

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155525	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/13/2013
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NAME OF PROVIDER OR SUPPLIER SHADY NOOK CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 36 VALLEY DR LAWRENCEBURG, IN 47025
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00127502 and IN00129485.</p> <p>Complaint IN00127502 - Substantiated - Federal/state deficiencies related to the allegations are cited at F323.</p> <p>Complaint IN00129485 - Unsubstantiated due to lack of evidence.</p> <p>Survey dates: June 5, 6, 10, 11, 12, and 13, 2013</p> <p>Facility number: 000304 Provider number: 155525 AIM number: 100266810</p> <p>Survey team: Diana Sidell RN, TC Gordon Tyree RN</p> <p>Census bed type: SNF/NF: 73 Total: 73</p> <p>Census payor type: Medicare: 9 Medicaid: 58</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>Other: 6 Total: 73</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 6/19/13 by Suzanne Williams, RN</p>				

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F000225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and</p>	F000225	WHAT CORRECTIVE ACTIONS	07/13/2013			

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	<p>interview, the facility failed to immediately report an allegation of abuse to the State Agency. This affected 1 of 2 residents reviewed for abuse of 2 residents who met the criteria for abuse. (Resident #56)</p> <p>Findings include:</p> <p>Resident # 56's record was reviewed on 6/12/13 at 10:40 a.m. The record indicated Resident #56 was admitted with diagnoses that included, but were not limited to, angina pectoris, chronic obstructive pulmonary disease, congestive heart failure, diabetes mellitus, fibromyalgia, arthritis, high blood pressure, and depression.</p> <p>An annual Minimum Data Set Assessment, dated 4/8/13, indicated Resident # 56 was independent in cognitive skills for daily decision making.</p> <p>During an interview on 6/6/13 at 3:17 p.m., Resident #56 indicated someone threatened to take away her call light and phone, and she had reported it to the Social Service Director and the Administrator.</p> <p>An investigation of the reported threat to take away the call light and phone</p>		<p>WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: We have reviewed our policy and removed the statement that the State Licensing agency must be notified within 24 hours.HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN: We will continue to identify residents that may have potentially been mistreated/abused by staff/family/resident/visitor reporting any potential abuse to Administrator/DON/Department Heads/Supervisor/Charge Nurse immediately.WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: With each potential abuse/mistreatment reported we will continue to investigate and now report immediately, instead of within 24 hours, as per our old policy and follow the federal guideline versus the ISDH guideline, as the federal guideline is the more stringent of the two.HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE DOES NOT RECUR, IE., WHAT QUALITY</p>	

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	<p>was provided by the Director of Nursing on 6/12/13 at 10:45 a.m. The investigation included, but was not limited to: "On 4/30/13...at 7:00 p.m. the [family member] called back to report the girls were rough ...[family member] called back and said she did not want the girls to care for her mother anymore. At no time was abuse of any type mentioned. The resident has a history of using the word rough and not wanting certain employees and then later asking for or allowing the employees to care for her. I did have the ADON move the aides as I knew from past experiences that it calms the resident. The resident did not have any care provided by the aides...On 5/1/13 the [another family member] came to the facility and met with the administrator because [Resident #56] was punched per his infor[mation] from [family member]. By the end of the conversation he said well maybe punched is not the right word possibly shoved or rough. At this point we were already investigating the accusation of rough...the 2 aides were not permitted to be on the schedule since 5/1/13 on until resolution of investigation. On 5/2/13 after meeting with the [family member] and res. (resident) and the conflicting statements it was decided</p>		<p>ASSURANCE PROGRAM WILL BE PUT INTO PLACE: With each report social services will monitor that the first report was sent timely. The report will be discussed at morning meeting. If the report was not sent timely social services will follow-up with appropriate staff to re-educate. The director of QAPI will also be tracking. This will be ongoing.PLAN OF CORRECTION DATE: July 13, 2013</p>				

