

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155210	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/03/2015
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NAME OF PROVIDER OR SUPPLIER HERITAGE HOUSE OF GREENSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 410 PARK RD GREENSBURG, IN 47240
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00174566.</p> <p>Complaint IN00174566 - Substantiated. Federal/State deficiencies related to the allegations are cited at F323.</p> <p>Survey dates: June 2 and 3, 2015</p> <p>Facility number: 000117 Provider number: 155210 AIM number: 100266460</p> <p>Census bed type: SNF/NF: 36 NCC: 21 Total: 57</p> <p>Census payor type: Medicare: 4 Medicaid: 32 Total: 36</p> <p>Sample: 3</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	<p>Please accept this Plan of Correction as our credible allegation of compliance for the deficiency noted in the 2567 for Heritage House of Greensburg. In respectfully submitting the required Plan of Correction our facility is not admitting to the allegations of non-compliance contained within. Requesting a paper compliance review if applicable.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0323 SS=D Bldg. 00	<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 with a fall history had supervision to prevent falls, in that alarms were used in place of supervision and the resident was not routinely toileted, resulting in multiple falls for 1 of 3 residents reviewed for falls (Resident B).</p> <p>Findings include:</p> <p>Resident B's clinical record was reviewed on 6/2/2015 at 11:02 a.m. Diagnoses included, but were not limited to, diabetes, atrial fibrillation, and depression.</p> <p>The most recent Minimum Data Set assessment, dated 4/30/2015, indicated a Brief Interview for Mental Status (BIMS) score of 12 of 15, with 15 indicating cognitively intact. The assessment indicated Resident B required extensive, one person physical assist for most</p>	F 0323	<p>1. Resident B was relocated to a room directly across from the nurse's station for closer observation and was being placed on a toileting program requiring staff to assist to bathroom before meals, at bedtime and as needed. However, the toileting program was not implemented because the resident left the facility on 6/2/15 with her son to visit a family member. While they were out Resident B became ill and the family transported Resident B to the hospital. Resident B never returned to the facility after her hospital stay. Resident B was transferred to sister facility per family request from the hospital. Resident B was not in the facility at the completion of the survey on 6-3-15. Resident B was alert and oriented and capable of using call light for assistance when desired. Resident B did not have any further falls up to the time resident transferred from the facility. It is erroneously stated in the 2567 that a post fall</p>	06/22/2015

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	<p>activities of daily living (ADLs), including bed mobility, transfers, walking, dressing, toilet use, personal hygiene and bathing. Resident B was not steady and only able to stabilize with staff assistance during transitions and walking. She required a walker and/or wheelchair for mobility. The resident was frequently incontinent of bowel and bladder. MDS assessment indicated the resident had experienced a fall in the last month prior to admission/entry or re-entry to the facility.</p> <p>A Care Plan, initiated 12/31/14, indicated: "Resident is at risk for falls r/t [related to]: [blank]. Interventions included: 1) Call light within reach while in room.... 4) Proper footwear as indicated. 5) Use of proper assistive device, w/c [wheelchair]/walker as needed.... 8) Observe for safety. 9) Cues/redirect prn [as needed], 10) Work order to fix w/c lock. 11) Remind pt [patient] to use call light for assist with changing.... 5/10/15: Non-skid socks on @ [at] all x's [times] and up in w/c before breakfast.... 5/14/15: Chair alarm to w/c. 5/25/15: Personal alarm while up in w/c...."</p> <p>A Care Plan, initiated and last updated 3/27/2015, indicated, "Resident requires assistance with ADLs d/t [due to]</p>		<p>assessment was not completed, it was completed for each of the falls. 2. All residents have the potential to be affected by this practice. There were no other residents found to be affected. All fall risk assessments of current residents will be reviewed and each fall care plan interventions will be evaluated for appropriateness and effectiveness. Any necessary changes will be made. All residents at risk for falls will be evaluated for the need for a toileting plan and implemented as necessary. A fall risk assessment will be completed for all new admissions, on a quarterly basis and as needed. A care plan with appropriate interventions will be implemented for all fall risk residents. 3. A new committee will be developed to specifically review the fall risk assessments and focus on appropriate interventions including the need for toileting plans, alarm reduction with alternative interventions implemented as well as any other appropriate interventions. This committee will also review all falls and post fall assessments. They will meet weekly and prn. 4. In addition to this system as stated in #3 the residents falls will be reviewed utilizing the fall quality assurance tool (see attachment). This will be completed weekly X4 weeks then monthly thereafter. The results will be reviewed by</p>	

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	<p>weakness. There were no interventions documented related to transfers, ambulation and/or toileting.</p> <p>A Post Fall Assessment and Follow Up, dated 12/31/2014, indicated, "Injuries: Lump back of head 3 cm [centimeter] dm [diameter]...Send ER [to Emergency Department].... Additional Comment: Pt [patient] stated w/c [wheelchair] still moves even after it is locked. Resident comments about fall if able to communicate: States was changing clothes...fell on floor." (Fall # 1).</p> <p>Most recent Occupational Therapy Plan of Care, dated 4/19/2015, indicated, Functional Deficits...Current Level: ADL [activities of daily living] Self Care, Toileting: maximum assistance.... Funct [functional] Transfers, Wheelchair/Bed: moderate assistance x 2. Funct Transfers, Toilet: moderate assistance x 2.... Current Level of Function: ...Patient requires maximum assistance x 2 with 25% verbal, visual and tactile cueing to safely perform all toileting tasks...."</p> <p>Nurses Progress Notes, dated 4/3/2015 at 8:45 p.m., indicated, "...Son told nurse pt [patient] fell [at] [local store name indicated] [while out of facility during leave of absence with family]."</p>		the QA committee will be followed.				

