

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155674	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/10/2013
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NAME OF PROVIDER OR SUPPLIER  ST CHARLES HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 3150 ST CHARLES ST JASPER, IN 47546
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: September 3, 4, 5, 6, 9,10, 2013</p> <p>Facility number: 002628 Provider number: 155674 AIM number: 200299110</p> <p>Survey team: Dorothy Watts, RN TC Martha Saull, RN Terri Walters, RN</p> <p>Census bed type: SNF: 10 SNF/NF: 33 Residential: 32 Total :75</p> <p>Census payor type: Medicare: 10 Medicaid: 22 Other: 43 Total: 75</p> <p>Residential Sample: 7</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p>	F000000	<p>The submission of this plan of Correction does not indicate an admission by St.Charles Health Campus that the findings and allegations contained herein are an accurate and true representation of the quality of care and services provided to the residents of St.Charles Health Campus. This facility recognized its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities (for Title 18/19 programs). To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only.</p>	
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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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	Quality review completed on September 18, 2013, by Jodi Meyer, RN			

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F000247 SS=D	<p>483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. Based on interview and record review, the facility failed to ensure a resident was informed of the receipt of a new roommate prior to the new roommate's arrival for 1 of 2 residents reviewed for admission, transfer and/or discharge status. Resident #51</p> <p>Findings include:</p> <p>On 9/4/13 at 8:46 A.M., Resident #51 was interviewed. He indicated he had not been given notice prior to having received a new roommate.</p> <p>On 9/5/13 at 9 A.M., the clinical record of Resident #51 was reviewed. The MDS (Minimum Data Set Assessment) dated 6/17/13, indicated the resident had a total cognition score of 12, which indicated independent cognition.</p> <p>On 9/9/13 at 2 P.M., the Social Service Director (SSD) was interviewed. She indicated she was involved when a resident changed rooms. She indicated she had talked to both Resident #51 and his</p>	F000247	<p>F 247 Residents #51 suffered no ill effects from the alleged deficiency. Completion Date 10-10-13 All residents have the potential to be affected and therefore through alterations in provision of care and in servicing the campus will assure resident is informed of a new roommate prior to the new roommate's arrival. Completion Date 10-10-13 An in-service has been completed concerning room change notification form. Systemic change is the campus will complete a room change notification form when a room change occurs. Completion Date 10-10-13 ED or designee will audit room changes for completion of notification 5x a week for a month then 3x a week for a month then weekly with results forwarded to QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments. Completion Date 10-10-13</p>	10/10/2013			

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	<p>daughter prior to a new roommate being admitted to Resident #51's room, but "just didn't document it."</p> <p>At the time, the SSD indicated she was unsure of the date Resident #51 received a new roommate. She contacted the MDS staff (Minimum Data Set Assessment) who indicated Resident #51's new roommate arrived on 8/23/13.</p> <p>The SSD indicated that typically when a resident received a new roommate, she notified the resident and/or family prior to the new roommate moving in. She indicated she would have documented that in the Social Service notes (SSN) but did not do this.</p> <p>On 9/9/13 at 2:40 P.M., the SSD provided a copy of Resident #51's SSN for 2013. Documentation was lacking of Resident #51 and/or his daughter having been notified of a new roommate. At that time, the SSD indicated no additional documentation had been provided.</p> <p>3.1-3(v)(2)</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 observation, interview and record review, the facility failed to ensure that a resident was transferred with the assistance of two staff as required and /or safety devices/alarms were intact and functioning properly for 2 of 3 residents reviewed for falls. Resident #88, Resident #57</p> <p>Findings include:</p> <p>1. The clinical record for Resident #88 was reviewed on 9/05/13 at 9:12 A.M. Nurses notes dated 8/17/13 at 7:00 A.M., read as follows: "CNA (Certified Nursing Assistant) came et (and) got this nurse in report. CNA stated she was transferring resident from bed to w/c et resident's leg gave out. Resident was assisted to floor with use of gait belt. ...staff educated on utilizing 2 assist for transfers..."</p> <p>Nurses notes dated 8/11/13 at 11:15 A.M. read as follows: "Resident was found in room on the floor in front of his w/c (wheelchair). ...no injuries</p>	F000323	F 323 Resident #88 and 57 suffered no ill effects from the alleged deficiency. Resident #88's C.N.A. sheet reflects 2 assist with gait belt for transfers. The C.N.A. who transferred the resident was counseled. Resident # 57's alarms are functional. Completion Date 10-10-13 All other residents are at risk to be affected by the alleged deficiency and through alterations in processes and in servicing the campus will 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. Completion Date 10-10-13 Nursing staff have been in serviced concerning C.N.A. assignment sheets, usage to assure proper assistance given to residents, monthly changing of batteries to alarms, and rounding tool. Systemic change is C.N.A are to carry assignment sheets to review assistance needed for transfers, batteries in alarms changed monthly, and a new rounding tool to check safety devices. Completion Date	10/10/2013			

