

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155041	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/29/2014
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NAME OF PROVIDER OR SUPPLIER  NORTHWEST MANOR HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6440 W 34TH ST INDIANAPOLIS, IN 46224
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F000000	<p>This visit was for a recertification and state licensure survey.</p> <p>Survey dates: January 21-24 and 27-29, 2014</p> <p>Facility number: 000015 Provider number: 155041 AIM number: 1000273750</p> <p>Survey Team: Laura Brashear, RN, TC Lora Brettnacher, RN Connie Landman, RN</p> <p>Census bed type: SNF: 8 SNF/NF: 105 Total: 113</p> <p>Census payor type: Medicare: 18 Medicaid: 68 Other: 27 Total: 113</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 2/5/14 by Brenda Marshall, RN.</p>	F000000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F000225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and</p>	F000225		02/22/2014	

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	<p>interview, the facility failed to report to the State survey and certification agency an injury of unknown origin and an allegation of verbal abuse. This deficient practice affected two of three residents reviewed for abuse (Resident #28 &amp; Resident #128).</p> <p>Findings include:</p> <p>1. Resident #28's record was reviewed on 1/27/14 at 12:18 P.M. Resident #28 had diagnoses which included, but were not limited to, altered mental status, atrial fibrillation, depressive disorder, dementia, and a history of a pulmonary embolism.</p> <p>An annual Minimum Data Assessment Tool (MDS) dated 9/28/2013, indicated Resident #28 was cognitively impaired with a BIMS (Brief Mini Mental Status) score of 4 out of 10 and was totally dependant on staff for all activities of daily living.</p> <p>A nurse's note dated 10/15/2013 at 9:03 P.M., indicated, "...this writer to residents room, upon arrival and assessing resident this writer noted that res. [resident] mid chest and both lower parts of both breast had</p>		<p>I)Residents #28 &amp; #183 were reported to ISDH.</p> <p>Staff was re-inserviced on reporting unusual occurrences timely.</p> <p>II) Staff was re-inserviced on reporting unusual occurrences timely.</p> <p>III) An investigation checklist was added to the facility procedure of completing investigations. The injuries of unknown origin facility policy/procedure was updated.</p>				

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	<p>bruising present. Mid chest is purple in areas with yellowing present near the upper area of the bruised tissue, and both breast have purple colored bruising present toward the lower aspect of each breast. Resident states there is 0 pain based on the pain scale. Resident unable to convey how bruising occurred. Reported to Unit Manager and DON [Director of Nursing]...."</p> <p>A document titled "Wounds" and dated 10/16/2013, indicated, "...injury wound dimensions L [length] 10.0 cm [centimeters] and W [width] 32.0 cm... purple, yellow bruising...."</p> <p>During an interview on 1/27/2014 at 1:03 P.M., the DON indicated the cause of the injury was unknown and the injury was "extensive across her chest."</p> <p>During an interview with the DON and the Administrator on 1/27/2014 at 3:07 P.M., the DON indicated they were informed of the "bruising" on 10/15/13. The DON stated, "...We immediately involved the wound nurse.... It was determined at some point she was repositioned incorrectly in the broda chair... and because she is hyper sensitive due</p>		<p>IV) Reportable Unusual Occurrences</p> <p>are reported to the DON and/or Administrator timely. DON and/or designee to monitor the incidents. The DON or Administrator reports to ISDH as required. Timely reporting to ISDH will</p> <p>be monitored by the Administrator for 3 months. QAPI committee to</p> <p>review and give direction as appropriate.</p>				

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	<p>to anticoag [anticoagulation] meds [medications] ... it did not qualify for the criteria to report...."</p> <p>During an interview with the Administrator and the owner of the facility on 1/28/14 at 10:05 A.M., the owner stated, "If we determine it isn't anything, we don't report it. We don't want to get everyone worked up if it isn't anything. If it turns out to be abuse we take care of it and of course report it."</p> <p>2. Resident #183's record was reviewed on 1/27/14 at 12:30 PM. Resident #183 had diagnoses which included, but were not limited to, pneumonia, sepsis, diabetes, depressive disorder, chronic airway obstruction, hypertension, hypothyroidism, myalgia, and thrush.</p> <p>Resident #183 was interviewed on 1/22/14 at 11:30 AM. During the interview, Resident #183 alleged the Maintenance Man was verbally abusive towards her but she had not reported the incident to the staff.</p> <p>On 1/24/14 at 8:30 A.M., the Administrator was interviewed and queried if she had been notified of the allegation. She indicated she had not been made aware of the</p>						

