

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155282	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2012
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO	STREET ADDRESS, CITY, STATE, ZIP CODE 2515 NEWTON ST JASPER, IN 47547
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F0000	<p>This visit was for the recertification and State Licensure Survey.</p> <p>Survey dates: November 26, 27, 28, 29, 30, December 4, 5, 2012,</p> <p>Facility number: 000180 Provider number: 155282 AIM number: 100274190</p> <p>Survey Team: Dorothy Watts, RN, TC Martha Saull, RN 11/27, 11/28, 11/29, 11/30, 12/4, 12/5, 2012 Terri Walters, RN</p> <p>Census bed type: SNF: 0 SNF/NF: 99 Residential: 13 Total: 112</p> <p>Census payer type: Medicare: 6 Medicaid: 56 Other: 50 Total: 112</p> <p>Residential sample: 5</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC16.2</p>	F0000	Credible Allegation of Compliance and Correction:Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual.	

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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	Quality review completed on 12/11/12 by, Jodi Meyer, RN			

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F0280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on interview and record review, the facility failed to ensure a care plan was revised and new interventions were implemented for 1 of 2 residents randomly selected and/or reviewed for falls. Resident #118</p> <p>On 11/29/12 at 10:48 A.M., Resident #118's clinical record was reviewed. Her admission date was 7/26/12. Her admission Minimum Data Set Assessment (MDS) dated 8/1/12, indicated a cognitive summary score of 10. A score of 8-12 indicated a moderate cognition impairment. Bed mobility, transfer, and toilet use were noted as 3,3 (extensive</p>	F0280	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #118 care plan was reviewed and revised on 11/19/12, 12/4/12, and 12/7/12. Fall team reviewed and ensured interventions appropriate on 12/18/12. No falls/accidents noted. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken; All residents have the potential to be affected. Care plan team will be in-serviced on reviewing and revising care plan as appropriate after each assessment. Nursing staff will be in-serviced on up-dating care</p>	01/04/2013			

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	<p>assistance with 2 plus persons physically assist). The current MDS dated 10/23/12, indicated a cognition score of 7 which indicated a severe cognition impairment. Bed mobility, transfer, and toilet use were coded as 3,3.</p> <p>Her admission care plan dated 7/26/12 addressed the problem of: "potential for injury and impaired physical mobility r/t (related to) decreased mobility, weakness, dementia, lung ca (lung cancer) with h/o (history of) RLL (right lower lobe) lobectomy aeb (as evidenced by) requires 1pgbs (1 person with gait belt use) and walker for walking and transfers, prn(when needed) 2 pgbs (2 person with gait belt use), w/ch (wheelchair) for locomotion." Interventions included: "Every shift: check bed/chair alarm for function c (with) sensor pads. Transfer and walk with 1pgbs and walker-prn 2 pgbs, wheelchair for locomotion-propels self and propelled by staff, low bed-to be in lowest position when in use, keep call light within reach when in room-encourage to call for assist for transfers/ walking, monitor for c/o (complaint) pain- have resident rate on scale of 1 to 10- administer prn analgesic as ordered, monitor effectiveness of prn analgesic,</p>		<p>plans after change of condition. Falls team reviewed care plans on 12/18/12 of residents with a fall safety plan to ensure all interventions are current and appropriate for the resident. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Nursing staff will be in-serviced to revise falls care plan at the time a current intervention is not effective. Nursing staff to communicate to the falls team via voice mail on new intervention put into place for review. Falls team will review the next business day and ensure intervention was written on care plan and being followed. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; QA nurse will do random audits weekly x4, then monthly x3 and quarterly thereafter on care plan review of residents with safety plans. Audit will include review of charting and timely revisions of current interventions not effective and that approaches and communication tools are current. Audits will be reviewed by the QA comminttee and recommendations made to do further audits or other systemic change required if not 100% compliant.</p>		