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	<p>noted. Resident did not have call light attached to him et (and) was found on the floor. Educated staff to give res. access to call light."</p> <p>The clinical record for Resident #88 was reviewed on 9/05/13 at 9:12 A.M. Resident #88 was admitted to the facility on 8/8/13.</p> <p>The record indicated the diagnoses for Resident #88 included, but were not limited to, right side hemiparesis, expressive aphasia, cognitive impairment, gait impairment, left middle cerebral artery and cerebrovascular accident.</p> <p>Physician's orders dated 8/9/13 read as follows: "Up with 2 (A) (assist) et (and) gait belt. Pressure cushion to w/c (wheelchair)."</p> <p>Nursing Admission Assessment form dated 8/8/13 read as follows: "Mobility and ADL Plan of Care (Activities of Daily Living), transfer with assist of 2..."</p> <p>Assessment Review and Consideration form dated 8/8/13 read as follows: "Fall Risk: this resident has the following risk factors that may contribute to falls: CVA with Rt sided hemiparesis, cognitive impairment, mobility impairment...Other: ...Up with</p>		<p>10-10-13 DHS /designee will monitor 3 random resident at risk for falls to assure safety interventions in place as per plan of care, transfers occurring per plan of care, and adequate supervision to prevent incidents 5x a week for a month then 3x a week for a month then weekly with results forwarded to QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/commentsCompletion Date 10-10-13</p>				

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	<p><b>2 assist and gait belt."</b></p> <p>The MDS (Mimimum Data Assesment) dated 8/15/13 indicated Resident #88 required extensive assistance of two people for transfer to and from the bed.</p> <p>The care plan for falls dated 8/12/13 read as follows: "...Up with 2 assist..."</p> <p>During an observation on 9/5/13 at 10:00A.M., Resident #88 was transferred by CNA #2 and CNA #3 from his wheelchair to his commode using a gait belt.</p> <p>During an interview with DON on 9/9/13 at 1:55 P.M., the DON indicated that when a resident has been assessed for 2 staff to be used during transfer, then 2 staff should have been used for transfer.</p> <p>2. On 9/5/13 at 9:10 A.M., Resident #57 observed sitting on a wheelchair in his room. A pressure pad alarm box was observed on the back of his wheelchair.</p> <p>9/5/13 at 1:28 P.M., Resident #57's clinical record was reviewed. He had been admitted to the facility on 3/8/13. His diagnoses included but</p>				

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	<p>were not limited to: Alzheimer's Dementia, a history of falls, and CVA (cardiovascular accident). Admission Minimum Data Set Assessments (MDS) 3/18/13 and 7/22/13, indicated a severe cognitive impairment and extensive assistance of 2 or more staff needed for transfers.</p> <p>A care plan initiated on 3/20/13, addressed the problem of falls. Interventions at that time included but were not limited to: low bed, half rails as enablers, up with assistance, and pressure alarm to bed/chair at all times due to decreased safety awareness.</p> <p>A facility fall circumstance, assessment and intervention record dated 6/29/13 at 6:30 P.M., indicated the resident had been in the hall at the time of the fall. "...Resident restless, malfunction of pressure alarm box..."The prevention update section of the documentation indicated a new intervention to prevent falls: "Batteries to alarm Box chng'd (changed)."</p> <p>A nursing note dated 6/29/13 at 7:00 P.M., indicated, "...Resident fell D/T (due to) malfunction of alarm box to pressure alarm. Batteries chngd (changed) et is now functioning</p>			

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	<p>properly..."</p> <p>A nursing note dated 7/12/13 at 7:00 A.M., indicated, "Resident was sitting in front of nurses's desk before breakfast et when aides turned around they saw res (resident) on the floor. 0 (zero) injuries noted..."</p> <p>A fall circumstance, assessment and intervention record dated 7/12/13 at 7:00 A.M., indicated the resident was in front of the nurse's desk transferring self. The prevention update section of the record indicated a new intervention was to change out the alarm. The Interdisciplinary Team (IDT) note of 7/15/13, indicated, "...Attempting to ambulate, alarm changed."</p> <p>A fall circumstance, assessment and intervention record dated 8/21/13, indicated a fall had occurred at 4:30 P.M. The fall had occurred in the hall and the alarm had been unplugged. The prevention update section of the record indicated the new intervention to prevent falls had been to educate the staff.</p> <p>The Interdisciplinary Team (IDT) review dated 8/23/13, indicated, "...Resident was attempting to ambulate unassisted/alarm off."</p>						

