

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155661	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/04/2014
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NAME OF PROVIDER OR SUPPLIER OWEN VALLEY HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 920 W HWY 46 SPENCER, IN 47460
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F000000	<p>This visit was for the Investigation of Complaint IN00144765.</p> <p>Complaint IN00144765 - Substantiated. Federal/state deficiencies related to the allegations are cited at F157.</p> <p>Survey dates: March 3 & 4, 2014</p> <p>Facility number: 010892 Provider number: 155661 AIM number: 200229560</p> <p>Survey team: Susan Worsham, RN-TC</p> <p>Census bed type: SNF: 6 SNF/NF: 80 Total: 86</p> <p>Census payor type: Medicare: 14 Medicaid: 65 Other: 7 Total: 86</p> <p>Sample: 03</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2.</p>	F000000	Please accept this plan of correction for paper compliance.	

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 March 07, 2014; by Kimberly Perigo, RN.			

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F000157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review, the facility failed to ensure the POA (Power of Attorney) had been notified as indicated by facility policy of a fall which required</p>	F000157	<p>F 157</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient</p>	04/03/2014	

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	<p>physician intervention for 1 of 2 residents reviewed for falls. (Resident #A)</p> <p>Findings include:</p> <p>Resident #A's clinical record was reviewed on 03/03/14 at 2:15 p.m. and on 03/04/14 at 3:00 p.m. Diagnoses included, but not limited to, Parkinson's dementia and atrial fibrillation (cardiac dysrhythmia treated with Coumadin therapy/anticoagulant which increases the risk of bleeding). Resident #A's BIMS (Brief initial Mental Status) was 10 (moderately cognitively impaired). Nurses notes dated 2/4/14 at 12:30 a.m., indicated Resident #A was found on the floor, assessed, and assisted back to bed. Resident #A's clinical record indicated a message (to POA) was left at 7:00 a.m., with no other follow up.</p> <p>03/03/14 at 10:00 a.m. the POA was notified. At that time, the POA indicated not having been immediately notified of the fall. It was not until the resident was being sent out to the hospital.</p> <p>The clinical record lacked documentation regarding having</p>		<p>practice: Resident #A POA was notified of fall and hospital transfer. Resident #A has been discharged.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: 1). DHS or designee will review all residents with falls since March 1st, 2014 to ensure responsible party was notified of event.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Licensed Nurses on the following campus guidelines: 1.) Responsible Party Notification. Education will be completed by April 3rd, 2014.</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits will be conducted by the DHS or designee daily during Clinical Care meetings for 8 weeks, once weekly for 8 weeks, once monthly for 2 months ensure compliance: 1). Review of all residents with falls to ensure responsible party was notified.</p> <p>The results of the audit observations will be reported,</p>				

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	<p>called the POA at the time of the fall. Physician was notified at 1:15 a.m., and indicated since Resident #A was not complaining of any pain or discomfort, let [gender] rest and continue to monitor.</p> <p>Resident #A's Nurse's Notes dated 02/05/14 at 9:30 a.m., indicated Resident #A was assisted to bathroom, dressed, and informed nurse of being sore after the fall, but refusing any pain medication.</p> <p>On 2/5/14 at 1:40 p.m. Resident #A returned from lunch and complained of increased left leg pain. Assessment by the nurse indicated no shortness or rotation of leg was noted. Physician called and order to send to the Emergency Room for evaluation and treatment was given. Ambulance was notified to transfer Resident #A to local acute care hospital.</p> <p>Resident #A's clinical record indicated the POA was notified at 7:00 a.m. on 2/5/14, via a message. No Actual contact was made with the POA until Resident #A was to be transferred to the Emergency Room for evaluation for increased left leg/hip pain. .</p>		<p>reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation. *Consideration for paper compliance requested.</p>	

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	<p>Interview with the DON on 02/05/14 at 3:45 p.m., indicated if a resident falls during the night and is not hurt, then the interested family member is notified in the morning. The DON did not indicate there was a policy in place for calling more than once if a message had to be left.</p> <p>On 3/3/14 at 12:00 noon, the DON provided the Guidelines for Responsible Party Notification, effective date 11/28/10, which indicated "... if the responsible party is unable to be reached a message may be left if this person has given their permission to do so."</p> <p>Interview on 3/4/14 at 1:30 p.m., the ED, indicated there was no section in the facility Admission Packet regarding receiving any written permission to leave a message if unable to be reached. She indicated the Admission Packet was the one currently used by the facility.</p> <p>Interview with ED/DON on 3/4/15, at 4:30 p.m., were not able to provide documentation which indicated Resident #A's legal representative/interested family member had been notified of a fall which occurred on 2/5/14 at 12:30 a.m., as indicated by facility policy.</p>						

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	<p>Review of acute care hospital notes dated February 05, 2014; indicated a diagnosis of a fractured left hip.</p> <p>This Federal tag relates to Complaint IN00144765</p> <p>3.1-5(a)</p>			