

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/21/2012
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NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203
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F0000	<p>This visit was for the investigation of complaint IN00105617.</p> <p>Complaint IN00105617 Substantiated Federal/State deficiencies related to the allegations are cited at F279, F281, F309 and F323.</p> <p>Unrelated deficiency cited.</p> <p>Survey dates March 16 & 21, 2012</p> <p>Facility number: 004700 Provider number: 155741 AIM number: 100266630</p> <p>Survey team: Mary Jane G. Fischer RN</p> <p>Census Bed Type: SNF/NF: 49 Total: 49</p> <p>Census Payor Type: Medicare: 3 Medicaid: 43 Other: 3 Total: 49</p> <p>Sample: 6</p> <p>These deficiencies also reflect state</p>	F0000		
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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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	findings cited in accordance with 410 IAC 16.2 Quality review completed 3/27/12 Cathy Emswiler RN			

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F0157 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 immediately notify a resident's physician, in that when a resident was found on the floor and assessed with multiple skin tears and a</p>	F0157	F1571. What corrective action will be accomplished for those residents found to be affected by the deficient practice? Resident B physician was notified as was spouse and administrator. He	04/20/2012

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	<p>head injury, the nursing staff failed to completely assess the resident for the possibility of a fracture, and physician notification for 1 of 2 resident's with a fall from bed who sustained injury in a sample of 6. [Resident "B"]</p> <p>Findings include:</p> <p>The record for Resident "B" was reviewed on 03-16-12 at 10:30 a.m. Diagnoses included but were not limited to Parkinson's disease, senile dementia, tremors hallucinations and anxiety disorder. These diagnoses remained current at the time of the record review.</p> <p>The resident's Minimum Data Set [MDS] assessment dated 01-23-12 indicated the resident required total care for transfer and extensive assistance for bed mobility and two staff members for both nursing activity's. Further review the Social Service assessment, related to the resident's cognitive status indicated the resident was severely cognitively impaired.</p> <p>Review of the current signed physician rewrite for March 2012 instructed the nursing staff to keep bed "in lowest position."</p> <p>Observation on 03-16-12 at 9:00 a.m., the</p>		<p>was completely assessed per nurse's notes and internal tracking measures as to any possible injury, vitals, etc. Only two small skin tears were located and reported to above persons. The next day the spouse noted a contusion and pinpoint scab and complaints of pain. Nursing staff did not note any scabs, contusions or pain the day of incident, this day or during next few days per daily meeting and nursing notes. We did send Resident out on spouse request 3/16 even though resident is own responsible party. No new medications, treatments, precautions or diagnosis, not even a Band-Aid was added after emergency visit. On 3/26 new DON looked at head and observed area on skin to be discolored area, size too small to measure. Remeasured with weekly skin review and still same size. She determined with team not a wound just discoloration. 2. 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 practice. A revised incident accident program begins 4/15 as this date is regular payday inservice. It was developed by team using ideas from Indiana Healthcare leadership collaborative, current forms, input from staff. A fall response team</p>		

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	<p>resident's room was observed located directly in front of the nurses station with clear view of the resident.</p> <p>During an additional observation on 03-16-12 at 11:20 a.m., the resident's spouse was at the resident's bedside. The spouse indicated being "upset" because the resident had sustained an injury the night before when falling from the bed. "[Resident] can't get up by [self] but somehow received scrapes to [resident] leg and arm and also has a knot on [resident] head, pointing to the resident's right eyebrow area."</p> <p>During this observation, the resident, in an attempt to converse, the words were garbled and indistinguishable. The resident's spouse indicated, [Resident] doesn't know what [resident] is saying, [resident] is confused, but states [resident] is having pain in [resident] left leg."</p> <p>During this observation the resident had a knot over the right eyebrow which was raised. A request was made to Licensed Practical Nurse employee #1, to observe the resident's legs and arm. The licensed nurse removed the bedsheet to expose the resident's lower legs. The licensed nurse indicated, "[resident] left leg looks shorter than the right leg."</p>		<p>started 4/3/12. 3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur? Weekly care coordination meetings, care plan meetings, morning meeting are times to review for incidents and accidents and that accident and incident program was followed and documented correctly until next policy review. 4. How will the corrective actions be monitored to ensure the deficient practice will not recur? After each fall, the team will review documentation to ensure each item of the incident/ accident program is followed. Any actions not within the policy and procedures or standards of nursing will be addressed with an employee memo by the DON or designee. 5. By what date the systemic changes will be completed? 4/20/12</p>				

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	<p>During this observation, the resident also had a significant skin tear to the right lower extremity which measured 2 inches by 1 inch, and had bright red blood which oozed from the area. The licensed nurse also indicated a skin tear to the right arm, and removed the dressing. During this observation, the kerlix dressing had significant bloody drainage and the area also oozed blood.</p> <p>The resident's spouse indicated being unaware of how bad the injuries were when notified by the nursing staff the evening before.</p> <p>A review of the Nurses Notes, dated 03-16-12 at 10:30 a.m., indicated the following: "Res. [resident] wife came to desk crying, yelling. 'They [in reference to the nursing staff] said [resident] was ok look at [resident], [resident] is not ok.' Writer went to res. room - res. in bed HOB [head of bed] up res. resting with eyes closed, skin pink w/d [warm and dry] resp. [respirations] even non labored - dressing noted to RUE [right upper extremity], RLE [right lower extremity]. [Spouse] yelling look at this [resident] is in terrible pain. [Spouse] states [resident] c/o [complained of] left shoulder, hip, knee, ankle and right hip and knee pain. Res. now has eyes open staring at [spouse].</p>				

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	<p>Dressing removed s/t [skin tear] noted areas cleansed with saline et dry non-adherent dsg. [dressing] applied. [Spouse] demanding res. go to ER [emergency room]. 'I want [resident] checked from head to toe cause look at this on [resident] head.' [Spouse pointing to pinpoint scab on side of head.]</p> <p>A review of the facility "Accident/Incident Report," dated 03-15-12 at 9:20 p.m., indicated the following: "Res. [resident] lying supine in bed, a newly admitted res. was walking by room of res. who fell. Res. called to new res. to 'help me get oob [out of bed]' when res. grabbed both of [name of resident "B"] et [and] attempted to raise res. up from bed et. res. slid off bed et landed onto right side."</p> <p>In addition this report indicated the resident's physician had been "faxed" with the information related to the resident's fall.</p> <p>Further review of the nurses notes and the "Accident/Incident Report" lacked identification of the resident's left leg appearing shorter then the right leg.</p> <p>Review of the facility "Incident Report" policy on 03-21-12 at 2:15 p.m. and dated as "revised 11-03, indicated the</p>				

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	<p>following:</p> <p>"POLICY [underscored]: An incident Report form is to be completed for all incidents involving Residents, Employees, and Visitors. An exact written description of circumstances surrounding the incident is to be completed and submitted to the Director of Nursing as soon as possible."</p> <p>"STEP ACTION [underscored] Provide emergency care, notify physician, psychologist, family and Director of Nursing."</p> <p>3.1-5(a)</p>				