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	<p>increased use- keep MD informed, and PT (physical therapy) as ordered - D/cd (discontinued on 10/18/12), and 11/19/12- put bed up against the wall and pad on floor."</p> <p>The care plan was revised on with a date of 10/26/12. The 10/26/12 care plan, which addressed the problem for potential for injury had the added interventions: 11/19/12- autolocking w/c (wheelchair), bed against the wall and pad on floor next to the bed, and 12/4/12- sensor pad in recliner.</p> <p>Nursing note dated 8/5/12 at 8:00 P.M., indicated, "Care giver walked past resident's room et saw resident standing in her room. Care giver asked why she was up et if she needed anything. Resident stated she was trying to find some pants because the ones she had on was wet. Care giver assisted c (with) care. Resident had an incont (incontinence) urine on self, got up by herself, went to bathroom, changed out of wet clothes, et was looking for dry pants. Resident was educated on using her call light for wants, et needs. Will cont (continue) to monitor."</p> <p>Nursing note dated 8/18/12 at 6:45 P.M., indicated, "Resident was found to be walking to MDR (main dining</p>				

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	<p>room) by herself et had 0 (zero) walker or assistance. Resident was educated on using call light when having any wants or needs. Resident stated she understood. This nurse found resident up in her bathroom changing her clothes for bed. Educated resident again on using call light. Resident had unclipped chair alarm et had got up out of her w/c. Resident has been non-compliant c (with) using call light. Will cont (continue) to monitor."</p> <p>Nursing note dated 10/18/12 at 12:45 P.M., indicated, "ST (Speech Therapy) notified of increased confusion in res (resident) during therapy on 10/17/12 eve (evening) et this am..."</p> <p>Nursing note dated 10/23/12 at 3:00 A.M., indicated, " Res increase confusion. Gets lost. Does not remember her Rm (room) location. Needs cueing."</p> <p>Nursing note dated 11/14/12 at 2:00 A.M., indicated, "Resident found sitting in her w/c in hallway when the nurse seen (sic) her et asked her if she was ok et why she was out of bed in hallway. Resident confused didn't know where she was or time of day..."</p>						

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	<p>Nursing note dated 11/19/12 at 9:15 P.M., indicated, "Res (Resident) found lying on floor in her room. Full body assessment completed et full set of vitals obtained. Hematoma to R (right) forehead. Hospice care contacted. Nurse in route to facility."</p> <p>On 12/4/12 at 2:43 P.M., the Director of Nursing (DON) and the RN Safety Coordinator were interviewed regarding documented incidents in the nursing notes of Resident #118 transferring without assistance in 8/2012,10/2012, and 11/2012, and incidences of increased confusion. Discussed lack of care plan interventions initiated after the resident had been observed on several occasions transferring without assistance of staff. Also that the care plan had not been changed from 7/26/12 until 11/19/12 after the fall. The DON indicated at that time that documentation was lacking of new interventions initiated to prevent falls until after 11/19/12 fall.</p> <p>3.1-35(d)(2)(B)</p>						

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F0322 SS=D	<p>483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>Based on observation, interview and record review, the facility failed to follow its policy and procedure for administering medications through a feeding tube (g-tube) for 1 of 2 residents observed for medication administration via a feeding tube. Resident # 35</p> <p>Findings include:</p> <p>The clinical record of Resident #35 was reviewed on 12/5/12 at 9:32A.M. The Resident's diagnoses included, but were not limited to, Huntington's Chorea, Chronic Fatigue Syndrome, Gastro Esophageal Reflux Disease, Joint Pain and Recurrent Aspiration Pneumonia. The Physicians' orders dated 11/16/2012 included but were not limited to:</p> <p>1. Check g-tube placement and residual with each medication</p>	F0322	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice; Nurse administering G-tube meds to resident #35 was educated by the DNS on 12/4/12 on correct procedure in administering G-tube medications. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken; Residents with G-tube and receiving medication thru the G-tube have the potential to be affected. Nurses will be in-serviced on correct procedure in medication administration thru a G-tube. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Nurses will be in-serviced on correct procedure for administering medication thru a G-tube. Facility will continue to do Nurse Competency Checklist annually with each nurse. DNS/ADNS will do random audits</p>	01/04/2013			