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	<p>that [local agencies] were contacted by social service...."</p> <p>During an interview, on 6/12/13 at 5:50 p.m., RN #1 indicated that on 4/30/13, he did not hear any comments the CNA's made about the resident's weight. When he went in the room, he observed the call light clipped to her BSC (bedside commode). He didn't hear them threaten to keep her call light out of reach. The CNA's had reported earlier that Resident #56 was saying things to them that weren't true, he told them to be calm and do their job. He said they need two staff to move her due to fibromyalgia and arthritis. He said he contacted the house nurse (Assistant Director of Nursing who was in the building), and there was another person there he told them they had a disagreement going on, and wanted to give them a 'head's up'. He said someone went in to talk to her and she had been calling her daughter to tell her what was going on. He said he saw no shoving or pushing with the resident's care. He checked Resident #56 after that, and saw no indication of sore spots, said she is in different levels of pain most of the time and "we take it easy with her to give her time to pause before moving her."</p>			
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	<p>During an interview on 6/13/13 at 2:46 p.m., the Director of Nursing indicated this incident was reported to the Indiana State Department of Health on 5/3/13.</p> <p>A policy titled "Resident Abuse", with a review date of 6/6/11, was provided by the Director of Nursing on 6/5/13 at 11:40 a.m. The policy included, but was not limited to, "It is the policy of this facility that each resident has the right not to be subjected to abuse by anyone, including staff members, other residents, consultants, volunteers, staff of other agencies serving the resident, family members, legal guardians, sponsors, friends or other individuals. All personnel must report any incident or suspected incident of resident abuse, including injuries of an unknown source and misappropriation of resident property immediately upon suspecting or observing...3. The administrator or a designee will notify the following persons immediately, by phone and/or in writing, of the mistreatment, neglect or abuse: a) State Licensing and Certification Agency (must be notified within 24 hours)...."</p> <p>3.1-28(c)</p>						

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F000226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to implement their policy for abuse in that one allegation of abuse was not reported timely to the State Agency. This affected 1 of 2 residents reviewed for abuse of 2 residents who met the criteria for abuse. (Resident #56)</p> <p>Findings include:</p> <p>Resident # 56's record was reviewed on 6/12/13 at 10:40 a.m. The record indicated Resident #56 was admitted with diagnoses that included, but were not limited to, angina pectoris, chronic obstructive pulmonary disease, congestive heart failure, diabetes mellitus, fibromyalgia, arthritis, high blood pressure, and depression.</p> <p>An annual Minimum Data Set Assessment, dated 4/8/13, indicated Resident # 56 was independent in cognitive skills for daily decision making.</p>	F000226	<p>WHAT CORRECTIVE ACTIONS WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: We have reviewed our policy and removed the statement that the State Licensing agency must be notified within 24 hours.HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN: We will continue to identify residents that may have potentially been mistreated/abused by staff/family/resident/visitor reporting any potential abuse to Administrator/DON/Department Heads/Supervisor/Charge Nurse immediately.WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: With each potential abuse/mistreatment reported we will continue to investigate and now report immediately, instead of within 24 hours, as per our old</p>	07/13/2013			

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	<p>During an interview on 6/6/13 at 3:17 p.m., Resident #56 indicated someone threatened to take away her call light and phone, and she had reported it to the Social Service Director and the Administrator.</p> <p>An investigation of the reported threat to take away the call light and phone was provided by the Director of Nursing on 6/12/13 at 10:45 a.m. The investigation included, but was not limited to: "On 4/30/13...at 7:00 p.m. the [family member] called back to report the girls were rough ...[family member] called back and said she did not want the girls to care for her mother anymore. At no time was abuse of any type mentioned. The resident has a history of using the word rough and not wanting certain employees and then later asking for or allowing the employees to care for her. I did have the ADON move the aides as I knew from past experiences that it calms the resident. The resident did not have any care provided by the aides...On 5/1/13 the [another family member] came to the facility and met with the administrator because [Resident #56] was punched per his infor[mation] from [family member]. By the end of the conversation he said well maybe</p>		<p>policy and follow the federal guideline versus the ISDH guideline, as the federal guideline is the more stringent of the two.HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE DOES NOT RECUR, IE., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: With each report social services will monitor that the first report was sent timely. The report will be discussed at morning meeting. If the report was not sent timely social services will follow-up with appropriate staff to re-educate. The director of QAPI will also be tracking. This will be ongoing.PLAN OF CORRECTION DATE: July 13, 2013</p>	

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	<p>punched is not the right word possibly shoved or rough. At this point we were already investigating the accusation of rough...the 2 aides were not permitted to be on the schedule since 5/1/13 on until resolution of investigation. On 5/2/13 after meeting with the [family member] and res. (resident) and the conflicting statements it was decided that [local agencies] were contacted by social service...."</p> <p>During an interview, on 6/12/13 at 5:50 p.m., RN #1 indicated that on 4/30/13, he did not hear any comments the CNA's made about the resident's weight. When he went in the room, he observed the call light clipped to her BSC (bedside commode). He didn't hear them threaten to keep her call light out of reach. The CNA's had reported earlier that Resident #56 was saying things to them that weren't true, he told them to be calm and do their job. He said they need two staff to move her due to fibromyalgia and arthritis. He said he contacted the house nurse (Assistant Director of Nursing who was in the building), and there was another person there he told them they had a disagreement going on, and wanted to give them a 'head's up'. He said someone went in to talk</p>			