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	<p>On 9/6/13 at 10:37 A.M., the Director of Nursing (DON) was interviewed regarding Resident #57's falls. She indicated in regard to the 6/29/13 fall, documentation indicated a malfunction of the pressure alarm box. She then indicated the intervention had been to change the battery. She indicated in regard to the 7/12/13 fall, the resident's bed pressure alarm pad had been used in his chair by folding the pad to fit it the chair. She indicated the longer length bed pressure alarm pad had been taken off the resident's bed and had been used in his chair instead of a chair pressure alarm pad. She indicated the bed pressure alarm had not worked in his chair. She indicated the facility had then ordered more chair pressure pad alarms. She also indicated during the interview the alarm had been unplugged in regard to the 8/21/13 fall. She indicated the evening CNAs were supposed to do walking rounds at 2:00 P.M., (when coming on duty). She indicated the CNAs were supposed to check all resident alarms at that time.</p> <p>On 9/6/13 at 10:42 A.M., the DON was made aware of the problem with the pressure pad alarms functioning properly on 6/29/13, 7/12/13, and</p>			

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	8/21/13. She indicated at that time she agreed there had been a problem with the alarms functioning properly.  3.1-45(a)(2)				

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R000000	The following Residential deficiencies were cited in accordance with 410 IAC 16.2-5.	R000000	The submission of this plan of Correction does not indicate an admission by St.Charles Health Campus that the findings and allegations contained herein are an accurate and true representation of the quality of care and services provided to the residents of St.Charles Health Campus. This facility recognized its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities (for Title 18/19 programs). To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only.		

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R000090	<p>410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency</p> <p>(g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following:</p> <p>(1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to:</p> <p>(A) epidemic outbreaks; (B) poisonings; (C) fires; or (D) major accidents.</p> <p>If the division cannot be reached, a call shall be made to the emergency telephone number published by the division.</p> <p>(2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative.</p> <p>(3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility.</p> <p>(4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the:</p> <p>(A) employee's full name; and (B) dates and hours worked during the past twelve (12) months.</p> <p>(5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any</p>			

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	<p>subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability.</p> <p>(6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request</p> <p>Based on interview and record review, the facility failed to follow the policy and procedure for an abuse allegation which was reported by a resident to staff. Staff failed to report the allegation to the Health Care Administrator immediately as dictated by the facility's policy and procedure for 1 of 3 residents interviewed from a sample of 7. Resident R1</p> <p>Findings include:</p> <p>During an interview with Resident R1 on 10/9/13 at 9:45 A.M., Resident R1 indicated that another resident (Resident R2), who lived on the same hall, had yelled at her 2 weeks earlier. Resident R1 indicated she went to ask Resident R2 to please stop playing his musical horn because there was a resident in a room near his room that was ill and dying and the family was standing in the hall</p>	R000090	R 090Residents R1 suffered no ill effects from the alleged deficiency. The allegation was reported to the ISDH when it was reported to the ED by the surveyor. The nurse was counseled.Completion Date 10-10-13 All residents have the potential to be affected by the alleged deficient practice and through changes in provision of care and in servicing will prevent the recurrence of the deficient practice. Completion Date 10-10-13 All staff have been in serviced on the campus procedure for reporting abuse. Systemic change includes posting the ED's phone numbers at each nursing station for staff to call the ED directly for any allegation of abuse.Completion Date 10-10-13 ED/designee will interview 3 staff daily to assure understanding of abuse policy 5 x a week x one month then 3x a week x one month then weekly with results forwarded to QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/commentCompletion Date 10-10-13	10/10/2013			

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NAME OF PROVIDER OR SUPPLIER  ST CHARLES HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 3150 ST CHARLES ST JASPER, IN 47546			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>crying. Resident R1 indicated she was just trying to help. Resident R1 said, "He yelled, get your a** out of my room". Resident R1 said, "I've never had anyone talk to me like that before. I left the room immediately." Resident R1 indicated she had told the nurse about the incident involving Resident R2 but had never heard any more about it.</p> <p>The clinical record for Resident R1 was reviewed on 9/10/13 at 10:00 A.M. Resident R1 was admitted to the facility on 8/29/09. Diagnoses included but were not limited to the following: A-fib and difficulty walking.</p> <p>Nurses notes dated 8/29/13 at 13:10 (4:10 P.M.) read as follows: "Spoke with resident et (and) she explained story about what was said to another res. (resident) last evening et this nurse explained to her that next time she should let the nurse know so she can take care of it."</p> <p>The facility's policy and procedure for Prevention and Reporting of Suspected Resident Abuse and Neglect was provided by the Health Care Administrator and reviewed on 9/10/13 at 11:15 A.M. The facility's policy and procedure read as follows:</p>						

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	<p>"...Staff are required to report concerns, incidents, and grievances immediately to your manager and /or Executive Director and Director of Health Services."</p> <p>During an interview with the Health Care Administrator (HCA) on 9/10/13 at 12:15 P.M., the HCA indicated the allegations concerning Resident R1 had not been reported to her.</p>				