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	<p>Nurses Progress Notes, dated 4/14/2015 at 5:00 a.m., indicated, "...New onset of incontinence of BM [bowel] et [and] bladder. [up arrow] use of nursing staff assistance."</p> <p>A Fall Risk Assessment, dated 4/21/2015, indicated a score of 10; indicating Resident B was at "high risk" for falls.</p> <p>A Social Services Note, dated 4/30/2015, indicated, "Res [resident] has had general decline in health. Incontinent of B+B [bowel and bladder] at this time. Some loss in memory/cognition noted. Will continue to observe and ensure needs are met daily."</p> <p>Nurses Progress Notes, dated 5/6/2015 at 5:45 p.m., "Res [resident] came from dinner went to room [and] tried to put self on toilet - landed on her bottom on floor...assisted up and to BR [bathroom]. Reminder to use call light or ask for assist." (Fall # 2).</p> <p>There was no Post Fall Assessment and Follow Up provided by the facility for this fall.</p> <p>Nurses Progress Notes, dated 5/10/2015 at 8:34 a.m., indicated, "Resident put call light on, staff walked in and resident was</p>			

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	<p>sitting on the floor next to her bed...no non skids [non-skid footwear] on, placed non skids on...." (Fall # 3).</p> <p>Post Fall Assessment and Follow Up, dated 5/10/2015, indicated, "Factors contributing to the fall: Resident had no socks on, feet slid, and she slid out of bed."</p> <p>Nurses Progress Notes, dated 5/14/2015 at 10:30 a.m., indicated, "Resident turned on BR [bathroom] call light, staff entered and found resident on her knees in front of the toilet, noted [with] incont [incontinence] BM in [brief]. Resident said she got weak and fell to her knees.... Assisted to feet x 2 [person] assist...encouraged Resident to use call light, chair alarm applied." (Fall # 4).</p> <p>Post Fall Assessment and Follow up, dated 5/14/2015, indicated, "Interventions: Chair Alarm placed p [after] fall. Injuries: bruising/abrasion to bilateral knees.... Factors contributing to the fall: Taking herself to BR [bathroom]...."</p> <p>Nurses Progress Notes, dated 5/25/2015 at 10:30 a.m., indicated, "Answered chair alarm + [and] found res on floor. Res said that she hit her forehead on the floor. Right forehead with redness and</p>			

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	<p>swelling. Res said that she fell asleep in her w/c [wheelchair] and fell forward..." (Fall # 5).</p> <p>Post Fall Assessment and Follow Up, dated 5/25/2015, indicated, "Type of injury: area to [right] forehead.... Resident comment about fall: Fell asleep while sitting in w/c [wheelchair]."</p> <p>Nurses Progress Notes, dated 5/28/2015 at 10:20 a.m., indicated, "Pt found on bathroom floor in room...chair alarm on...pt called for help after pt already fell." (Fall # 6).</p> <p>Post Fall Assessment and Follow Up, dated 5/28/2015, indicated, "Factors contributing to the fall: Needed to have a BM [bowel movement]."</p> <p>On 6/2/2015 at 11:15 a.m., a hand-written note taped to the nurses' station counter was observed, which indicated, "5/28/15 Please stay with [Resident B] when she is on toilet. Please do not leave her & [and] tell her you'll be back. Tx [thanks], [LPN # 2]"</p> <p>Resident B was interviewed on 6/2/2015 at 11:55 a.m. She indicated she was "sometimes" incontinent related to waiting for staff to assist her with toileting.</p>			

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	<p>Certified Nursing Assistant (CNA) #1 was interviewed on 6/3/2015 at 1:45 p.m. She indicated Resident B was not on a toileting routine or schedule and that staff relied on Resident B to indicate with her call light when she required staff assistance.</p> <p>A current copy of the Fall Management Policy and Procedure was provided by the Director of Nursing Services (DNS) on 6/3/2015 at 10:25 a.m. The purpose indicated, "To identify Resident(s) at risk for falls and to develop a Plan of Care with the appropriate interventions to reduce a Resident's risk for falls and injury." Policy indicated, "Residents are assessed for fall risk upon admission, quarterly, annual [sic], a significant change, and after a fall."</p> <p>The Director of Nursing Services (DNS) was interviewed on 6/3/2015 at 1:55 p.m. She indicated there was no care plan or intervention for Resident B related to incontinence/toileting and falls.</p> <p>This Federal tag relates to Complaint IN00174566.</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p>			

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