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F0279 SS=E	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, record review and interview, the facility failed to develop a plan of care, in that when residents had siderails the facility failed to ensure a plan of care was developed for 4 of 5 residents reviewed with siderails in a sample of 6. [Residents "A", "B", "D" and "E"].</p> <p>Findings include:</p> <p>1. The record for Resident "A" was reviewed on 03-16-12 at 11:45 a.m. Diagnoses included but were not limited to Dementia with agitation, history of</p>	F0279	F2791. What corrective action will be accomplished for those residents found to be affected by the deficient practice? Resident A has passed so we could not correct care plan. All other identified residents have a side rail care plan. 2. 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. At their care plans a care plan analysis sheet will be used. If side rails are assessed to be needed, they will be care planned.3. What	04/20/2012	

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	<p>cerebral aneurysm, seizure disorder, anxiety disorder and hypertension. These diagnoses remained current at the time of the record review.</p> <p>Review of the resident re-admission assessment, dated 03-05-12 indicated the resident had "bil [bilateral] foot amputations."</p> <p>A review of the resident's MDS dated 02-11-12 indicated the resident had moderate cognitive impairment, and required extensive assistance with toileting. The MDS indicated "balance during transition and walking on/off toilet - not steady only able to stabilize with human assistance."</p> <p>In addition the assessment indicated the resident required assistance with bed mobility and transfer.</p> <p>The resident's current plan of care originally dated 04-27-11 indicated the resident had "Potential for injuries for falls due to requiring assistance for transfers." Approaches to this plan of care included "[resident] ask for assistance for transfers, discourage resident from abrupt position changes, monitor resident for steadiness, call light available and answered promptly."</p> <p>Review of a subsequent current plan of</p>		<p>measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur?5 resident charts will be reviewed a week to ensure if side rails are in place that assessments were done, care plans are in place, doctors order are current.4. How will the corrective actions be monitored to ensure the deficient practice will not recur? Monthly QA will randomly review 15 charts for side rail assessments, physician orders, and care plans are current and accurate by DON or designee.5. By what date the systemic changes will be completed? 4/20/12</p>				

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	<p>care dated 02-23-12 indicated "Problem - Fall." Approaches to this plan of care included "Non slip sock applied, cushion mat/pad beside bed."</p> <p>Review of the facility reported incident, dated 03-08-12 at 5:20 a.m. indicated the following:</p> <p>"DON [Director of Nurses] while doing rounds found resident kneeling on floor near bedpan with head on mattress near siderail."</p> <p>The Nurses Notes, dated 03-08-12 at 6:00 a.m. indicated the following: "Res. had been on call light very frequently during the noc [night] for several reasons. At 5:00 a.m. res. turned on call light and CNA answered light, res. requested use of bedpan which CNA placed under res. Per CNA res. stated [resident] needed to have a BM [bowel movement]. DON went down hall to check res. rooms and came to nurses station stating res. was on floor. Upon arriving to room res found in kneeling position with hand on mattress next to bedrail. It was noticed res. not breathing. Res. positon <sic> flat on back on floor and CPR [cardiopulmonary resuscitation] initiated. 911 called. CPR continued until EMT [Emergency Medical Technicians] arrived and they took over</p>						

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	<p>CPR. EMT's worked with res. for approx. [approximately] 30 min. [minutes]. EMT's called code at 5:55 a.m."</p> <p>The facility was unable to provide requested documentation regarding staff interviews and investigation when requested on 03-16-12 at 2:00 p.m.</p> <p>On 03-21-12 at 12:30 p.m. the facility provided documentation for review related to staff statements.</p> <p>[Written statement from Licensed Practical Nurse employee #6] and undated. "On 03-07-12 <sic> CNA [name of CNA employee #5] had informed me [name of Licensed Practical Nurse employee #6] that resident had been on call light several times for various needs. She [in reference to CNA employee #5] stated that at 5 a [a.m.] resident turned light on and wanted on the bedpan. DON was making rounds and at 5:20 a.m. came down the hall stating that res. was on the floor. When I arrived to room res. was kneeling on the floor next to bed with right side of head against mattress and top of left side of head against siderail.</p> <p>[Written statement from CNA employee #5] On 03-07-12 <sic> about 5:00 a.m. resident turned on call light wanting to be</p>						

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	<p>put on bed pan. Placed resident on bedpan put call light within reach about 5:20 a.m. heard nurse call for help. Went to resident's room and found [resident] kneeling on the floor right side head on mattress top left side head against bedrail."</p> <p>During interview on 03-16-12 at 12:05 p.m. Licensed Practical Nurse employee #6 indicated the following: "[Resident] had been on light for various needs. the CNA put [resident] on bedpan...when I got to the room I saw [resident] kneeling on floor with head next to mattress and the side rail - the side of it. There was no pulse or respirations, but [resident] was still warm. The top of [resident] head was wedged between the mattress and siderail. We didn't lower the side rail because I was afraid it would cause more damage. There were two half rails on the bed - one had netting and the other one didn't."</p> <p>Interview on 03-21-12 at 1:00 p.m. CNA employee #5 indicated, "[Resident] had been on the call light about 7 times that night. [Resident] complained [resident] couldn't breath and had to go to the bathroom and stuff. The last time [resident] said [resident] needed the bedpan. [Resident] didn't use the urinal because [resident] had declined so much</p>				

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	<p>lately. I put [resident] on the bedpan and left out the room - I was doing 2 things at one time and went to the other resident room. I heard someone yelling - it was the DON and she was saying 'someone fell and was on the floor.' When I got there [resident] face was on the mattress and knees on the floor next to the bed and facing toward the bed. [Resident] head was on the side of the bed on the rail and the bedpan still in bed and hadn't been used."</p> <p>The record lacked a plan of care for the use of siderails.</p> <p>2. The record for Resident "B" was reviewed on 03-16-12 at 10:30 a.m. Diagnoses included but were not limited to Parkinson's disease, senile dementia, tremors hallucinations and anxiety disorder. These diagnoses remained current at the time of the record review.</p> <p>The resident's Minimum Data Set [MDS] assessment dated 01-23-12 indicated the resident required total care for transfer and extensive assistance for bed mobility and two staff members for both nursing activity's. Further review the Social Service assessment, related to the resident's cognitive status indicated the resident was severely cognitively impaired.</p>			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Observation on 03-16-12 at 9:00 a.m., with Licensed Practical Nurse employee #1 in attendance, the resident was observed lying in bed, facing in the direction of the nurses station. The bed was in the highest position and both upper siderails and lower rails [also known as split rails] were placed in the "up" position.</p> <p>The licensed nurse immediately notified the Maintenance Supervisor, employee #9. During this observation the licensed nurse employee #1 indicated the resident recently was admitted to Hospice service and "bed had been changed. I think they did something with the siderails."</p> <p>In addition, the facility owner/RN employee #4 made a handwritten entry dated 03-17-12 at 12:00 p.m., into the resident record which indicated a conversation with the resident for the use of the siderails. The employee indicated the resident "prefers side rails up for bed control use and turns."</p> <p>The record lacked a plan of care for the use of siderails.</p> <p>3. The record for Resident "D" was reviewed on 03-16-12 at 1:45 p.m. Diagnoses included but were not limited</p>				

