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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155608 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 07/28/2014 |
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| NAME OF PROVIDER OR SUPPLIER WITTENBERG LUTHERAN VILLAGE | STREET ADDRESS, CITY, STATE, ZIP CODE 1200 E LUTHER DR CROWN POINT, IN 46307 |
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| F000000 | <p>This visit was for the Investigation of Complaints IN00151602, IN00152340, and IN00152790.</p> <p>This visit was in conjunction with the Post Survey Revisit (PSR) to the Investigation of Complaint IN00150211 completed on June 11, 2014.</p> <p>Complaint IN00151602-Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00152340- Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00152790- Substantiated. Federal/State deficiency related to the allegations is cited at F323.</p> <p>Survey dates: July 25 & 28, 2014</p> <p>Facility number: 000515 Provider number: 155608 AIM number: 100290820</p> <p>Survey team: Janet Adams, RN-TC Regina Sanders, RN (July 28, 2014)</p> | F000000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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| F000323 SS=G | <p>Census bed type: SNF: 15 SNF/NF: 113 Total: 128</p> <p>Census payor type: Medicare: 27 Medicaid: 69 Other: 32 Total: 128</p> <p>Sample: 16</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on July 31, 2014, by Janelyn Kulik, RN.</p> <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, record review, and interview, the facility failed to provide adequate supervision to prevent accidents related to leaving a resident unattended on the bathroom commode without</p> | F000323 | <p>1. What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident #E was discharged from the facility on</p> | 08/20/2014 | | | |

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| | <p>non-skid socks in place resulting a hip fracture for 1 of 3 residents reviewed for falls in the sample of 16. (Resident #E) (CNA #1)</p> <p>The facility also failed to ensure a resident's bed was in the lowest position at the time the resident fell out of bed for 1 of 3 residents reviewed for falls in the sample of 16. (Resident #Q)</p> <p>Findings include:</p> <p>1. The closed record for Resident #E was reviewed on 7/25/14 at 11:10 a.m. The resident's diagnoses included, but were not limited to, vascular dementia, anxiety state, esophageal reflux, chronic kidney disease, seizures, stroke, arthritis, and emphysema.</p> <p>The 4/7/14 Minimum Data Set (MDS) Annual Assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (6). A score of (6) indicated the resident's cognitive patterns were severely impaired. The assessment also indicated the resident required extensive assistance (resident involved in activity, staff provide weight-bearing support) with physical assist of (2) or more persons for bed mobility, transfers, dressing, and personal hygiene. The assessment also indicated the resident did not walk in his room or</p> | | <p>7/8/14. Resident#Q did not sustain any injury related to the incident. 2. How you will identify other residents having the potential to beaffected by the same deficient practice and what corrective action will betaken. A whole houseaudit was completed on 8/12/14 by the nurse leadership team ensuring thatappropriate interventions are in place for each resident in the facilityrelated to safety. Further this audit ensures that the interventions match the resident's care plan and the C.N.A. assignmentsheet and are in place and functioning properly. Please see attached audit sheet – attachmentA. 3. What measures will be put into place or what systemic changes you willmake to ensure that the deficient practice does not recur. The facilityimplemented the attached policy, "Resident Supervision and Safety"-attachmentB. All staff received education relatedto this policy as well as safety and interventions related to each resident'splan of care. This education wascompleted on 8/13/14. Education related to incidents and accidentsand completing a thorough investigation was provided to nurses on 8/5/14 &8/6/14.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficientpractice will not recur. Director ofNursing or Designee</p> | | | | |

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| | <p>the corridors on the unit during the assessment reference period. The assessment also indicated the resident was not steady moving from a seated position to a standing position and mobility devices he utilized included a walker or a wheelchair. The assessment also indicated the resident had two or more falls since his most recent admission, entry/reentry, or prior assessment.</p> <p>A Fall Risk Assessment completed on 4/7/14 indicated the resident's score was (14). A score of (14) indicated the resident was at high risk for falls.</p> <p>The resident's Care Plans were reviewed. A Care Plan initiated on 4/8/2014 indicated the resident had the potential for injuries from falls due to his history of falls, unsteady gait with balance problems, impaired cognition, and mobility limitations from a previous CVA (stroke). Care plan interventions included to keep the bed in the lowest position, non-skid strips to the room floor, rolling walker during ambulation with a gait belt and staff assistance, non-skid slipper socks when not wearing shoes, and a bed sensor alarm as ordered.</p> <p>The 5/2014 Nursing Notes were reviewed. An entry made on 5/28/14 at</p> | | <p>to randomly audit 4 charts per week to ensure that appropriate interventions are in place for each resident related to safety. Audit will be done monthly for the longer of 6 months or until 100% compliance is achieved. See attached audit sheet –attachment C. Date of Compliance: 8/20/14</p> | |

