mat) at bedside table and lost balance and fell to ground...Resident has an approximate 1 inch gash on right side of head..."</p> <p>A progress note dated 10/08/13 at 9:11 A.M., indicated, "Follow up to resident fall..."Returned from (hospital name)-ER with 2 staples in place...Alarm mat bed side bed continues. Resident remains on 15 min checks. Grab poles remain in room. Resident uses 1/2 SR for enablers. Re-educated resident and family regarding risks and consequences with falls and decline low bed, hipsters, and helmet. Resident up per self with walker. Toilets self with assist at times and as</p>			

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	<p>resident will allow staff to assist. Resident is high risk for falls and falls are anticipated due to history of several falls at home, non-compliance with safety measures, getting up without assist/walker. Will continue to re-educate resident and family regarding as deemed necessary. Will continue current plan of care." Documentation was lacking of an intervention initiated after the 10/08/13 fall to prevent further falls.</p> <p>A progress note dated 10/20/13 at 6:08 A.M., indicated, "Resident was found on floor at the foot of bed on left side, bedside commode tip over in front of bed. Resident yelling get me up !!!..."</p> <p>A progress note dated 10/21/13 at 9:48 A.M., indicated, "...Grab poles to room, 1/2 SR utilized for enablers. POA/family aware of risks associated with frequent falls such as tissue injury, fractures, and death. POA/family and resident decline hipsters, helmet, and low bed. Continues on 15 min checks...Sensor alarm mat beside bed when in bed and in front of recliner when in recliner continues and functional. Will continue current plan of care and re-educate POA/family and resident with risks associated with falls."</p>			

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	<p>Documentation was lacking of an intervention initiated after the 10/20/13 fall to prevent further falls.</p> <p>A progress note dated 10/23/13 at 1:55 P.M., indicated, "Resident fell hitting head was not using walker, alarm on and functioning but not sounding. Walked around device. Neuro (neurological) check started. Dr. (Dr.'s name) aware. Resident refused all interventions, hipster, helmet, etc. POA (Power of Attorney) notified of fall. Resident at risk for further falls due to poor safety awareness."</p> <p>A progress note dated 10/24/13 at 1:06 P.M., indicated, "Follow up to fall 10/23. Upon investigation, resident up from bed per self without walker. Was ambulating out of room and fell hitting head on wall. Was noted alarm mat not sounding but was turned on. Investigated alarm functional status and was noted to be functional as staff stepped on mat to alarm. It appears resident stepped around mat or towards the end of mat as not to step on mat to alarm...15 -min checks continue...Resident non-compliant with safety measures. Motion sensor alarm attempted with resident refusal as evidenced by resident throwing alarm. Low bed</p>			

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	<p>previously attempted with POA/family refusal. Family/POA and resident decline hipsters, helmet. POA/family aware of risks of falls such as tissue injury, fractures and death. Resident unsteady with weakness. Staff assists with ambulation as resident allows. Will continue current plan of care and continue to re-educate POA/family and resident on risks associated with falls."</p> <p>A progress note dated 10/24/13 at 7:30 A.M., indicated, "Alarm mat sounding, CNA, (CNA's name) found lying on floor, with head against bathroom door frame. No new injuries noted..."</p> <p>A progress note dated 10/24/13 at 4:15 P.M., indicated, "Follow up to resident's fall this day. Staff responded to resident's sounding alarm and found resident lying on back with head against bathroom door frame. MAEs. No red, open, or edematous areas noted..." "... Meeting with interdisciplinary care team and wife, daughter, and Ombudsman to discuss falls, risk and consequences of falls, and safety interventions. Wife and daughter at this time is agreeable to attempt low bed. Also agreeable to wheelchair with velcro seat belt as resident has</p>			