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	<p>to left below the knee amputation, insulin dependent diabetes mellitus, hypertension and diabetic neuropathy. These diagnoses remained current at the time of the record review.</p> <p>During observation on 03-16-12 at 9:25 a.m., the resident was seated in a wheelchair in room. With Licensed Practical Nurse employee #1 in attendance the resident had a siderail attached to one side of the bed.</p> <p>The resident record lacked a plan of care for the use of siderails.</p> <p>4. The record for Resident "E" was reviewed on 03-16-12 at 2:00 p.m. Diagnoses included but were not limited to diabetes mellitus, hypertension mental retardation and dementia. These diagnoses remained current at the time of the record review.</p> <p>Review of the resident's MDS [minimum data set] dated 10-03-11, indicated the resident required extensive assistance with transfer and bed mobility.</p> <p>During observation on 03-16-12 at 9:15 a.m., the resident was observed lying in bed. Attached to the resident's bed were four half rails [known as split bed rails] - two rails at the top of the bed and two</p>				

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	<p>rails at the lower section of the bed. The two upper rails were raised as well as the lower left rail.</p> <p>Further review of the resident record lacked a plan of care plan for the use of siderails.</p> <p>5. Review of the facility policy on 03-16-12 at 4:10 p.m. and titled "SIDERAIL ASSESSMENT," indicated the following:</p> <p>"Complete assessment on admission, quarterly and with condition change. Check the column(s) that most clearly identify the resident status and need for siderail use. Determine need for or not for siderails and determine appropriate type of siderail equipment. Contact physician to request order and contact Resident or Responsible Party for consent. Write work order for maintenance as needed. Note on care plan and CNA assignment sheets."</p> <p>This Federal tag relates to IN00105617.</p> <p>3.1-35(a)</p>				

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F0281 SS=G	<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 record review and interview, the facility failed to ensure professional standards of care, in that was a resident who was identified as a "full code," the nursing staff failed to immediately start emergency procedures [CPR - cardiopulmonary resuscitation] for a resident who was found non responsive and eventually expired for 1 of 1 resident's reviewed in a sample of 6. [Resident "A"].</p> <p>Findings include:</p> <p>The record for Resident "A" was reviewed on 03-16-12 at 11:45 a.m. Diagnoses included but were not limited to Dementia with agitation, history of cerebral aneurysm, seizure disorder, anxiety disorder and hypertension. These diagnoses remained current at the time of the record review.</p> <p>Review of the resident re-admission assessment, dated 03-05-12 indicated the resident had "bil [bilateral] foot amputations."</p> <p>A review of the resident's MDS</p>	F0281	<p>F2811. What corrective action will be accomplished for those residents found to be affected by the deficient practice? Professional standards of the facility were maintained. Before hire, her license was reviewed for findings, her CPR certification was current, and her references were checked and were impeccable. The facility followed emergency procedures. Staff called owner at 6:30a to inform of incident and lack of response of DON and how other staff responded appropriately. The former DON did not follow policies, CPR policies or nursing practices. 2. 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 resident have the potential to be affected. All staff are reviewed for professional standards. Continuing education is required for licensed staff. Ongoing in service education is also mandatory. 3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur? Emergency response policy and procedures will be part of the payday in</p>	04/20/2012			

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	<p>[minimum data set] assessment dated 02-11-12 indicated the resident had moderate cognitive impairment, and required extensive assistance with toileting. The MDS indicated "balance during transition and walking on/off toilet - not steady only able to stabilize with human assistance."</p> <p>In addition the assessment indicated the resident required assistance with bed mobility and transfer.</p> <p>Review of the resident's current plan of care, and originally dated 04-27-11 indicated the resident "needed assist with ADL's [activity's of daily living] due to weakness related to chronic obstructive pulmonary disease." An approach to this plan of care instructed the nursing staff to assist with ADL's as needed."</p> <p>In addition, the record indicated the resident had "falls" dated 01-24-12 [slid off side of bed], 02-23-12 [slid off bed], 03-02-12 [slid out of wheelchair] and 03-08-12.</p> <p>Review of the resident "fall risk assessments," completed after each of the above falls indicated the resident was a "high fall risk." The fall risk assessment indicated "if the total score is 10 or greater, the resident should be considered at HIGH RISK for potential falls. Initiate</p>		<p>service 4/15/12 to all staff. 4. How will the corrective actions be monitored to ensure the deficient practice will not recur? Monthly review of staff to ensure all attended with make up times required for those who miss bu DON or designee and or each department head.5. By what date the systemic changes will be completed? 4/20/12</p>				

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	<p>fall prevention and document of care plan."</p> <p>The resident's current plan of care originally dated 04-27-11 indicated the resident had "Potential for injuries for falls due to requiring assistance for transfers." Approaches to this plan of care included "[resident] ask for assistance for transfers, discourage resident from abrupt position changes, monitor resident for steadiness, call light available and answered promptly."</p> <p>Review of a subsequent current plan of care dated 02-23-12 indicated "Problem - Fall." Approaches to this plan of care included "Non slip sock applied, cushion mat/pad beside bed."</p> <p>Review of the facility reported incident, dated 03-08-12 at 5:20 a.m. indicated the following:</p> <p>"DON [Director of Nurses] while doing rounds found resident kneeling on floor near bedpan with head on mattress near siderail."</p> <p>The Nurses Notes, dated 03-08-12 at 6:00 a.m. indicated the following: "Res. had been on call light very frequently during the noc [night] for several reasons. At 5:00 a.m. res. turned</p>			

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	<p>on call light and CNA answered light, res. [resident] requested use of bedpan which CNA placed under res. Per CNA res. stated [resident] needed to have a BM [bowel movement]. DON went down hall to check res. rooms and came to nurses station stating res. was on floor. Upon arriving to room res. found in kneeling position with hand on mattress next to bed rail. It was noticed res. not breathing. Res. positon <sic> flat on back on floor and CPR [cardiopulmonary resuscitation] initiated. 911 called. CPR continued until EMT [Emergency Medical Technicians] arrived and they took over CPR. EMT's worked with res. for approx. [approximately] 30 min. [minutes]. EMT's called code at 5:55 a.m."</p> <p>The facility was unable to provide requested documentation regarding staff interviews and investigation when requested on 03-16-12 at 2:00 p.m.</p> <p>On 03-21-12 at 12:30 p.m. the facility provided documentation for review related to staff statements.</p> <p>[Written statement from Licensed Practical Nurse employee #6] and undated. "On 03-07-12 <sic> CNA [name of CNA employee #5] had informed me [name of Licensed Practical Nurse employee #6] that resident had</p>						

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	<p>been on call light several times for various needs. She [in reference to CNA employee #5] stated that at 5 a [a.m.] resident turned light on and wanted on the bedpan. DON was making rounds and at 5:20 a.m. came down the hall stating that res. was on the floor. When I arrived to room res. was kneeling on the floor next to bed with right side of head against mattress and top of left side of head against siderail. CNA assisted nurse lowering res. flat to floor, CPR initiated by [name of Licensed Practical Nurse employee #6]. DON went to get ambu bag, another staff member (name of unidentified discipline employee #12] called 911. Upon DON returning to room, DON took over CPR for short time, then nurse took over and cont. [continued] CPR and cont. CPR until EMT's arrive at 5:25 a.m. EMT's took over CPR and cont. for 30 min. before calling code."</p> <p>[Written statement from CNA employee #5] On 03-07-12 <sic> about 5:00 a.m. resident turned on call light wanting to be put on bed pan. Placed resident on bedpan put call light within reach about 5:20 a.m. Heard nurse call for help. Went to resident's room and found [resident] kneeling on the floor right side head on mattress top left side head against bedrail. Help <sic> nurse move [resident] to the</p>						