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	<p>administration.</p> <p>2. 60 cc water flush per g-tube.</p> <p>3. Risperidone 5 mg per g-tube 3 times a day.</p> <p>4. Ativan 1 mg per g-tube every 4 hours routine.</p> <p>5. Percocet 5/325 mg give 1 and 1/2 tablet per g-tube every 4 hours.</p> <p>6. May crush medication and administer per g-tube.</p> <p>7. Creatine 7.5 mg Twice a day per g-tube</p> <p>On 12/4/12 at 4:24 P.M., during medication administration observation, R.N.(Registered Nurse) #13 prepared Resident #35's medications by crushing Resident 35's Percocet 5/325 mg,(1 1/2 tablets) and poured them into a small plastic medication cup. R.N. #13 then crushed Resident #35's 1/2 tablet of 2 mg Ativan and placed it in a separate medication plastic cup. Creatine 75 mg powder was dissolved in an unknown amount of water in a small paper drink cup. The Risperidone 5mg/5 ml was measured into a separate small plastic medication cup and the Reglan 5mg/5ml was measured into a separate small plastic medication cup. Both the Risperidone and the Reglan were observed to be 5 ml in the plastic cups. R.N. #13 then proceeded to</p>		<p>observing medication administration thru G-tube to ensure correct procedure is followed.How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;DNS/ADNS to do random audits weekly x4, then monthly x3, and quarterly thereafter and observe nurse administering medications thru G-tube. Audit will ensure correct procedure was followed. Audit will be reported to the monthly QA committee and if not 100% compliant, committee will make recommendations for further education to ensure 100% compliance is reached.</p>		

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	<p>Resident #35's room where she followed facility policy for hand washing and applied gloves before medication administration. Residual and tube placement were checked. R.N. #13 poured 10 cc's of water into the 60ml catheter tip syringe and the water passed through the syringe into the feeding tube with ease. R.N. #13 then poured the crushed Ativan powder into the 60 ml syringe and followed with 10 cc of water. The medication and water flowed through the catheter tip of the syringe without difficulty, but when R.N. #13 poured the crushed Percocet into the syringe and then poured 10 cc of water on top of the medication, the medication became lodged in the catheter tip of the syringe and the medication and water were unable to flow through to the feeding tube. R.N. # 13 inserted the plunger into the 60 ml syringe and repeatedly, forcefully and unsuccessfully applied pressure trying to force the medication through the catheter tip. After these failed attempts, she removed the syringe from the feeding tube and used a sterile needle to dislodge some of the medication in the catheter tip. She reconnected the syringe to the feeding tube catheter and poured 10 cc of water into the syringe, and when the water and medication did not flow,</p>			

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	<p>she reinserted the plunger of the syringe and reapplied pressure, trying to push the lodged medication through the syringe tip. When this attempt failed to force the medication through the tip of the syringe, R.N. # 13 made a third attempt to dislodge the medication in the tip of the syringe by using a needle (again at the tip), trying to dislodge the compacted medication. She then reconnected the syringe to the feeding tube, put the plunger into the syringe and forced the medication and water into the feeding tube. R.N. # 13 stated, "Sometimes this happens. It gets clogged up." She then finished administering the liquid medications and flushed the feeding tube tube with water.</p> <p>Medication Administration Record (MAR) was reviewed on 12/5/12 at 3:30 p.m. The following medications were to be administered during the evening medication pass for Resident #35. Risperidone 5 mg per g tube 3 times a day. Ativan 1 mg per g tube every 4 hours routine. Reglan 5 mg through g tube every 8 hours. Percocet 5/325 mg give 1 and 1/2 tab per g tube every four hours. May crush medications and administer per g tube. Creatine 7.5 gm two times per day per g tube. 60 CC water</p>			

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	<p>flush per g tube with as needed medications.</p> <p>The Director of Nursing (D.O.N.) provided a copy of the facility's procedure for medication administration through a tube feeding. The procedure states "...if tablets can be crushed, crush finely and mix with warm water."</p> <p>During an interview with R.N. # 13 on 12/4/12 at 5:10 P.M., she indicated she does not dissolve crushed medication in water when she administers them through a feeding tube. She said, "Oh, you can if you want, but I don't."</p> <p>During an interview with D.O.N. 12/4/12 at 5:20 PM, she indicated the facility's procedure was to mix the crushed medications with water before administering them through a feeding tube and then follow with 5 cc of water after each medication. The D.O.N. stated, "I will refresh her on the correct procedure."</p> <p>3.1-44(a)(2)</p>						

