

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155738	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/03/2013
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NAME OF PROVIDER OR SUPPLIER MILTON HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 206 E MARION ST SOUTH BEND, IN 46601
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F000000	<p>This visit was for an Investigation of Complaints #IN00124094 and #IN00126417.</p> <p>Complaint #IN00124094 - Substantiated. No deficiencies related to the allegation are cited.</p> <p>Complaint #IN00126417 - Substantiated - Federal/State findings are cited at F323 and F328.</p> <p>Survey Dates: April 1, 2, and 3, 2013</p> <p>Facility Number: 001141 Provider Number: 155738 AIM Number: 200905640</p> <p>Survey Team: Debora Kammeyer, RN</p> <p>Census Bed Type SNF: 9 SNF/NF: 15 Residential: 19 Total: 43</p> <p>Census Payor Type Medicare: 4 Medicaid: 13 Private: 23 Other: 3 Total: 43</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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	<p>Sample: 11</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed on 4/9/13, by Brenda Meredith, R.N.</p>				

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F000323 SS=D	<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 implement new interventions and/or monitor the resident after a fall, for 2 of 3 residents reviewed for accidents/incidents. (Resident #A, Resident #C)</p> <p>Findings include:</p> <p>The clinical record of Resident #C was reviewed on 4-2-13 at 11:15 a.m. The diagnoses included, but were not limited to: hypertension, Parkinson's Disease, coronary artery disease, depression, anemia, and angina. The Fall Risk Assessment, dated 3-3-13, indicated the resident had a fall risk score of 14. A total score of 10 or above represents high risk. The Careplan initiated 12-18-12, indicated the resident was at risk for falls due to decreased mobility. The interventions included: keep bed in low position, transfer with supervision, and personal items within reach.</p> <p>On 4-2-13 at 11:30 a.m. review of an</p>	F000323	<p>F323</p> <p>1. RN #1 received corrective action on 3/6/13 for failure to follow up by monitor resident as documented in the interventions to the incidents. 2. All residents will have a fall risk assessments completed by 4/19/13 and then resume quarterly assessments or as needed related to new accidents and incidents. After completion interdisciplinary team will ensure any resident scoring above 10 has appropriate and individualized interventions are implemented. 3. The facilities interdisciplinary team will review all accident and incident reports to ensure that appropriate assessments and interventions are completed. All nursing staff will be in-services regarding incident and accident reports, appropriate individualized interventions, modifying care plans related to accident and incidents by 4/25/13. 4. DON and designees will complete safety device systems audit weekly for 3 months or until 100% compliant then bi-weekly for 3 months and then reviewed monthly. The results will be reported at the</p>	04/30/2013	

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	<p>Incident/Accident Report, dated 3-3-13, and completed by RN #1 indicated Resident #C "... was found on floor after he slid himself out of bed to lay on floor. Resident stated his was not hurt or in any pain. Daughter present...." The Neurological Assessment indicated "...refused vital signs MD (medical doctor) aware...." Pain Screen and Assessment form indicated resident was capable of reporting pain and reported no pain. One witness report completed by CNA #2 indicated resident was found on the floor and that no one was present at time of the accident.</p> <p>A review of the nursing notes by RN #1 indicated, on 3-3-13 at 8 p.m. the resident "...was found on floor saying he needed air. Res [resident] had slid out of chair onto floor on own. Nurse put res [resident] back in bed, applied O2 [oxygen] via nursing measure and will to cont. [continue] to monitor res [resident] frequently...." At 3:00 a.m. on 3-4-13 "...CNA called nurse to room, after examing res. [resident], absence of vital sign was called @ 2:10 a.m. Dr informed and gave release order @ 2:25 a.m. Funeral home called per family request @ 2:25 a.m. Family notified @ 2:21 a.m....." On 3-4-13 a late entry made</p>		<p>quarterly quality assurance meeting. 5. Systematic changes will be completed by 4/30/13. The facility is asking for paper compliance.</p>				

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	<p>by RN #1 indicated "...9 p Res [resident] laying with head of bed elevated, O2 [oxygen] @ 3 L PO2 @85%. Instructed to breath in through nose...." Another late entry made by RN #1 "...3/3/13 10p Res [resident] moving around on bed with O2 on. Again reminded to breath through nose...."</p> <p>On 4-2-13 at 11:20 a.m., a review of the Accident/Incident and Unusual Occurrence Policy indicated on line #9 "...Residents who have been involved in accidents/incidents shall have appropriated clinical assessments performed and sings and symptoms monitored in accordance with assessed needs...."</p> <p>During an interview on 4-2-13 at 9:15 p.m., the Director of Nursing indicated, she was aware of the lack of documentation regarding resident's follow up after a fall by RN #1.</p> <p>A policy titled "Accident/Incident and Unusual Occurrence Policy," reviewed on 4-2-13 at 9:45 p.m., indicated under "Standards...9. Residents who have been involved in accidents/incidents shall have appropriate clinical assessments performed and signs and symptoms monitored in accordance with</p>						