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	<p>allegation but immediately removed the staff member and initiated an investigation.</p> <p>On 1/28/14 at 11:30 A.M., the Administrator was interviewed if she had reported the allegation to Indiana State Department of Health. She indicated she had not.</p> <p>A policy titled "Abuse and Neglect-Clinical Protocol, identified as current by the Administrator on 1/28/2014 at 10:05 A.M., indicated, "It is the responsibility of our employees, facility consultants, attending physicians, family, members, visitors etc., to promptly report any incident or suspected incident of neglect or resident abuse, including injuries of unknown source, and theft or misappropriation of resident property to facility management. Policy Interpretation and Implementation...When an alleged or suspected case of mistreatment, neglect, injuries of unknown source, or abuse is reported, the facility Administrator, or his/her designee, will immediately (within twenty-four hours of the alleged incident) notify the following persons or agencies of such incident: a. The State licensing/certification agency</p>			

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	<p>responsible for surveying/licensing the facility.... To help with recognition of incidents of abuse, the following definitions of abuse are provided: ..."Neglect" is defined as failure to provide goods and services necessary to avoid physical harm.... "Injury of unknown source" is defined as an injury that meets both of the following conditions: (1) The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and (2) The injury is suspicious because of: the extent of the injury; or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma).... "</p> <p>3.1-28(c)</p>			

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F000242 SS=D	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on record review and interview, the facility failed to ensure residents' choice in regard to prescribed diet and bathing preferences for 2 of 20 residents reviewed for choices (Resident #168 and Resident #139).</p> <p>Findings include:</p> <p>1. Resident #168's record was reviewed on 1/27/2014 at 10:18 A.M. Diagnoses included, but were not limited to, coronary artery disease, hypertension, failure to thrive, and depression.</p> <p>An annual Minimum Data Assessment Tool [MDS] dated 10/7/13, indicated Resident #168 was alert with some confusion. She had a BIMS [Brief Interview Mini Status] score of 8 out of 15. The MDS indicated it was somewhat important for her to make choices regarding bathing and she required</p>	F000242	<p>l)Residents #168 and #139 have had</p> <p>their choices listed on their care delivery guides.</p>	02/22/2014			

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	<p>the assistance of staff for activities of daily living. Her record indicated she was able to make her own health care decisions and had not been judged incompetent by a court of law.</p> <p>Resident #168's record lacked documentation which indicated the facility assessed her preference regarding her bathing schedule.</p> <p>A care plan dated 10/2/2013, indicated the facility would determine her food preferences.</p> <p>January 2014 physician's recapitulation of orders indicated Resident #168's diet order was "mechanical soft."</p> <p>A nurse's note dated 1/24/2014 at 8:39 A.M. indicated, "Was checking on resident and [Resident #168 named] stated she wanted regular food. I asked her what she was getting and she said ground meat and also stated the reason why was because she had no teeth. Resident stated she has always eaten regular food..."</p> <p>During an interview on 1/22/2014 at 10:22 A.M., Resident #168 indicated she did not have a choice regarding</p>		<p>Resident's #168 nutritional requests</p> <p>have been update.</p>	

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	<p>her bathing schedule and whether she took a shower, tub, or bed bath. Resident #168 stated, "...they decide."</p> <p>During an interview on 1/22/2014 at 10:27 A.M., Resident #168 stated, "I have a real problem with the food" The resident indicated she was on a mechanically altered diet and was given "mushed up chicken." The resident indicated she preferred her food served at regular consistency and indicated she ate in her room because she was embarrassed when others saw what she ate. The resident indicated facility staff informed her she was on a mechanically altered diet due to not unitizing dentures to chew food.</p> <p>During an interview on 1/27/14 at 11:25 A.M., Licensed Practical Nurse #3 indicated Resident #168 had been complaining about having ground meat since she was admitted. LPN #3 stated, "She has a poor appetite and she thinks she can still chew."</p> <p>During an interview on 1/27/2014 at 11:30 A.M., Unit Manger LPN #1 indicated she obtained an order for a speech therapy evaluation on 1/24/14, but the evaluation had not</p>		<p>Staff was re-inserviced on resident</p> <p>choices listed on their care delivery guides. The unit managers are are</p> <p>interviewing all residents in regard to their choices. The care delivery guides will be updated accordingly.</p>				