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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>A. Based on observation, interview and record review, the facility failed to ensure assistive devices for fall prevention were utilized and/or a resident received adequate supervision for safe transfer for 2 of 2 randomly selected and/or observed residents reviewed for falls. For 1 of 2 residents, the lack of usage of assistive devices by a CNA (certified nursing assistant), resulted in injury to the resident. (Resident #126) Resident # 126, Resident #118</p> <p>B. Based on observation, interview and record review, the facility failed to ensure the resident environment was free of accidents and hazards related to the unlocked door of the beauty salon and the potentially hazardous materials in the unlocked cabinets. This deficiency had the potential to affect 2 of the 22 residents residing in the 100 Hall who were cognitively impaired. Resident # 29, Resident # 6</p> <p>Findings include:</p>	F0323	<p>We respectfully request an IDR of this tag for reduction in scope/severity level. Supportive documentation attached. What corrective action will be accomplished for those residents found to have been affected by the deficient practice; A. CNA was educated on 12/1/12 to use assistive devices-gait belt-for all transfers ambulation with resident #126.A2. Resident #118 care plan was up-dated on 11/19/12, 12/4/12, and 12/7/12 with new interventions to prevent accidents.B. The visitor here on 11/26/12 using the beauty shop was educated immediately for the affected residents #29 and #6. Cabinets were also locked immediately upon notification. Visitor educated to pull door close to lock whenever leaving beauty shop unattended. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken; All residents have the potential to be affected. Nursing staff will be in-serviced on following care plan and use assistive devices listed as an intervention. Nurses will be</p>	01/04/2013			

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	<p>A. 1. On 12/4/12 at 10 A.M., nurses notes of Resident #126 were reviewed and indicated the following: On 12/1/12 at 11 P.M., the "resident was assisted to the bathroom per 1 assist et (and) her walker, resident tripped over her feet and fell to her left side on ground hitting her head on either the sink or the wall...type of alleged injury: bump on her head L (left); bump/abrasion 5 cm (centimeters) circle on L buttock; abrasion 8 cm on L buttock...immediate intervention put in place...educated CNAs (certified nursing assistants) on the using of a gait belt with each transfer/ambulation on resident..."</p> <p>On 12/5/12 at 9 A.M., the DON (Director of Nursing) provided a copy of the facility policy and procedure for "Gait (transfer) belt." This form was dated most recently as 1/09. This policy included, but was not limited to, the following: "Purpose: to safely transfer or ambulate resident, to aid resident in maintaining balance, to avoid injury to both resident and staff member."</p> <p>On 12/5/12 at 9:50 A.M., the DON was interviewed. She indicated the resident should have had a gait belt on when she was being transferred by a CNA and fell on 12-1-12 at 11 P.M. The DON indicated the resident did not have a gait belt on during this transfer.</p>		<p>in-serviced on up-dating safety plans with new interventions if previous are not effective. Visitors using the beauty shop will not have access to facility supplies. The beauty shop door will have a code lock entry put on it to keep it secure from residents. Visitors using the beauty shop will be educated on closing door when leaving. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Nursing staff will be educated on the use of assistive devices as directed by each individual care plan. Education for nurses will include up-dating the care plan for new interventions it previous approach is not effective. The beauty shop will have a code lock entry put on it to keep it secure from residents. Visitors will be educated on closing the beauty shop door upon leaving the room. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; The QA coordinator will do random audits weekly x4 then monthly x3 and quarterly thereafter on watching nursing staff during transfer/ambulation and ensure correct assistive device is used. Audit will include review of documentation and review of care plans to ensure plan and approaches are appropriate and</p>	

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	<p>On 12/5/12 at 10:08 A.M., the DON provided a copy of the resident's fall risk assessment. On admission, 10/30/12, the resident had a total score of 23. This form indicated a score of 12 or more equals high risk for falls. On 12/1/12, post fall, the fall risk assessment, was completed again. The total score remained at 23. This form included, but was not limited to, the following: resident was 80 years or older; in the last 90 days, has had 3 or more falls; ambulates with problems and devices; elimination with assistance and vision status is highly or severely impaired.</p> <p>At this time, the DON also provided a current copy of the resident's plan of care, dated 11/9/12, for "Potential for injury and impaired physical mobility r/t (related to) h/o (history of) CVA (cerebral vascular accident), general debility, hx (history) of falls aeb (as evidenced by) requires assist of walker and staff assist with transfers, walking..." Approaches included, but were not limited to, the following: "every shift: transfers and walks with 1 PGBS (person gait belt standby) and use of rolling walker..."</p> <p>A.2. On 11/26/12 at 10:15 A.M., during initial tour of the facility, Resident # 118 was observed sitting in a recliner chair near the nurses station for the 100, 200, and 300 hall. Resident #118's complete face and anterior neck was discolored/bruised which included her forehead, both cheeks, chin and anterior neck. The discoloration was a dark purple, and brown with slight yellowing discoloration along the edges of the bruising. On interview at this time, the RN coordinator of the 100, 200,</p>		<p>current for the resident. QA coordiator will do random audit on checking closure of the beauty shop door that locks automatically, weekly x4, monthly x3 then quarterly thereafter. The audit reports will be reviewed by the monthly QA committee and will make further recommendation for re-education or new interventions if not 100% compliant.</p>	