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	<p>floor and nurse began CPR. I witnessed <sic> DON walking down he hall behind charge nurse."</p> <p>During interview on 03-16-12 at 12:05 p.m. Licensed Practical Nurse employee #6 indicated the following: "[Resident] had been on light for various needs. The CNA put [resident] on bedpan. That night one of the resident's set off the fire alarm and the DON came to the building. The DON was doing rounds and I heard her yelling my name. I was in the med [medication] room. She came all the way down to get me to tell me [resident] was on the floor. When I got to the room I saw [resident] kneeling on floor with head next to mattress and the side rail - the side of it. It took 2 of us [in reference to CNA employee #5] to get [resident] on the floor and then I initiated CPR. There was no pulse or respirations, but [resident] was still warm. The top of [resident] head was wedged between the mattress and siderail. It must have just happened. The DON left the room and didn't initiate CPR. [Resident] had just gotten out of the hospital. There was no mat next to the bed and I couldn't swear to it but I think [resident] was suppose to have an alarm. We didn't lower the siderail because I was afraid it would cause more damage. There were two half rails on the bed - one had netting and the</p>						

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	<p>other one didn't."</p> <p>Interview on 03-21-12 at 1:00 p.m. CNA employee #5 indicated, "[Resident] had been on the call light about 7 times that night. [Resident] complained [resident] couldn't breath and had to go to the bathroom and stuff. The last time [resident] said [resident] needed the bedpan. [Resident] didn't use the urinal because [resident] had declined so much lately. I put [resident] on the bedpan and left out the room - I was doing 2 things at one time and went to the other resident room. I heard someone yelling - it was the DON and she was saying 'someone fell and was on the floor.' When I got there [resident] face was on the mattress and knees on the floor next to the bed and facing toward the bed. [Resident] head was on the side of the bed on the rail and the bedpan still in bed and hadn't been used. I had to help [name of Licensed Practical Nurse employee #6] a whole lot to get [resident] on the floor. [Resident] was non responsive and [resident] was very heavy. The DON left the room and she should have started CPR. She [in reference to the DON] was no help, she was standing there. [Name of Licensed Practical Nurse employee #6] was yelling at the DON that [resident] was a full code. It was frustrating. [Resident] blood sugar was real low on evening shift and I</p>			
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	<p>took [resident] vitals before I put [resident] on the bedpan. I can remember his heart rate was 123, and I told [name of Licensed Practical Nurse employee #6]. I was worried but [resident] seemed so medicated."</p> <p>Review of the facility Policy and Procedure on 03-16-12 at 2:30 p.m., titled "Cardiopulmonary Resuscitation (CPR) for Adults," and dated 11-01 indicated the following:</p> <p>"PURPOSE [bold type and underscored]: CPR is a set of assessments and skills used in sequence to provide rescue support thereby keeping oxygen-rich blood flowing to the brain until defibrillation attempts and advanced life support can be provided."</p> <p>"POLICY [bold type and underscored]: CPR will be performed only by trained personnel."</p> <p>"BASIC PROCEDURE FOR CPR [bold type and underscored]: STEP ACTION [bold type and underscored] - 1. Establish that Resident is unresponsive. Gently shake Resident. Shout to Resident 'are you okay ?' Activate the emergency response system."</p> <p>Review of employee file for Director of</p>						

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	<p>Nurses employee on 03-16-12 at 3:00 p.m., indicated certification in CPR, with an expiration/renewal date of 4/2013.</p> <p>Review of the "Handbook of Geriatric Nursing Care," on 03-21-12 at 4:00 p.m. indicated the following: "Cardiopulmonary resuscitation - a basic life support procedure performed on victims of cardiac arrest. Cardiopulmonary resuscitation (CPR)) seeks to restore and maintain the patient's respiration and circulation after his heartbeat and breathing have stopped. In most instances, you perform CPR to keep the patient alive until advanced cardiac life support can begin. The basic CPR procedure consists of assessing the victim, calling for help and then following the ABC protocol: opening the airway, restoring breathing, and then resorting circulation. Implementation - Determine the patient's level of consciousness. Gently shake his shoulder and shout, "are you okay?" in both ears in case he has difficulty hearing. Quickly scan the patient for major injuries, particularly to the head or neck. Call for help."</p> <p>This Federal tag relates to IN00105617.</p> <p>3.1-35(g)(1)</p>			

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F0309 SS=G	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, interview and record review the facility failed to ensure that a resident who was identified as a "full code," the nursing staff failed to provide prompt action and immediately start emergency procedures [CPR - cardiopulmonary resuscitation] for a resident who was found non responsive and eventually expired, failed to ensure a complete assessment for the need of siderails for residents who were identified by the nursing staff as dependent, failed to perform complete assessments for the need of siderails for bed mobility, failed to obtain a physician order for the use of the rails, and failed to develop a plan of care in which the use of siderails was periodically reviewed for 5 of 5 residents reviewed for siderails in a sample of 6. [Resident "A", "B", "D" "E" and "F"].</p> <p>Findings include:</p> <p>1. The record for Resident "A" was reviewed on 03-16-12 at 11:45 a.m. Diagnoses included but were not limited</p>	F0309	<p>F309</p> <p>1. What corrective action will be accomplished for those residents found to be affected by the deficient practice? Regarding CPR not being performed immediately on Resident A, she was terminated when owner and consultant Administrator arrived in building to assess the situation. Her license is being reported to the professional licensure board, and the attorney general or any other authorities recommended by the professional board. As for the practice of side rails, assessments, and doctors orders, the identified residents were assessed, care planned and if orders needed, orders were obtained. One resident did not need or want side rails so an order was not obtained.</p> <p>2. 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. A RN reviewed all side rails assessments completed as needed,</p>	04/20/2012	

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	<p>to Dementia with agitation, history of cerebral aneurysm, seizure disorder, anxiety disorder and hypertension. These diagnoses remained current at the time of the record review.</p> <p>Review of the resident re-admission assessment, dated 03-05-12 indicated the resident had "bil [bilateral] foot amputations."</p> <p>A review of the resident's MDS dated 02-11-12 indicated the resident had moderate cognitive impairment, and required extensive assistance with toileting. The MDS indicated "balance during transition and walking on/off toilet - not steady only able to stabilize with human assistance."</p> <p>In addition the assessment indicated the resident required assistance with bed mobility and transfer.</p> <p>Review of the resident's current plan of care, and originally dated 04-27-11 indicated the resident "needed assist with ADL's due to weakness related to chronic obstructive pulmonary disease." An approach to this plan of care instructed the nursing staff to assist with ADL's as needed."</p> <p>In addition, the record indicated the resident had "falls" dated 01-24-12 [slid</p>		<p>care plans adjusted, and physician orders obtained if needed.</p> <p>3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur?</p> <p>5 resident charts will be reviewed a week to ensure if side rails are in place that assessments were done, care plans are in place, doctors order are current.</p> <p>4. How will the corrective actions be monitored to ensure the deficient practice will not recur? Monthly QA will randomly review 15 charts for side rail assessments, physician orders, and care plans are current and accurate.</p> <p>5. By what date the systemic changes will be completed? 4/20/12</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/21/2012	
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203			
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	<p>off side of bed], 02-23-12 [slid off bed], 03-02-12 [slid out of wheelchair] and 03-08-12.</p> <p>Review of the resident "fall risk assessments," completed after each of the above falls indicated the resident was a "high fall risk." The fall risk assessment indicated "if the total score is 10 or greater, the resident should be considered at HIGH RISK for potential falls. Initiate fall prevention and document of care plan."</p> <p>The resident's current plan of care originally dated 04-27-11 indicated the resident had "Potential for injuries for falls due to requiring assistance for transfers." Approaches to this plan of care included "[resident] ask for assistance for transfers, discourage resident from abrupt position changes, monitor resident for steadiness, call light available and answered promptly."</p> <p>Review of a subsequent current plan of care dated 02-23-12 indicated "Problem - Fall." Approaches to this plan of care included "Non slip sock applied, cushion mat/pad beside bed."</p> <p>Review of the facility reported incident, dated 03-08-12 at 5:20 a.m. indicated the following:</p>						