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	<p>to her and she had been calling her daughter to tell her what was going on. He said he saw no shoving or pushing with the resident's care. He checked Resident #56 after that, and saw no indication of sore spots, said she is in different levels of pain most of the time and "we take it easy with her to give her time to pause before moving her."</p> <p>During an interview on 6/13/13 at 2:46 p.m., the Director of Nursing indicated this incident was reported to the Indiana State Department of Health on 5/3/13.</p> <p>A policy titled "Resident Abuse", with a review date of 6/6/11, was provided by the Director of Nursing on 6/5/13 at 11:40 a.m. The policy included, but was not limited to, "It is the policy of this facility that each resident has the right not to be subjected to abuse by anyone, including staff members, other residents, consultants, volunteers, staff of other agencies serving the resident, family members, legal guardians, sponsors, friends or other individuals. All personnel must report any incident or suspected incident of resident abuse, including injuries of an unknown source and misappropriation of resident property immediately upon suspecting or</p>			

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	<p>observing...3. The administrator or a designee will notify the following persons immediately, by phone and/or in writing, of the mistreatment, neglect or abuse: a) State Licensing and Certification Agency (must be notified within 24 hours)...."</p> <p>3.1-28(a)</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, record review, and interview, the facility failed to ensure a non-ambulatory resident, dependent on staff for transfers, remained free from injuries from a fall after being transferred to a weight chair. This affected 1 of 3 residents reviewed for falls of 4 who met the criteria for accidents. (Resident #A)</p> <p>Findings include:</p> <p>Resident #A's record was reviewed on 6/11/13 at 10:02 a.m. The record indicated Resident #A was admitted with diagnoses that included, but were not limited to, hand and foot fracture injuries, history of cerebrovascular accident, previous brain surgery, seizure disorder, hypothyroidism, mental retardation, vitamin D deficiency, and new onset diabetes.</p> <p>A "Nursing Summary", dated from 3/15/13 to 3/21/13, indicated Resident #A required extensive assist of two for bed mobility, transfers, and toileting,</p>	F000323	<p>WHAT CORRECTIVE ACTIONS WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: In-services will be provided to nursing staff on handling resident's who are a one person transfer with one staff stand-by. The staff was provided a verbal in-service for the employees of that unit at the time of the incident.HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN: Any resident designated as a one person, with one person stand-by, has the potential to be at risk. The staff will be in-serviced on how to handle these residents to prevent falls.WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: The staff will be in-serviced and the charge nurse/supervisor will monitor for compliance on rounds and PRN</p>	07/13/2013	

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	<p>did not ambulate, and was frequently incontinent of bowel and bladder.</p> <p>A fall risk assessment, dated 2/25/13 indicated a score of 15, where a total score of 10 or higher indicated a high risk for falls.</p> <p>A fall care plan, with a start date of 12/2/12, indicated a problem of: "Increased risk of injury (falls) R/T (related to): seizure disorder, mental retardation, [decreased] safety awareness, H/O (history of) stroke, H/O hand & foot fracture injuries, fall risk assessment = 18. (High risk), H/O falls, balance problems, (R) side weakness, incontinent bowel & bladder, psychoactive med, has vagal nerve stimulator, 12-19-12 [increased] seizure activity. Goal: Fall risk will be minimized thru next review AEB (as evidenced by): Resident will accept staff assist for all transfers on daily, on-going basis." The approach or plan included but was not limited to: "1) Transfer/Ambul[ate] assist as per Kardex...36) 3/14/13 PT/OT (Physical therapy/Occupational therapy) eval & treat. 37) 3/14/13 Meds per order. 38) 3/14/13 See pain careplan. 39) 3/25/13 [change] to hoyer lift as per order - D/C 4/15/13."</p> <p>A care plan update, dated 6/8/13,</p>		<p>with the system and will handle breaks in system as they are noted.HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE DOES NOT RECUR, IE., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: QA and nursing supervisor/ADON/DON will monitor and discuss in AM meeting of any deficient practice noted and the remedy used. QAPI director will oversee and monitor for the next three months. A threshold of ninety percent, per month, has been established. If this threshold has not been reached and/or maintained for three months the QAPI Director will monitor at additional three month increments until ninety percent is reached and maintained. PLAN OF CORRECTION DATE: July 13, 2013</p>		