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	<p>and 300 unit, indicated the resident had fallen in her room and there were no fractures.</p> <p>On 11/29/12 at 10:48 A.M., Resident #118's clinical record was reviewed. Her admission date was 7/26/12. Her admission Minimum Data Set Assessment (MDS) dated 8/1/12, indicated a cognitive summary score of 10. A score of 8-12 indicated a moderate cognition impairment. Bed mobility, transfer, and toilet use were noted as 3,3 (extensive assistance with 2 plus persons physically assist). The current MDS dated 10/23/12, indicated a cognition score of 7 which indicated a severe cognition impairment. Bed mobility, transfer, and toilet use were coded as 3,3.</p> <p>Her admission care plan dated 7/26/12 addressed the problem of: "potential for injury and impaired physical mobility r/t (related to) decreased mobility, weakness, dementia, lung ca (lung cancer) with h/o (history of) RLL (right lower lobe) lobectomy aeb (as evidenced by) requires 1pgbs (1 person gait belt stand by) and walker for walking and transfers, prn (when needed) 2 pgbs (2 person gait belt stand by), w/ch (wheelchair) for locomotion."</p>			

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	<p>Interventions included: "Every shift: check bed/chair alarm for function c (with) sensor pads. Transfer and walk with 1pgbs and walker-prn 2 pgbs, wheelchair for locomotion-propels self and propelled by staff, low bed-to be in lowest position when in use, keep call light within reach when in room-encourage to call for assist for transfers/ walking, monitor for c/o (complaint) pain- have resident rate on scale of 1 to 10- administer prn analgesic as ordered, monitor effectiveness of prn analgesic, increased use- keep MD informed, and PT (physical therapy) as ordered - D/cd (discontinued on 10/18/12), and 11/19/12- put bed up against the wall and pad on floor."</p> <p>The care plan was revised on with a date of 10/26/12. The 10/26/12 care plan, which addressed the problem for potential for injury had the added interventions: 11/19/12- autolocking w/c (wheelchair), bed against the wall and pad on floor next to the bed, and 12/4/12- sensor pad in recliner.</p> <p>Nursing notes dated 7/26/12 at 4:30 P.M., indicated, resident arrived to this facility from another nursing facility in Michigan."... General condition appears pale multiple bruises et wound on head c (with)</p>			

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	<p>steri strips noted..."</p> <p>Nursing notes dated 7/26/12 at 9:00 P.M., indicated, "...Gait unsteady. Alert & oriented c (with) some confusion noted..."</p> <p>Nursing note dated 7/27/12 at 10:00 A.M., indicated, "... Resident has had recent fall @ (Michigan facility name). Checked @ local hosp (hospital) ER. No injury/fx (fracture). Resident has episodes of decreasing B/P (blood pressure) esp (especially) Am's and feels faint & must lay or sit down. Other dx. (diagnosis) include Lung CA (cancer)..." "...Dementia & Memory loss. Unable to answer most questions that are specific..."</p> <p>Nursing note dated 8/5/12 at 8:00 P.M., indicated, "Care giver walked past resident's room et saw resident standing in her room. Care giver asked why she was up et if she needed anything. Resident stated she was trying to find some pants because the ones she had on was wet. Care giver assisted c (with) care. Resident had an incont (incontinent) urine on self, got up by herself, went to bathroom, changed out of wet clothes, et was looking for dry pants. Resident was educated on using her call light for wants, et needs. Will</p>			