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	<p>been completed.</p> <p>During an interview on 1/27/2014 at 11:50 A.M., Speech Therapist #11, indicated an evaluation of Resident #168 had not been completed.</p> <p>2. Resident #139's record was reviewed on 1/27/2014 at 11:36 A.M. Resident #139 had diagnoses which included, but were not limited to, chronic airway obstruction, depression. A quarterly MDS dated 11/24/13, indicated he was cognitively intact with a BIMS score of 14 out of 15 and required assistance from staff for activities of daily living.</p> <p>Resident #139's record lacked documentation which indicated the facility assessed his preference regarding his bathing schedule.</p> <p>During an interview on 1/22/14 at 9:57 A.M., Resident #139 indicated he did not have a choice regarding his bathing schedule. Resident #139 stated, "I go by their schedule. Never thought about it being my choice."</p> <p>During an interview on 1/27/14 at 1:40 P.M., The Social Service Director (SSD) was queried</p>		<p>II)</p> <p>Resident's choices are reviewed</p> <p>with each assessment.</p>		

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	<p>regarding the facility's system for assessing residents' bathing schedule preferences. The SSD replied, "I don't ask that but I think nursing or activities does."</p> <p>During an interview on 1/27/14 at 2:04 P.M., Unit Manager Licensed Practical Nurse (LPN) #1 indicated the facility did not have a system in place to assess bathing schedule preferences and to ensure residents were chose their preferred bathing schedule.</p> <p>Review of a policy titled "Refusal of Treatment" dated 12/06, and identified as current by the Administrator as current on 1/28/14 at 1:30 P.M., indicated, "...Our facility shall honor a resident's request not to receive medical treatment as prescribed by his or her physician, as well as care routines outlined on the resident's assessment and plan of care.... The resident is not forced to accept any medical treatment and may refuse specific treatment even though it is prescribed by a physician. "Treatment" is defined as care provided for purposes of maintaining/restoring health, improving functional level, or relieving symptoms...."</p>		<p>Staff was re-inserviced on resident</p> <p>choices listed on their care delivery guides.</p> <p>III)The resident choice procedure has</p> <p>been updated to include documentation on the resident</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 record review and interview, the facility failed to ensure a resident was properly repositioned in a broda chair (chair used for seating and positioning) resulting in extensive bruising across the mid chest area for 1 of 3 residents reviewed for accidents (Resident#28).</p> <p>Finding includes:  Resident #28's record was reviewed</p>	F000323	<p>rounds will be reported to the QAPI committee to review and give direction as appropriate.</p> <p>l)Nursing staff was reeducated for resident</p> <p>#28 positioning in a broda chair (chair used for seating and positioning).</p>	02/22/2014

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	<p>on 1/27/14 at 12:18 P.M. Resident #28 had diagnoses which included, but were not limited to, altered mental status, atrial fibrillation, depressive disorder, dementia, and a history of a pulmonary embolism.</p> <p>An annual Minimum Data Assessment Tool (MDS) dated 9/28/2013, indicated Resident #28 was cognitively impaired with a BIMS (Brief Mini Mental Status) score of 4 out of 10 and was totally dependant on staff for all activities of daily living.</p> <p>A nurse's note dated 10/15/2013 at 9:03 P.M., indicated, "...this writer to residents room, upon arrival and assessing resident this writer noted that res. [resident] mid chest and both lower parts of both breast had bruising present. Mid chest is purple in areas with yellowing present near the upper area of the bruised tissue, and both breast have purple colored bruising present toward the lower aspect of each breast. Resident states there is 0 pain based on the pain scale. Resident unable to convey how bruising occurred. Reported to Unit Manager and DON [Director of Nursing]...."</p> <p>A document titled "Wounds" and</p>		<p>II) Nursing was re-inserviced on resident positioning in a broda chair  (chair used for seating and positioning).</p> <p>III) Staff was re-inserviced on the resident's  care delivery guides for their new resident assignment prior to providing care.</p> <p>IV) Unit Managers/Supervisors will observer staff when residents are being positioned  in a broda chair for weekly for 1 month and then monthly. The results of the audit will be reported to</p>				