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	<p>"DON [Director of Nurses] while doing rounds found resident kneeling on floor near bedpan with head on mattress near side rail."</p> <p>The Nurses Notes, dated 03-08-12 at 6:00 a.m. indicated the following: "Res. had been on call light very frequently during the noc [night] for several reasons. At 5:00 a.m. res. turned on call light and CNA answered light, res. requested use of bedpan which CNA placed under res. Per CNA res. stated [resident] needed to have a BM [bowel movement]. DON went down hall to check res. rooms and came to nurses station stating res. was on floor. Upon arriving to room res found in kneeling position with hand on mattress next to bedrail. It was noticed res. not breathing. Res. positon <sic> flat on back on floor and CPR [cardiopulmonary resuscitation] initiated. 911 called. CPR continued until EMT [Emergency Medical Technicians] arrived and they took over CPR. EMT's worked with res. for approx. [approximately] 30 min. [minutes]. EMT's called code at 5:55 a.m."</p> <p>The facility was unable to provide requested documentation regarding staff interviews and investigation of the incident when requested on 03-16-12 at</p>				

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NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203		
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	<p>2:00 p.m.</p> <p>On 03-21-12 at 12:30 p.m. the facility provided documentation for review related to staff statements regarding the incident.</p> <p>[Written statement from Licensed Practical Nurse employee #6] and undated. "On 03-07-12 <sic> CNA [name of CNA employee #5] had informed me [name of Licensed Practical Nurse employee #6] that resident had been on call light several times for various needs. She [in reference to CNA employee #5] stated that at 5 a [a.m.] resident turned light on and wanted on the bedpan. DON was making rounds and at 5:20 a.m. came down the hall stating that res. was on the floor. When I arrived to room res. was kneeling on the floor next to bed with right side of head against mattress and top of left side of head against side rail. CNA assisted nurse lowering res. flat to floor, CPR initiated by [name of Licensed Practical Nurse employee #6]. DON went to get ambu bag, another staff member (name of unidentified discipline employee #12] called 911. Upon DON returning to room, DON took over CPR for short time, then nurse took over and cont. [continued] CPR and cont. CPR until EMT's arrive at 5:25 a.m. EMT's took</p>				

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	<p>over CPR and cont. for 30 min. before calling code."</p> <p>[Written statement from CNA employee #5] On 03-07-12 <sic> about 5:00 a.m. resident turned on call light wanting to be put on bed pan. Placed resident on bedpan put call light within reach about 5:20 a.m. heard nurse call for help. Went to resident's room and found [resident] kneeling on the floor right side head on mattress top left side head against bedrail. Help <sic> nurse move [resident] to the floor and nurse began CPR. I witnessed <sic> DON walking down the hall behind charge nurse."</p> <p>During interview on 03-16-12 at 12:05 p.m. Licensed Practical Nurse employee #6 indicated the following: "[Resident] had been on light for various needs. the CNA put [resident] on bedpan. That night one of the resident's set off the fire alarm and the DON came to the building. The DON was doing rounds and I heard her yelling my name. I was in the med [medication] room. She came all the way down to get me to tell me [resident] was on the floor. When I got to the room I saw [resident] kneeling on floor with head next to mattress and the siderail - the side of it. It took 2 of us to get [resident] on the floor and then I initiated CPR. There was no pulse or</p>						

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	<p>respirations, but [resident] was still warm. The top of [resident] head was wedged between the mattress and siderail. It must have just happened. The DON left the room and didn't initiate CPR. [Resident] had just gotten out of the hospital. There was no mat next to the bed and I couldn't swear to it but I think [resident] was suppose to have an alarm. We didn't lower the siderail because I was afraid it would cause more damage. There were two half rails on the bed - one had netting and the other one didn't."</p> <p>Interview on 03-21-12 at 1:00 p.m. CNA employee #5 indicated, "[Resident] had been on the call light about 7 times that night. [Resident] complained [resident] couldn't breath and had to go to the bathroom and stuff. The last time [resident] said [resident] needed the bedpan. [Resident] didn't use the urinal because [resident] had declined so much lately. I put [resident] on the bedpan and left out the room - I was doing 2 things at one time and went to the other resident room. I heard someone yelling - it was the DON and she was saying 'someone fell and was on the floor.' When I got there [resident] face was on the mattress and knees on the floor next to the bed and facing toward the bed. [Resident] head was on the side of the bed on the rail and the bedpan still in bed and hadn't been</p>						

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	<p>used. I had to help [name of Licensed Practical Nurse employee #6] a whole lot to get [resident] on the floor. [Resident] was non responsive and [resident] was very heavy. The DON left the room and she should have started CPR. She was no help, she was standing there. [Name of Licensed Practical Nurse employee #6] was yelling at the DON that [resident] was a full code. It was frustrating. [Resident] blood sugar was real low on evening shift and I took [resident] vitals before I put [resident] on the bedpan. I can remember his heart rate was 123, and I told [name of Licensed Practical Nurse employee #6]. I was worried but [resident] seemed so medicated."</p> <p>Review of the facility Policy and Procedure on 03-16-12 at 2:30 p.m., titled "Cardiopulmonary Resuscitation (CPR) for Adults," and dated 11-01 indicated the following:</p> <p>"PURPOSE [bold type and underscored]: CPR is a set of assessments and skills used in sequence to provide rescue support thereby keeping oxygen-rich blood flowing to the brain until defibrillation attempts and advanced life support can be provided."</p> <p>"POLICY [bold type and underscored]: CPR will be performed only by trained</p>						

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NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203		
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	<p>personnel."</p> <p>"BASIC PROCEDURE FOR CPR [bold type and underscored]: STEP ACTION [bold type and underscored] - 1. Establish that Resident is unresponsive. Gently shake Resident. Shout to Resident 'are you okay ?' Activate the emergency response system."</p> <p>Review of employee file for Director of Nurses employee on 03-16-12 at 3:00 p.m., indicated certification in CPR, with an expiration/renewal date of 4/2013.</p> <p>Review of the "Handbook of Geriatric Nursing Care," on 03-21-12 at 4:00 p.m. indicated the following: "Cardiopulmonary resuscitation - a basic life support procedure performed on victims of cardiac arrest. Cardiopulmonary resuscitation (CPR)) seeks to restore and maintain the patient's respiration and circulation after his heartbeat and breathing have stopped. In most instances, you perform CPR to keep the patient alive until advanced cardiac life support can begin. The basic CPR procedure consists of assessing the victim, calling for help and then following the ABC protocol: opening the airway, restoring breathing, and then resorting circulation. Implementation - Determine the patient's level of consciousness.</p>				