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	<p>cont (continue) to monitor."</p> <p>Nursing note dated 8/7/12 at 2:00 A.M., indicated, "Resident was confused et CNA was taking resident to BR (bathroom) ..."</p> <p>Nursing note dated 8/18/12 at 6:45 P.M., indicated, "Resident was found to be walking to MDR (main dining room) by herself et had 0 (zero) walker or assistance. Resident was educated on using call light when having any wants or needs. Resident stated she understood. This nurse found resident up in her bathroom changing her clothes for bed. Educated resident again on using call light. Resident had unclipped chair alarm et had got up out of her w/c. Resident has been non-compliant c (with) using call light. Will cont (continue) to monitor."</p> <p>Nursing note dated 10/18/12 at 12:45 P.M., indicated, "ST (Speech Therapy) notified of increased confusion in res (resident) during therapy on 10/17/12 eve (evening) et this am..."</p> <p>Nursing note dated 10/23/12 at 3:00 A.M., indicated, " Res increase confusion. Gets lost. Does not remember her Rm (room) location.</p>						

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	<p>Needs cueing."</p> <p>Physician order dated 11/9/12 indicated Hospice care had been initiated.</p> <p>Nursing note dated 11/14/12 at 2:00 A.M., indicated, "Resident found sitting in her w/c in hallway when the nurse seen (sic) her et asked her if she was ok et why she was out of bed in hallway. Resident confused didn't know where she was or time of day..."</p> <p>Nursing note dated 11/15/12 at 2:30 P.M., indicated, "Orders to d/c (discontinue) prn (as needed) hs (at bedtime) Ativan (antianxiety medication) & start Ativan 0.5 mg po (by mouth) QID (four times a day) routinely..."</p> <p>Nursing note dated 11/16/12 at 12:00 P.M., indicated, " Very drowsy p (after) brkf (breakfast). Did take meds c (with) much enc. (encouragement) to swallow and to hold head up..."</p> <p>Nursing note dated 11/19/12 at 9:15 P.M., indicated, "Res (Resident) found lying on floor in her room. Full body assessment completed et full set of vitals obtained. Hematoma to R (right) forehead. Hospice care</p>						

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	<p>contacted. Nurse in route to facility."</p> <p>Facility incident documentation dated 11/19/12, indicated, "Res got out of bed without assistance et fell going to bathroom." Documentation indicated resident was barefoot and liquid was noted on the floor. Resident had been in a low bed and alarm sounded. Resident was observed to have hematoma on the right side of her head. Immediate interventions initiated after the fall were to put the bed against the wall and a pad on the floor.</p> <p>On 12/4/12 at 8:18 A.M., Resident #118 was observed sitting in her wheelchair with clip alarm visible, in the hall by the nurses station of 100, 200 and 300 hall. Resident #118 continued to have extensive bruising of purple discoloration of forehead, both cheeks, chin, and anterior neck area with some yellow discoloration also. She had her feet off the wheelchair pedals starting to stand. No staff were present at the nurses station area or visible in the 300, 200, and 100 hall. The Surveyor stood by the resident to monitor while making staff aware of the resident who was needing assistance (by waving at the CNA). CNA #1 was at the entry of the main dining room pushing another</p>			

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	<p>resident in a wheelchair and then proceeded to assist Resident #118.</p> <p>On 12/4/12 at 2:15 P.M., Resident #118 was observed in a recliner at nurses station of 100, 200, and 300 hall. The resident was holding the clip of her personal alarm and asked the surveyor what to do with it. No other staff present until RN Safety Coordinator randomly walked up the hall a few seconds later and was asked to assist the resident.</p> <p>On 12/4/12 at 2:43 P.M., the Director of Nursing (DON) and the RN Safety Coordinator were interviewed regarding documented incidents in the nursing notes of Resident #118 transferring without assistance in 8/2012,10/2012, and 11/2012, and incidences of increased confusion. Discussed lack of interventions initiated after the resident had been observed on several occasions transferring without assistance of staff. Also that the care plan had not been changed from 7/26/12 until 11/19/12 after the fall. The DON indicated at that time that documentation was lacking of new interventions initiated to prevent falls until after 11/19/12 fall.</p> <p>On 12/5/12 at 12:30 P.M., during</p>				

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	<p>interview with DON regarding lack of supervision and monitoring after resident noted to transfer self unassisted and when resident's prn ativan was increased to routine instead of when needed. The DON indicated she had talked to the hospice nurse after we had talked yesterday. She indicated the hospice nurse had indicated the ativan had been changed to routine to keep the resident calm and comfortable. The DON indicated at this time when the ativan was increased the facility had not increased monitoring of resident to prevent falls. The DON also indicated the resident had been put on celexa 10 mg po daily (antidepressant) and the ativan (antianxiety) dosage had been decreased to twice a day after the fall. The DON indicated no interventions to prevent falls had been initiated until after the fall of 11/19/12.</p> <p>B. During the initial tour of the facility on 11/26/2012 at 10:32 P.M., the door of the beauty salon, which is located across from the nurses' station on the 100 hall, was observed to be unlocked and slightly ajar. Upon entering the beauty salon, the cabinet which stores the hair supplies was observed to be unlocked and slightly opened. Located in the</p>				