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| | <p>3:30 p.m. indicated the resident was found on the bathroom floor lying on his right side with his head under the toilet. The resident complained of pain to the right leg and multiple skin tears were noted to the top of his right hand. The Physician and family were notified. An entry made at 9:15 p.m. indicated an X-ray showed a right hip fracture. The Nurse Practitioner was notified and orders were received to send the resident to the hospital Emergency Room.</p> <p>The 5/28/14 - 6/4/14 hospital records were reviewed. The results of 5/28/14 right hip X-ray showed a slightly comminuted intertrochanteric fracture. A 5/29/14 Physician Encounter Note indicated the resident was brought in after a fall at the nursing home and since then had been complaining of right hip pain. Another 5/29/14 Physician Encounter Note indicated the resident's right lower extremity was shortened and externally rotated and tenderness to his trochanter area was present. The Physician's plan was for the resident to have hip surgery. A 6/2/14 Operative Report indicated an Open Reduction and Internal Fixation of the right hip fracture was performed on 6/2/14.</p> <p>Review of the 5/28/14 Falls Management Investigation-Post Fall Tool form</p> | | | | | | |

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| | <p>indicated the resident fell in the bathroom on 5/28/14 at 3:30 p.m. The form indicated the resident was alone at the time of the fall and protective or safety devices were not in use at the time of the fall. The form also indicated the resident was not using a cane/walker as MD ordered and had improper footwear on. The form also noted the resident's wheelchair was not in the bathroom with the resident and the resident was without his non-skid socks. The form also noted the resident stated he was trying to walk back to bed at the time of the fall.</p> <p>The facility Administrator, Director of Nursing, and the Cooperate Nurse were interviewed on 7/25/14 at 4:00 p.m. The Cooperate nurse indicated the investigation indicated the fall report did appear that staff took the resident into the bathroom. The Director of Nursing indicated the report noted the CNA found the resident on the floor.</p> <p>When interviewed on 7/25/14 at 5:00 p.m., the Cooperate Nurse indicated Nursing Supervisor #1 spoke to Nursing Supervisor #2 (who was the Supervisor on 5/28/14) and Nursing Supervisor #2 indicated CNA #1 walked the resident into the bathroom on 5/28/14. The resident refused to use the wheelchair and refused his non skid socks at the time.</p> | | | |

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| | <p>The CNA went to get a gown for the resident and the resident stood up and fell. The CNA was in the room but not in the bathroom and no staff were with the resident when he fell.</p> <p>When interviewed on 7/28/14 at 9:10 a.m., Nursing Supervisor #2 indicated she was working the day shift on 5/28/14 when Resident #E fell. The Nursing Supervisor indicated CNA #1 said he had left the resident on the toilet to get a gown for the resident and the resident stood up and fell. The CNA stated the resident had regular black socks on and did not have non-skid socks on at the time. The Nursing Supervisor also indicated other fall interventions for the resident included a bed sensor alarm. The Nursing Supervisor indicated the CNA should have stayed with the resident in the bathroom on 5/28/14. The Nursing Supervisor indicated the fall was reviewed at a morning meeting but at the team meeting the next business day she did not bring up the information about the resident being left alone at the time of the fall.</p> <p>2. On 7/25/14 at 10:45 a.m., Resident #Q was observed in chair in the lounge area on the unit. The resident's head was leaning down to the right on a pillow.</p> | | | |

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| | <p>The record for Resident #Q was reviewed on 7/25/14 at 2:15 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's Disease, congestive heart failure, anxiety state, high blood pressure, and osteoporosis.</p> <p>The 5/11/14 Minimum Data Set (MDS) Annual Assessment indicated the resident's cognitive skills for decision making were severely impaired as the resident never or rarely made decisions. The assessment also indicated the resident had one fall since the last admission/entry or re-entry, or prior assessment.</p> <p>A Fall Risk Assessment completed on 7/6/14 indicated the resident's score was (26). A score of (26) indicated the resident was at high risk for falls.</p> <p>The resident's Care Plans were reviewed. A Care Plan initiated on 5/12/14 indicated the resident was at risk for falls due to history of falls, her poor safety awareness related to her impaired cognition, a diagnosis of Alzheimer's dementia, use of psychotropic medications, and having balance problems at times. Care plan interventions included a floor mat next to the bed with a floor alarm on top of the mat when the resident was in bed.</p> | | | |

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| | <p>Review of the 7/2014 Physician Order Statement indicated there was a Physician's order for a floor mat alarm to be in place next to the bed. There was also an order for the resident to have a defined perimeter mattress.</p> <p>The 7/2014 Nursing Notes were reviewed. An entry made on 7/13/14 at 10:25 a.m. indicated the CNA informed the writer the resident was on the mat in the room. The writer entered the room and found the resident on the floor mat next to the bed. The resident was on her left lateral side. The CNA stated the floor sensor alarm was sounding. The resident denied pain or discomfort. Staff was educated, the resident's medications were reviewed and the Physician was notified.</p> <p>Review of the 7/13/14 Incident Management Investigation Tool report indicated the resident was on the mat next to her bed at 10:25 a.m. The report indicated the floor mat sensor was in place at the time of the fall but the bed was not in the lowest position. The report indicated the resident was not alone at the time of the fall. The report also indicated the bed was at the improper height. The report indicated the resident had more than one fall or injury with similarities of rolls out of the bed.</p> | | | | | | |

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| | <p>The report indicated staff were educated to put the bed in the lowest position.</p> <p>When interviewed on 7/25/14 at 5:00 p.m., the Cooperate Nurse indicated the resident's fall investigation indicated the resident was on the floor mat and the mat sensor was sounding. The Nurse Consultant indicated the written report indicated the resident's bed was not in the lowest position.</p> <p>This Federal tag relates to Complaint IN00152790.</p> <p>3.1-45(a)(2)</p> | | | | |