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	<p>dated 10/16/2013, indicated, "...injury wound dimensions L [length] 10.0 cm [centimeters] and W [width] 32.0 cm... purple, yellow bruising...."</p> <p>A signed statement from the wound nurse dated 10/16/2013, indicated, "Observed an area of discoloration under resident's breasts. Measurements were documented. Appears to be an injury resulting from repositioning resident in her Broda chair by lifting Resident up under arms."</p> <p>During an interview on 1/27/2014 at 1:03 P.M., the DON indicated Resident #28's injury was "extensive across her chest." The DON indicated Resident #28 was on anticoagulant medication which made her bruise easily.</p> <p>During an interview with the DON and the Administrator on 1/27/2014 at 3:07 P.M., the DON indicated they were informed of the "bruising" on 10/15/13. The DON stated, "...We immediately involved the wound nurse.... It was determined at some point she was repositioned incorrectly in the broda chair... It was obvious someone went behind the broda and lifted her under her arms</p>		<p>DON. QAPI committee to review and give direction as appropriate.</p>		

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	<p>from behind. I would have expected them to have more than one person... This was one person going behind the broda and just lifting... it (bruised area) contained the whole area under the breast...."</p> <p>The DON was queried regarding facility policies for transferring and positioning. The facility was unable to provide a specific policy regarding positioning techniques. A document titled "Northwest Healthcare Topic: Education Related to Transferring Residents" provided by the DON on 1/29/2014 at 1:55 P.M., indicated, "...Education to include the possible complications resulting from an improper transfer technique, such as falls, strain/sprain/twisting/bruising..." At this time the DON indicated she expected staff not to pull or lift under resident's arms to reposition them.</p> <p>3.1-45(a)(2)</p>				

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F000334 SS=E	<p>483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p>			

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	<p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p> <p>Based on interview and record review the facility failed to include documentation in residents' clinical records of the residents or legal representatives being provided education regarding the benefits and potential side effects of the influenza immunization annually for 5 of 5 residents reviewed for the flu vaccine. Residents #139,#30, #28, #81, and #45</p> <p>Findings include:</p> <p>On 1/24/14 at 10:00 a.m., five clinical records were reviewed for</p>	F000334	<p>l) Residents #139, #30, #28 &amp; #45 will have documentation in their medical record that flu educational materials were provided upon admission/annually thereafter to them and/or their legal representative prior to the time they receive their vaccine.</p>	02/22/2014

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	<p>the administration of influenza vaccines, and the provision of education to the residents and/or legal representatives regarding benefits and potential side effects. The following was noted:</p> <p>a. Resident #139-Flu vaccine given 9/26/13 b. Resident #30-Flu vaccine given 9/26/13 c. Resident #28-Flu vaccine given 10/9/13 d. Resident #45-Flu vaccine given 10/14/13 e Resident #81-Flu vaccine declined.</p> <p>On 1/27/14 at 12:00 p.m., the Administrator and Director of Nursing (DON) were interviewed. The staff indicated nursing staff who administered the vaccines were to provide the educational information to the resident and/or legal representative prior to administration of the vaccine and document in the clinical records. The Administrator and DON indicated they were unable to locate the documentation.</p> <p>The facility's policy titled "Influenza Vaccine," dated 9/24/12, included but was not limited to. "...Between</p>		<p>Resident #81 will have documentation in their medical record that flu educational materials were provided to them upon admission/annually thereafter to them and/or their legal representative at the time they refuse the flu vaccine.</p> <p>Nursing was re-inserviced on flu educational materials being provided to residents and/or their legal representative upon admission/annually thereafter prior to the time they give/resident declines the vaccine.</p>	

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	<p>October 1 and March 31 each year, the influenza vaccine shall be offered to all residents, unless the vaccine is medically contraindicated or the resident has already ben immunized. ...Prior to the vaccination, the resident (or the resident's representative) will be provided information and education regarding the benefits and potential side effects of the influenza vaccine. Consent will be obtained and maintained in the resident's medical record at the time of admission. ..."</p> <p>3.1-13(a)</p>		<p>II) Nursing was re-in-services on flu educational materials being provided to residents and/or their legal representative upon admission/annually thereafter prior to the time they give/resident declines the vaccine.</p> <p>III) The flu record was updated to include documentation that the resident received educational materials upon admission/annually thereafter prior to receiving/declining the flu vaccine.</p>	

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			IV)  The Unit Managers will review the flu record after the flu vaccine is given/decline and report the results to the DON. The DON will report the results to QAPI committee. QAPI committee to review and give direction as appropriate.	