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	<p>unlocked cabinet was:</p> <ol style="list-style-type: none"> Opti Curl Permanant - Health Hazards (Acute & Chronic): Harmful if swallowed, inhaled, or absorbed through skin. This product may cause serious irritant, respiratory, and/or allergic reactions in sensitive individuals. Emergency & First Aid Procedure: If, call a physician, hospital emergency room, or poison control center immediately. Induce vomiting only if recommended by medical personnel. Get prompt medical attention. If eye or skin contact occurs, immediately flush with water and get medical attention if irritation occurs. Colorfusion - Haircolor can cause an allergic reaction which in certain rare cases can be severe. This product contains ingredients which may cause skin irritation on certain individuals and a preliminary test according to accompanying directions should first be made. This product must not be used for dyeing the eyelashes or eyebrows; to do so may cause blindness. Rusk Designer Collection Hairspray - Warning: Avoid spraying into eyes. Keep out of reach of children. Use only as directed. Inhaling contents can be harmful or fatal. Hand - E - Foam - Warning: For 			

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	<p>external use only do not apply to eyes or over large areas of the body. Also observed in the beauty salon were 2 curling irons and 1 blowdryer that were plugged into an active electrical outlet.</p> <p>On 11/26/12 at 2:15 p.m., the facility's policy and procedure for supervising the beauty salon and it's inventory of potentially hazardous products was requested. The Health Care Administrator indicated there was not a specific policy or procedure for ensuring the beauty salon was supervised at all times or that the hazardous products remained in locked storage when no supervision was available.</p> <p>During an interview with the Director of Nursing on 11/26/12 at 10:25 A.M., upon learning the door to the beauty salon was open and that no one was in the salon supervising the chemicals and equipment, the DON said, "Someone must have left the door open."</p> <p>During an interview with the Health Care Administrator (HCA) on 12/4/12 at 12:31 P.M., the HCA indicated the beautician was hired by the facility for the residents and that the beautician was scheduled for her services on</p>			

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	Tuesday thru Friday. On Monday, the facility allowed the residents' family members use the beauty salon. The HCA said, " One of the family members probably left the door open." 3.1-45(a)(2)				

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F0498 SS=G	<p>483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.</p> <p>A. Based on interview and record review, the facility failed to ensure a CNA (certified nursing assistant) performed personal care skills within the scope of practice of a CNA, which resulted in ear trauma and the resident being sent to the Emergency Room for 1 of 1 randomly reviewed residents. Resident #54</p> <p>B. Based on interview and record review, the facility failed to ensure a CNA performed a resident transfer without utilizing a required gait belt which resulted in physical injuries to the resident for 1 of 1 randomly reviewed residents. Resident #126</p> <p>Findings include:</p> <p>A. The clinical record of Resident #54 was reviewed on 12/3/12 at 10 A.M. The most recent MDS (minimum data set assessment) dated 8/20/12, indicated the following: a total cognition score of 15. This score indicated the resident is cognitively intact.</p> <p>Nurses notes, dated 11/3/12 at 10 P.M., indicated the following: "Resident told CNA her L (left) ear felt wet. CNA told this nurse resident L ear was bleeding. Noted blood slowly coming out of resident's L ear. This</p>	F0498	<p>We respectfully request an IDR of this tag for reduction in scope/severity level. Supportive documentation attached. What corrective action will be accomplished for those residents found to have been affected by the deficient practice; CNA was educated on 12/1/12 on correct use of assistive device---gait belt--for resident # 126 during transfer/ambulation. CNA was educated on 11/4/12 on not using Q-tips to cleanse ears for resident #54 or for any resident. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken; All residents have the potential to be affected. Nursing staff will be in-serviced on usage of assistive devices as listed in the approaches on the resident's plan of care. CNA's will be educated on performing personal care skills that are within their scope of practice as a CNA. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not</p>	01/04/2013	