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	<p>included, but was not limited to: an approach for "...23) Stand up lift per order."</p> <p>An "Incident Fax/Nurses Note Protocol" dated 3/23/13 at 8:50 p.m. indicated Resident #A "got [up] from wt. (weight) chair by self. Sitting on bottom, back to wt. chair...states her right foot hurts..." A box was check that indicated the resident had been lowered to the floor.</p> <p>The "Incident Report/Follow Up" indicated a staff member was in the room with the resident being weighed. The resident attempted to stand on her own as the staff member moved to the back of the chair to record the weight. The staff was able to reach the resident and lower her to the floor with use of a gait belt. The resident had non-skid footwear and the area around the chair was dry and clear of obstacles.</p> <p>An investigation of the fall was provided by the Director of Nursing on 6/13/13 at 10:45 a.m. The investigation included, but was not limited to, this statement by CNA #5: "[CNA #5] stated that she did try to catch the resident but they both went down...." CNA #5 also indicated the other CNA in the room placed his</p>			

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	<p>hands on the resident's shoulder when she tried to stand up, as the resident tried to stand up a couple of times. A statement taken from CNA # 6, as part of the investigation of the fall, indicated: "...I had stopped her from falling the first time. I had told [Resident #A] that if she was to keep trying to get up on her own, she was going to fall and she...kept trying to get up. I turned to grab her wheelchair and [Resident #A] had tried to reach for her bed but fell on (sic) the process."</p> <p>An Interdisciplinary Progress Record, dated 3/23/13 at 11:12 p.m. indicated: "N.O. (new order) Res. c/o (complained of) (R) foot pain. d/t (due to) noted on floor earlier. (R) foot [not] red or bruised, is edematous per norm. Prn (as needed) pain med given earlier, noted to be helpful. Ace wrap re-applied d/t res. stated it felt better [with] wrap on. Called on-call MD [name of physician] gave N.O. to obtain X-Ray of foot. Notified POA (power of attorney) of (R) foot pain & N.O. Stated she wanted X-ray done tonight d/t poss. bad weather tomorrow...."</p> <p>An x-ray from a local hospital, dated 3/23/13, indicated: "...Impression: Subtle nondisplaced fracture of the</p>						

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	<p>dorsum (back) of the navicular (ankle) bone which appears to extend to the navicular-first cuneiform (another ankle bone) joint. There is also some cortical irregularity at the proximal (near) dorsum (top of the foot) of the first cuneiform suggesting fracture."</p> <p>An x-ray from a local hospital, dated 5/23/13 indicated: "...Impression: Osteoporosis with a similar appearing fracture at the dorsum of the navicular bone. No new fracture or radiographic evidence of osteomyelitis."</p> <p>During an interview on 6/12/13 at 9:12 p.m., LPN #2 indicated she was working the evening when Resident #A fell; she got there (to work) about 6:00 p.m. She said she was passing meds in the hall and the CNAs said the resident complained of her right foot hurting. The resident had an ace wrap on her right foot and LPN removed it, she said she thought it might be too tight and she propped the foot up.</p> <p>During an observation, on 6/13/13 at 6:30 p.m., Resident #A was sitting in her wheel chair. When queried, she answered "yes" she was afraid she would fall and said "someone dropped me once" and said she hurt</p>				

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	<p>her foot. She was observed to have slippers on, and the resident said it was her right foot. The resident was observed to have slippers on over her compression stockings.</p> <p>On 6/13/13, at 6:53 p.m., Resident #A was observed as she was transferred from her wheel chair to the commode with a "sit to stand lift" and assistance of CNA #3 and QMA #4. Resident #A held onto the bars of the lift during the transfer and was moved to the commode and back with no signs of fear, and without any problems.</p> <p>A policy for "Fall Prevention Program" was provided by the DON on 6/13/13 at 5:30 p.m. The policy included, but was not limited to, "Policy: In accordance with the RAI (Resident Assessment Instrument) Manual, a fall is identified as: a witnessed fall, reported fall, noted on floor, interrupted fall, lowered to the floor. Procedure: 1. Complete Incident Report/Nurse's Note (IR/NN) (Incident Report/Nurse's Note). 2. Initiate a new intervention for each fall, this includes ER/MD evaluation, and could include any number of interventions necessary as listed in the Fall Prevention Booklet...."</p> <p>This federal tag relates to complaint</p>				

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