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NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203		
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	<p>Gently shake his shoulder and shout, "are you okay?" in both ears in case he has difficulty hearing. Quickly scan the patient for major injuries, particularly to the head or neck. Call for help."</p> <p>In addition continued record review, lacked a physician order for the use of siderails or a plan of care for the use of side rails for this resident.</p> <p>2. The record for Resident "B" was reviewed on 03-16-12 at 10:30 a.m. Diagnoses included but were not limited to Parkinson's disease, senile dementia, tremors hallucinations and anxiety disorder. These diagnoses remained current at the time of the record review.</p> <p>The resident's Minimum Data Set [MDS] assessment dated 01-23-12 indicated the resident required total care for transfer and extensive assistance for bed mobility and two staff members for both nursing activity's. Further review the Social Service assessment, related to the resident's cognitive status indicated the resident was severely cognitively impaired.</p> <p>Observation on 03-16-12 at 9:00 a.m., with Licensed Practical Nurse employee #1 in attendance, the resident was observed lying in bed, facing in the</p>				

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NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203			
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	<p>direction of the nurses station. The bed was in the highest position and both upper side rails and lower rails [split rails] were placed in the "up" position. The rail on the upper right side of the bed was observed with a large gap, between the rail and the bed mattress. This gap measured 5 inches in width. In addition, the gap between the right upper and lower rail [spilt rails], with the use of the facility measuring tape, measured at a 10 inches gap.</p> <p>The licensed nurse immediately notified the Maintenance Supervisor, employee #9. During this observation the licensed nurse employee #1 indicated the resident recently was admitted to Hospice service and "bed had been changed. I think they did something with the siderails."</p> <p>Record review lacked a physician order or an assessment for the use of the siderails.</p> <p>In addition, the facility owner/RN employee #4 made a handwritten entry, dated 03-17-112 at 12:00 p.m., in the resident record which indicated a conversation with the resident for the use of the siderails. The employee indicated the resident "prefers siderails up for bed control use and turns."</p> <p>The record lacked a physician order or an</p>						

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NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203			
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	<p>assessment for the use of the side rails.</p> <p>3. The record for Resident "D" was reviewed on 03-16-12 at 1:45 p.m. Diagnoses included but were not limited to left below the knee amputation, insulin dependent diabetes mellitus, hypertension and diabetic neuropathy. These diagnoses remained current at the time of the record review.</p> <p>During observation on 03-16-12 at 9:25 a.m., the resident was seated in a wheelchair in room. With Licensed Practical Nurse employee #1 in attendance the resident had a siderail attached to one side of the bed.</p> <p>Using the facility measuring tape the gaps between the vertical rails within the structure of the entire bedrail, measured 7 inches.</p> <p>Further review of the resident record lacked a physician order or assessment for the use of siderails.</p> <p>4. The record for Resident "E" was reviewed on 03-16-12 at 2:00 p.m. Diagnoses included but were not limited to diabetes mellitus, hypertension mental retardation and dementia. These diagnoses remained current at the time of the record review.</p>						

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NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203		
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	<p>Review of the resident's MDS dated 10-03-11, indicated the resident required extensive assistance with transfer and bed mobility.</p> <p>During observation on 03-16-12 at 9:15 a.m., the resident was observed lying in bed. Attached to the resident's bed were four half rails [split bed rails] - two rails at the top of the bed and two rails at the lower section of the bed.</p> <p>The Licensed Practical Nurse employee #1 measure the area/gap between the top and lower side rail when placed in the upright position. The Licensed Nurse indicated the gap measured 9 7/8 inches.</p> <p>Further review of the resident record lacked a physician order, care plan or assessment for the use of siderails.</p> <p>5. The record for Resident "F" was reviewed on 03-16-12 at 2:30 p.m. Diagnoses included but were not limited to neurotic disorder, schizophrenia - paranoid type and diabetes mellitus. These diagnoses remained current at the time of the record review.</p> <p>During observation on 03-16-12 at 9:15 a.m., the resident was observed lying in bed. Attached to the resident's bed were</p>				

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NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203		
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	<p>four half rails [split bed rails] - two rails at the top of the bed and two rails at the lower section of the bed.</p> <p>The Licensed Practical Nurse employee #1 measured the area/gap between the top and lower side rail when placed in the upright position. The Licensed Nurse indicated the gap measured 10 inches.</p> <p>Further review of the resident record lacked a physician order or assessment for the use of siderails.</p> <p>6. Review of the facility policy on 03-16-12 at 4:10 p.m. and titled "SIDERAIL ASSESSMENT," indicated the following:</p> <p>"Complete assessment on admission, quarterly and with condition change. Check the column(s) that most clearly identify the resident status and need for siderail use. Determine need for or not for siderails and determine appropriate type of siderail equipment. Contact physician to request order and contact Resident or Responsible Party for consent. Write work order for maintenance as needed. Note on care plan and CNA assignment sheets."</p> <p>This Federal tag relates to IN00105617.</p>				

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NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203
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NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203			
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F0323 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.</p> <p>Based on observation, interview and record review, the facility failed to ensure residents were free from accident/injury, in that when resident's were identified as dependent for bed mobility and/or transfers, the nursing staff failed to protect the residents from injury which included a scalp contusion, and extensive skin tears.</p> <p>This deficient practice effected 2 of 6 residents who received injury and the potential to effect 4 of 6 sampled residents. [Residents "A", "B", "C", "D", "E" and "F"].</p> <p>Findings include:</p> <p>1. The record for Resident "A" was reviewed on 03-16-12 at 11:45 a.m. Diagnoses included but were not limited to Dementia with agitation, history of cerebral aneurysm, seizure disorder, anxiety disorder and hypertension. These diagnoses remained current at the time of the record review.</p> <p>Review of the resident re-admission</p>	F0323	<p>F3231. What corrective action will be accomplished for those residents found to be affected by the deficient practice? Identified resident A was cared for per policy and procedures. Resident B was also cared for appropriately and then sent out in addition per spouses request. 2. 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. An RN reviewed all side rails assessments completed, care plans adjusted, and physician orders obtained if needed. 3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur? Emergency response policy and procedures will be part of the payday in service 4/15/12 to all staff. 4. How will the corrective actions be monitored to ensure the deficient practice will not recur? Monthly QA will randomly review 15 charts for side rail assessments, physician orders, and care plans are current and accurate. 5. By what date the</p>	04/20/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/21/2012	
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203			
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	<p>assessment, dated 03-05-12 indicated the resident had "bil [bilateral] foot amputations."</p> <p>A review of the resident's MDS dated 02-11-12 indicated the resident had moderate cognitive impairment, and required extensive assistance with toileting. The MDS indicated "balance during transition and walking on/off toilet - not steady only able to stabilize with human assistance."</p> <p>In addition the assessment indicated the resident required assistance with bed mobility and transfer.</p> <p>Review of the resident's current plan of care, and originally dated 04-27-11 indicated the resident "needed assist with ADL's due to weakness related to chronic obstructive pulmonary disease." An approach to this plan of care instructed the nursing staff to assist with ADL's as needed."</p> <p>In addition, the record indicated the resident had "falls" dated 01-24-12 [slid off side of bed], 02-23-12 [slid off bed], 03-02-12 [slid out of wheelchair] and 03-08-12.</p> <p>Review of the resident "fall risk assessments," completed after each of the above falls indicated the resident was a</p>		systemic changes will be completed? 4/20/12				