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	<p>nurse tried to visualize residents L ear drum but unsuccessful with the otoscope d/t (due to) the amt (amount) of blood in the canal...Resident stated during her shower this day she asked the CNA to clean out her ears with Q tips et (and) the CNA did as the resident asked. Resident stated there was some pain during the ear cleaning with the Q tips. Resident also stated she noticed a small amt of blood during the evening meal but did not tell anyone at that time."</p> <p>Nurses notes, dated 11/4/12 at 12:15 A.M., indicated the following: "(hospital name) ER (emergency room) called et stated they are sending the resident back et there is trauma to the ear canal...stated they removed a blood clot et there may be a small amt of bleeding for a little while."</p> <p>On 12/4/12 at 3:30 P.M., the DON (Director of Nursing) was interviewed. She indicated the CNA cleaned the resident's ear out with a Q tip as the resident requested. The DON stated CNAs are not to put anything in the resident's ears. She indicated the CNA was educated on not putting anything in resident's ears after the incident.</p> <p>On 12/5/12 at 8:30 A.M., the DON (Director of Nursing) provided a copy of the resident's emergency room visit from 11/3/12. This form included, but was not limited to, the following: "stated complaint: bleeding from ear...primary impression: left ear canal trauma..."</p> <p>On 12/5/12 at 1 P.M. the Indiana State Department of Health, Nurse Aide Training Program Core Curriculum manual was reviewed. This program was most recently dated 1998 and included, but was not limited</p>		<p>recur;Nursing staff will be in-serviced on usage of assistive devices as listed on the resident's plan of care. CNA's will be educated on performing personal care skills that are within their scope of practice--including not to cleanse ear canal with Q-tips. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;QA Nurse, DNS/ADNS will do random audits weekly x4, then monthly x3, quarterly thereafter that include observiing CNA's giving direct care to resident and also during transfer/ambulation of a resident to ensure assistive device is used as directed by plan of care. Observation of direct care will ensure CNA's are only doing care within their scope of practice. These audits will be reviewed by the monthly QA committee and if not 100% compliant will make recommendations for further education or interventions.</p>				

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	<p>to, the following: "Standard 14: Nurse Aide Scope of Practice: The nurse aide will perform only the task in the course standards and Resident Care Procedures Manual. The nurse aide will not perform any invasive procedures..."</p> <p>B. On 12/4/12 at 10 A.M., nurses notes of Resident #126 were reviewed and indicated the following: On 12/1/12 at 11 P.M., the "resident was assisted to the bathroom per 1 assist et (and) her walker, resident tripped over her feet and fell to her left side on ground hitting her head on either the sink or the wall...type of alleged injury: bump on her head L (left); bump/abrasion 5 cm (centimeters) circle on L buttock; abrasion 8 cm on L buttock...immediate intervention put in place...educated CNAs (certified nursing assistants) on the using of a gait belt with each transfer/ambulation on resident..."</p> <p>On 12/5/12 at 9 A.M., the DON (Director of Nursing) provided a copy of the facility policy and procedure for "Gait (transfer) belt." This form was dated most recently as 1/09. This policy included, but was not limited to, the following: "Purpose: to safely transfer or ambulate resident, to aid resident in maintaining balance, to avoid injury to both resident and staff member."</p> <p>On 12/5/12 at 9:50 A.M., the DON was interviewed. She indicated the resident should have had a gait belt on when she was being transferred by a CNA and fell on 12-1-12 at 11 P.M. The DON indicated the resident did not have a gait belt on during this transfer.</p> <p>On 12/5/12 at 10:08 A.M., the DON provided a copy of the resident's fall risk assessment.</p>			

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	<p>On admission, 10/30/12, the resident had a total score of 23. This form indicated a score of 12 or more equals high risk for falls. This form included, but was not limited to, the following: resident was 80 years or older; in the last 90 days, has had 3 or more falls; ambulates with problems and devices; elimination with assistance and vision status is highly or severely impaired.</p> <p>At this time, the DON provided a current copy of the resident's plan of care, dated 11/9/12, for the "Potential for injury and impaired physical mobility r/t (related to) h/o (history of) CVA (cerebral vascular accident), general debility, hx (history) of falls aeb (as evidenced by) requires assist of walker and staff assist with transfers, walking..."Approaches included, but were not limited to, the following: "every shift: transfers and walks with 1 PGBS (person gait belt standby) and use of rolling walker..."</p> <p>3.1-14(i)</p>				