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	<p>displayed unsteadiness and weakness. Discussed resident will not be left unattended in wheelchair with wife and daughter's verbalization of understanding. Rear anti-tipsters and rollbacks to wheelchair. At this time, wheelchair with velcro seat belt alarm in place without resident agitation. Resident made comment regarding his wheelchair with velcro belt as 'cadillac.' Continue 15-min checks...Resident's toileting plan discussed with interdisciplinary care team and family/wife and was changed to toileting plan before meals, after meals, and bedtime, and as needed. Alarm mat at bedside maintained and functional. Will continue current plan of care."</p> <p>On 11/21/13 at 9:23 A.M., the Director of Nursing was interviewed regarding Resident #2's falls. The DON was made aware of the problem of lack of adequate supervision being provided to prevent falls. She indicated at that time she agreed there was a problem with adequate supervision.</p> <p>On 11/21/13 at 10:06 A.M., the DON was made aware of the problem of a lack of interventions being initiated after the 7/28/13, 8/11/13, 8/15/13, 9/4/13, 9/28/13, 9/29/13, and</p>			

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	<p>10/20/13 falls. No further information was provided by the DON.</p> <p>On 11/20/13 at 4:00 P.M., the facility's fall policy was received and reviewed. The policy included but was not limited to: "... POLICY: Each resident must be assessed on admission, quarterly, any changes in condition, and recent fall for potential risk for falls to ensure preventative measure are approached..."</p> <p>"...PURPOSE: 2. Initiate preventative approaches..."</p> <p>3.1-45(a)(2)</p>			

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F000431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview and record review, the facility failed to ensure medications were labeled according to current practice, in that</p>	F000431	F431It is the practice of this facility to assure that residents' medications are stored and labeled appropriately in accordance with the	12/16/2013

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	<p>12 boxes of unlabeled medications were observed to be stored in 1 of 2 medication carts during medication storage review. Resident #25</p> <p>Findings include:</p> <p>During an observation of medication cart #2 on 11/22/13 at 10:35 P.M., 12 boxes of Xifaxan 550 mg with 2 tablets per box were observed to be in the 2nd drawer of the medication cart. The medication boxes were lacking labels identifying the resident to whom the medication belonged.</p> <p>During an interview with LPN #10 on 11/22/13 at 10:35 A.M., LPN #10 indicated that the 12 boxes of Xifaxan medication belonged to Resident #25. LPN #10 indicated Resident #25's family received the medication from Resident #25's physician and brought it to the facility 2 weeks ago. LPN #10 indicated a label should have been placed on the box identifying the resident to whom the medication belonged.</p> <p>On 11/22/13 at 12:35 P.M. the clinical record of Resident #25 was reviewed. Diagnoses included, but were not limited to, the following: hepatic encephalopathy, dementia,</p>		<p>regulation. The correction action taken for those residents found to be affected by the deficient practice include: Resident #25 medications are all properly labeled at this time. It should be noted that the unlabeled medications were sample medications that the physician had supplied in an attempt at cost effectiveness for the resident. Other residents that have the potential to be affected have been identified by: The medication carts and medication room in the building have been reviewed to assure that all medications were labeled properly. There were no other residents identified per this review. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include: Nurses and QMAs have been in-serviced related to assuring that all medications are labeled appropriately in accordance with the regulation. They have also been instructed that physician samples may not be utilized unless they are properly labeled. Please see below for means of monitoring. The corrective action taken to monitor performance to assure compliance through quality assurance is: A Performance Improvement tool has been established that reviews the medication carts as well as other areas that medications might be stored to assure that</p>		

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	<p>depression and anxiety.</p> <p>The most recent Quarterly MDS (Minimum Data Set Assessment) dated 10/23/13 indicated Resident #20 had mild cognitive impairment.</p> <p>The November 2013 Physician's Order read as follows: "Xifaxan (a medication used to treat hepatic encephalopathy) 550 mg Tablet Oral (By mouth) - once daily Everyday: Take one PO daily."</p> <p>On 11/22/13 at 11:45 A.M. the facility's policy and procedure for Medication Administration was provided by the DON. The policy and procedure for medication administration read as follows: "...2. Medication brought from home will be sent to the pharmacy to be reviewed. 3. After review by pharmacist, medication matching a resident's current physician's orders will be packaged for use at the facility."</p> <p>During an interview with the DON on 11/22/13 at 11:20 A.M., the DON indicated all medications brought into the facility by family members must be sent to the pharmacy, and labeled by the pharmacy, with the resident's name, prescription dosage, direction for administration and the prescribing</p>		<p>they are labeled properly in accordance with the regulation. The Director of Nursing, or designee, will complete the tool weekly x3, monthly x3, then quarterly x3. Any issues identified will be immediately addressed. The Quality Assurance committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed based on the outcome of the tools. The date the systemic changes will be completed: December 16, 2013</p>				