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	<p>assessed needs. Clinical information shall be documented in the medical record at least each shift for a period of twenty-hours, or longer, as necessary."</p> <p>2. The clinical record of Resident #A was reviewed on 4-2-13 at 11:25 a.m. The resident's diagnoses included but were not limited to: Shortness of breath, hypertension, congestive heart failure, and atrial fibulation.</p> <p>On 4-2-13 at 11:45 a.m., review of an Incident/Accident Report form indicated, on 1-5-13 at 5:15 p.m., Resident #A had a fall. The report stated "...nurse and CNA found resident on floor by the bed. When asked if she was hurt res. [resident] denied pain and stated she was alright...." The report was completed by RN #1. Vital signs were taken, investigation completed, and a neurological assessment was started. Statements were recorded regarding the incident. The physician and family were notified of the incident. The new interventions were "...check on res [resident] frequently when in room."</p> <p>Review of nursing notes for 1-5-13, indicated there were no entries made after 5:15 p.m.</p>			

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	<p>On 4-3-13 at 11:40 a.m. the Director of Nursing indicated she could not find further documentation that indicated the nurse checked on the resident frequently.</p> <p>This Federal tag relates to Complaint IN00126417.</p> <p>3.1-50(f)(2)</p>			

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F000328 SS=D	<p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on record review and interview, the facility failed to follow physician's orders and provide with oxygen per a nasal cannula for 1 of 4 residents reviewed for oxygen therapy. (Resident #C)</p> <p>Findings include:</p> <p>The clinical record of Resident #C was reviewed on 4-2-13 at 9:30 p.m. The resident's diagnoses included but were not limited to: shortness of breath, atrial fibrillation, congestive heart failure and Parkinson's.</p> <p>The physician's orders indicated the resident was sent to the emergency room on 1-23-13, and returned to the facility on 1-28-13, with orders for "...O2 [oxygen] 2 l. [2 liters - amount of oxygen flow] NC [nasal cannula]...."</p> <p>The Readmission Nurse's Note, dated</p>	F000328	<p>F 328</p> <ol style="list-style-type: none"> 1. RN #1 received corrective action on 1/25/2013 for failure to follow physician order. 2. All residents in the facilities orders will be reviewed by DON and designee for accuracy. Those with oxygen will be referred to the interdisciplinary team systems review. 3. When residents are admitted to the facility their physician orders will be review and second checked by another nurse within hour of being admitted to facility. All nursing staff will be in-services regarding transcription of physician orders and admission orders as well as proper treatment for residents with special services by 4/25/13. 4. DON and designee will complete respiratory system audit 	04/30/2013			

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	<p>1-28-13 at 5:30 p.m., completed by Nurse #1 indicated Resident #C had a cough with scattered crackles throughout the lungs. The resident's oxygen saturation was 91%. The next nursing note entry after admission on 1-29-13 at 1:00 a.m. indicated order clarification for "...O2 tubing changes and nebulizer. Mask/tubing changes noted...."</p> <p>During an interview on 4-2-13 at 9:15 p.m., the Director of Nursing (DON) indicated the order for oxygen was overlooked by RN #1 because the order was on another form titled Transfer Facility. The DON further indicated the night nurse, LPN #4, reported to duty on 1-28-13 at 10:30 p.m., and LPN #4 caught the error but didn't document when she placed the oxygen on the resident by nasal cannula.</p> <p>A policy titled Oxygen Therapy (not dated) was reviewed on 4-3-13 at 2:40 p.m. The policy indicated "...It is the policy of the facility to administer oxygen in accordance with physician's orders and on an emergency basis...."</p> <p>This Federal tag relates to Complaint IN00126417.</p> <p>3.1-47(a)(6)</p>		<p>weekly for 3 months or until 100% compliant then bi-weekly for 3 months and then reviewed monthly. The results will be reported at the quarterly quality assurance meeting. 5. Systematic changes will be completed by 4/30/13.</p> <p>The facility is asking for paper compliance.</p>		

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