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	<p>"high fall risk." The fall risk assessment indicated "if the total score is 10 or greater, the resident should be considered at HIGH RISK for potential falls. Initiate fall prevention and document of care plan."</p> <p>The resident's current plan of care originally dated 04-27-11 indicated the resident had "Potential for injuries for falls due to requiring assistance for transfers." Approaches to this plan of care included "[resident] ask for assistance for transfers, discourage resident from abrupt position changes, monitor resident for steadiness, call light available and answered promptly."</p> <p>Review of a subsequent current plan of care dated 02-23-12 indicated "Problem - Fall." Approaches to this plan of care included "Non slip sock applied, cushion mat/pad beside bed."</p> <p>Review of the facility reported incident, dated 03-08-12 at 5:20 a.m. indicated the following:</p> <p>"DON [Director of Nurses] while doing rounds found resident kneeling on floor near bedpan with head on mattress near side rail."</p> <p>The Nurses Notes, dated 03-08-12 at 6:00</p>						

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	<p>a.m. indicated the following: "Res. had been on call light very frequently during the noc [night] for several reasons. At 5:00 a.m. res. turned on call light and CNA answered light, res. requested use of bedpan which CNA placed under res. Per CNA res. stated [resident] needed to have a BM [bowel movement]. DON went down hall to check res. rooms and came to nurses station stating res. was on floor. Upon arriving to room res. found in kneeling position with hand on mattress next to bedrail. It was noticed res. not breathing. Res. position <sic> flat on back on floor and CPR [cardiopulmonary resuscitation] initiated. 911 called. CPR continued until EMT [Emergency Medical Technicians] arrived and they took over CPR. EMT's worked with res. for approx. [approximately] 30 min. [minutes]. EMT's called code at 5:55 a.m."</p> <p>The facility was unable to provide requested documentation regarding staff interviews and investigation when requested on 03-16-12 at 2:00 p.m.</p> <p>On 03-21-12 at 12:30 p.m. the facility provided documentation for review related to staff statements.</p> <p>[Written statement from Licensed Practical Nurse employee #6] and</p>				

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	<p>undated. "On 03-07-12 <sic> CNA [name of CNA employee #5] had informed me [name of Licensed Practical Nurse employee #6] that resident had been on call light several times for various needs. She [in reference to CNA employee #5] stated that at 5 a [a.m.] resident turned light on and wanted on the bedpan. DON was making rounds and at 5:20 a.m. came down the hall stating that res. was on the floor. When I arrived to room res. was kneeling on the floor next to bed with right side of head against mattress and top of left side of head against side rail. CNA assisted nurse lowering res. flat to floor, CPR initiated by [name of Licensed Practical Nurse employee #6]. DON went to get ambu bag, another staff member (name of unidentified discipline employee called 911. Upon DON returning to room, DON took over CPR for short time, then nurse took over and cont. [continued] CPR and cont. CPR until EMT's arrive at 5:25 a.m. EMT's took over CPR and cont. for 30 min. before calling code."</p> <p>[Written statement from CNA employee #5] On 03-07-12 <sic> about 5:00 a.m. resident turned on call light wanting to be put on bed pan. placed resident on bedpan put call light within reach about 5:20 a.m. heard nurse call for help. Went to resident's room and found [resident]</p>						

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	<p>kneeling on the floor right side head on mattress top left side head against bed rail. Help <sic> nurse move [resident] to the floor and nurse began CPR. I witnessed <sic> DON walking down he hall behind charge nurse."</p> <p>During interview on 03-16-12 at 12:05 p.m. Licensed Practical Nurse employee #6 indicated the following: "[Resident] had been on light for various needs. the CNA put [resident] on bedpan. That night one of the resident's set off the fire alarm and the DON came to the building. The DON was doing rounds and I heard her yelling my name. I was in the med [medication] room. She came all the way down to get me to tell me [resident] was on the floor. When I got to the room I saw [resident] kneeling on floor with head next to mattress and the side rail - the side of it. It took 2 of us to get [resident] on the floor and then I initiated CPR. There was no pulse or respirations, but [resident] was still warm. The top of [resident] head was wedged between the mattress and siderail. It must have just happened. The DON left the room and didn't initiate CPR. [Resident] had just gotten out of the hospital. There was no matt next to the bed and I couldn't swear to it but I think [resident] was suppose to have an alarm. We didn't lower the side rail because I was afraid it</p>						

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	<p>would cause more damage. There were two half rails on the bed - one had netting and the other one didn't."</p> <p>Interview on 03-21-12 at 1:00 p.m. CNA employee #5 indicated, "[Resident] had been on the call light about 7 times that night. [Resident] complained [resident] couldn't breath and had to go to the bathroom and stuff. The last time [resident] said [resident] needed the bedpan. [Resident] didn't use the urinal because [resident] had declined so much lately. I put [resident] on the bedpan and left out the room - I was doing 2 things at one time and went to the other resident room. I heard someone yelling - it was the DON and she was saying 'someone fell and was on the floor.' When I got there [resident] face was on the mattress and knees on the floor next to the bed and facing toward the bed. [Resident] head was on the side of the bed on the rail and the bedpan still in bed and hadn't been used. I had to help [name of Licensed Practical Nurse employee #6] a whole lot to get [resident] on the floor. [Resident] was non responsive and [resident] was very heavy. The DON left the room and she should have started CPR. She was no help, she was standing there. [Name of Licensed Practical Nurse employee #6] was yelling at the DON that [resident] was a full code. It was frustrating.</p>						

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	<p>[Resident] blood sugar was real low on evening shift and I took [resident] vitals before I put [resident] on the bedpan. I can remember his heart rate was 123, and I told [name of Licensed Practical Nurse employee #6]. I was worried but [resident] seemed so medicated."</p> <p>During interview on 03-16-12 at 2:45 p.m., the Maintenance Supervisor indicated the resident's bed had not been checked for any malfunction after the resident expired. "Actually we moved the bed over to [identification of another resident] room to use it."</p> <p>2. The record for Resident "B" was reviewed on 03-16-12 at 10:30 a.m. Diagnoses included but were not limited to Parkinson's disease, senile dementia, tremors hallucinations and anxiety disorder. These diagnoses remained current at the time of the record review.</p> <p>The resident's Minimum Data Set [MDS] assessment dated 01-23-12 indicated the resident required total care for transfer and extensive assistance for bed mobility and two staff members for both nursing activity's. Further review the Social Service assessment, related to the resident's cognitive status indicated the resident was severely cognitively impaired.</p>						