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	<p>physician's name before it can be administered to the residents.</p> <p>3.1-25(o)</p>				

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F000463 SS=E	<p>483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.</p> <p>Based on observation and interview the facility failed to ensure the call lights in 4 bathrooms located on 2 of the 3 resident halls were functioning. This had the potential to affect 6 residents (Resident #21, Resident #9, Resident #39, Resident #33, Resident #23, and Resident #3) residing on halls B and C. Room 16, 21, 28 and 30</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. On 11/18/13 at 12:27 P.M., Resident #21's bathroom call light was observed to be non-functional when activated. It didn't sound or light above the resident's room door. 2. On 11/18/13 at 12:27 P.M., Resident #9's bathroom call light was observed to be non-functional when activated. It didn't sound or light above the resident's room door. 3. On 11/18/13 at 12:43 P.M., Resident #39's bathroom call light was observed to be non-functional when activated. It didn't sound or 	F000463	<p>F463It is the practice of this facility to assure that the call system functions appropriately at all times. The correction action taken for those residents found to be affected by the deficient practice include: Resident rooms 16, 21, 28, and 30 (and their correlating bathrooms) have had call lights reviewed and they are working appropriately. Other residents that have the potential to be affected have been identified by: All resident rooms (and correlating bathrooms) have been reviewed to assure that the call lights are functioning properly. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include: The checking and logging of call lights is now part of the preventive maintenance plan with documentation to show what lights have been checked and what the results are. All call lights throughout the building will be checked a minimum of monthly to assure that they are functioning properly and easily activated. The Maintenance Director has been in-serviced related to the checking and documenting the checks of the call lights. All staff</p>	12/16/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155688		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/22/2013	
NAME OF PROVIDER OR SUPPLIER FREELANDVILLE COMMUNITY HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 310 W CARLISLE ST FREELANDVILLE, IN 47535			
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	<p>light above the resident's room door.</p> <p>4. On 11/18/13 at 12:51 P.M., Resident 33's bathroom call light was observed to be non-functional when activated. It didn't sound or light above the resident's room door.</p> <p>During an interview and observation with the Maintenance Supervisor (MS) in room 16, on 11/18/13 at 1:32 P.M., the MS pulled the bathroom call light string and checked for the light above the entrance door to illuminate and sound. When the call light neither sounded nor illuminated, the MS indicated the call light must have a loose connection and that he (the MS) would fix it. At that time the MS was also informed of three other rooms where the call lights were malfunctioning.</p> <p>5. On 11/18/13 at 2:20 P.M., Resident 23's bathroom call light was observed to be non-functional when activated. It didn't sound or light above the resident's room door.</p> <p>6. On 11/18/13 at 2:29 P.M., Resident #3's bathroom call light was observed to be non-functional when activated. It didn't sound or light above the resident's room door.</p>		<p>has been in-serviced that if they identify a call light not working properly that they are to notify maintenance immediately so that it can be corrected. The corrective action taken to monitor performance to assure compliance through quality assurance is: A Performance Improvement Tool has been initiated will review proper functioning of call lights. The tool will randomly review 5 resident rooms/bathrooms to assure that the call light system is functioning properly. The Administrator, or designee, will complete this audit weekly x3, monthly x3, and then quarterly x3. Any issue identified will be immediately corrected. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed based on the outcome of the audit. The date the systemic changes will be completed: December 16, 2013</p>				

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	<p>During an interview with the Maintenance Supervisor (MS) on 11/18/13 at 2:35 P.M., the MS indicated he checked the call lights once a month. The MS said, "I go to every room and pull the cord. I don't write it down." The MS indicated he did not have a preventive maintenance log where he documented the monthly call light checks. The MS indicated that whenever staff members discover a call light is not functioning, they complete a work order. The MS indicated that whenever maintenance receives a work order to repair a call light, the call light is fixed.</p> <p>During an interview with the MS on 11/18/13 at 3:15 P.M., the MS indicated he replaced the call light in the bathroom of room 16 and that he cleaned the call light switches in rooms 21, 28 and 30, because the switches were sticking when the string was pulled to activate the call lights in those rooms.</p> <p>3.1-19(u)(1)</p>			