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	<p>Review of the current signed physician rewrite for March 2012 instructed the nursing staff to keep bed "in lowest position."</p> <p>Observation on 03-16-12 at 9:00 a.m., the resident's room was observed located directly in front of the nurses station with clear view of the resident.</p> <p>During an additional observation on 03-16-12 at 11:20 a.m., the resident's spouse was at the resident's bedside. The spouse indicated being "upset" because the resident had sustained an injury the night before when falling from the bed. "[Resident] can't get up by [self] but somehow received scrapes to [resident] leg and arm and also has a knot on [resident] head, pointing to the resident's right eyebrow area."</p> <p>During this observation, the resident, in an attempt to converse, the words were garbled and indistinguishable. The resident's spouse indicated, [Resident] doesn't know what [resident] is saying, [resident] is confused, but states [resident] is having pain in [resident] left leg."</p> <p>During this observation the resident had a knot over the right eyebrow which was</p>				

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	<p>raised. A request was made to Licensed Practical Nurse employee #1, to observe the resident's legs and arm. The licensed nurse removed the bedsheet to expose the resident's lower legs. The licensed nurse indicated, "[resident] left leg looks shorter than the right leg."</p> <p>During this observation, the resident also had a significant skin tear to the right lower extremity which measured 2 inches by 1 inch, and had bright red blood which oozed from the area. The licensed nurse also indicated a skin tear to the right arm, and removed the dressing. During this observation, the kerlix dressing had significant bloody drainage and the area also oozed blood.</p> <p>The resident's spouse indicated being unaware of how bad the injuries were when notified by the nursing staff the evening before.</p> <p>A review of the Nurses Notes, dated 03-16-12 at 10:30 a.m., indicated the following: "Res. [resident] wife came to desk crying, yelling. 'They [in reference to the nursing staff] said [resident] was ok look at [resident], [resident] is not ok.' Writer went to res. room - res. in bed HOB [head of bed] up res. resting with eyes closed, skin pink w/d [warm and dry] resp. [respirations] even non labored - dressing</p>						

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NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203
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	<p>noted to RUE [right upper extremity], RLE [right lower extremity]. [Spouse] yelling look at this [resident] is in terrible pain. [Spouse] states [resident] c/o [complained of] left shoulder, hip, knee, ankle and right hip and knee pain. Res. now has eyes open staring at [spouse]. Dressing removed s/t [skin tear] noted areas cleansed with saline et dry non-adherent dsg. [dressing] applied. [Spouse] demanding res. go to ER [emergency room]. 'I want [resident] checked from head to toe cause look at this on [resident] head.' [Spouse pointing to pinpoint scab on side of head.]</p> <p>A review of the facility "Accident/Incident Report," dated 03-15-12 at 9:20 p.m., indicated the following: "Res. [resident] lying supine in bed, a newly admitted res. was walking by room of res. who fell. Res. called to new res. to 'help me get oob [out of bed]' when res. grabbed both of [name of resident "B"] et [and] attempted to raise res. up from bed et. res. slid off bed et landed onto right side."</p> <p>Further review of the nurses notes and the "Accident/Incident Report" lacked identification of the resident's left leg appearing shorter then the right leg.</p>			

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	<p>In addition, observation on 03-16-12 at 9:00 a.m., with Licensed Practical Nurse employee #1 in attendance, the resident was observed lying in bed, facing in the direction of the nurses station. The bed was in the highest position and both upper side rails and lower rails were placed in the "up" position [split bed rails]. The rail on the upper right side of the bed was observed with a large gap, between the rail and the bed mattress. This gap measured 5 inches in width. In addition, the gap between the right upper and lower rail, with the use of the facility measuring tape, measured at a 10 inch gap.</p> <p>The licensed nurse immediately notified the Maintenance Supervisor, employee #9. During this observation the licensed nurse employee #1 indicated the resident recently was admitted to Hospice service and "bed had been changed. I think they did something with the siderails."</p> <p>3. The record for Resident "C" was reviewed on 03-16-12 at 12:30 p.m. Diagnoses included but were not limited to paraplegic, schizophrenia, and congestive heart failure. These diagnoses remained current at the time of the record review.</p> <p>Review of the resident's MDS, dated 12-25-11 indicated the resident required</p>						

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	<p>total care for transfer and bed mobility with the assistance of 2 staff members.</p> <p>During observation on 03-16-12 at 9:20 a.m. the resident was observed in bed. The bed was in the high position. The resident indicated a preference to the elevation of the bed to watch television. When further interviewed if the resident had ever fallen from bed, the resident indicated, "Yes when [name of Certified Nurses Aide employee #10] was pulling me over and I fell out of bed. That happened about 1 1/2 weeks ago. It happened at night and she [in reference to the CNA] was by herself." When interviewed if there was an injury, the resident indicated [resident] sustained a "bruise to both hips."</p> <p>Review of the Nurses Notes, dated 03-09-12 at 4:30 a.m., indicated the following: "This nurse was in another res. room with other noc [night] nurse speaking to resident. Heard a shout and crash come from across hall. Upon entering res. room resident found on floor on right side. CNA had rolled res. toward her without assistance to do ADL's [activity's of daily living] and res. rolled off bed onto floor. Upon assessment res. c/o [complained of] right side and leg pain as well as pain in the back of her head. Upon inspection no</p>			

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	<p>injury noted to back of head. Some excoriation to right back side. c/o pain with ROM [range of motion]. Contacted MD [Medical Doctor] for order to send to [name of local area hospital for tx. [treatment] and eval. [evaluation]."</p> <p>A review of the local area hospital emergency room report indicated the resident had a "fall with scalp contusion and lumbar strain."</p> <p>4. The record for Resident "D" was reviewed on 03-16-12 at 1:45 p.m. Diagnoses included but were not limited to left below the knee amputation, insulin dependent diabetes mellitus, hypertension and diabetic neuropathy. These diagnoses remained current at the time of the record review.</p> <p>During observation on 03-16-12 at 9:25 a.m., the resident was seated in a wheelchair in room. With Licensed Practical Nurse employee #1 in attendance the resident had a siderail attached to one side of the bed.</p> <p>Using the facility measuring tape the gaps between the rails measured 7 inches.</p> <p>5. The record for Resident "E" was reviewed on 03-16-12 at 2:00 p.m. Diagnoses included but were not limited</p>				

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	<p>to diabetes mellitus, hypertension mental retardation and dementia. These diagnoses remained current at the time of the record review.</p> <p>Review of the resident's MDS dated 10-03-11, indicated the resident required extensive assistance with transfer and bed mobility.</p> <p>During observation on 03-16-12 at 9:15 a.m., the resident was observed lying in bed. Attached to the resident's bed were four half rails [split bed rails] - two rails at the top of the bed and two rails at the lower section of the bed.</p> <p>The Licensed Practical Nurse employee #1 measure the area/gap between the top and lower side rail when placed in the upright position. The Licensed Nurse indicated the gap measured 9 7/8 inches.</p> <p>6. The record for Resident "F" was reviewed on 03-16-12 at 2:30 p.m. Diagnoses included but were not limited to neurotic disorder, schizophrenia - paranoid type and diabetes mellitus. These diagnoses remained current at the time of the record review.</p> <p>During observation on 03-16-12 at 9:15 a.m., the resident was observed lying in bed. Attached to the resident's bed were</p>						

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	<p>four half rails [split bed rails] - two rails at the top of the bed and two rails at the lower section of the bed.</p> <p>The Licensed Practical Nurse employee #1 measure the area/gap between the top and lower side rail when placed in the upright position. The Licensed Nurse indicated the gap measured 10 inches.</p> <p>This Federal tag relates to IN00105617.</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p>			