

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155718	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2013
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NAME OF PROVIDER OR SUPPLIER COMMUNITY NORTHVIEW CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1235 W CROSS ST ANDERSON, IN 46011
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F000000	<p>This visit was for the Investigation of Complaint IN00138421.</p> <p>Complaint IN00138421-Substantiated. Federal deficiencies related to allegation are cited at F323.</p> <p>Unrelated deficiencies are cited.</p> <p>Survey date: 10/24/13 & 10/25/13</p> <p>Facility number: 000562 Provider number: 155718 AIM number: 100267150</p> <p>Survey team: Shelley Reed, RN</p> <p>Census bed type: SNF: 4 SNF/NF: 62 Residential: 26 Total: 92</p> <p>Census payor type: Medicare: 21 Medicaid: 34 Other 37 Total: 92</p> <p>Sample: 4</p>	F000000	<p>Submission of the plan of correction and credible allegation does not constitute an admission by the certified provider at Community Northview Care Center. The Community Northview Care Center also does not constitute admission that the allegations contained in the survey report are true and accurate portrayal of the provision of nursing care and services at this health facility. Community Northview Care Center as licensed and certified provider recognizes it obligation to provide legally and medically required care and services to our residents in an economic and efficient fashion. The following will serve as the plan of correction and allegation of compliance for the cited deficiencies. Community Northview Care Center respectfully requests desk review for compliance. If you have any questions, please contact me. Thank you! R 052</p>	

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>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed by Debora Barth, RN.</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 interview and record review, the facility failed to ensure residents were correctly identified on admission as a potential fall risk for 1 of 3 residents reviewed for accidents. (Resident B)</p> <p>Findings include:</p> <p>The clinical record for Resident (B) was reviewed on 10/25/13 at 10:00 a.m.</p> <p>The clinical record indicated Resident (B) was admitted to the facility on 4/27/13 directly following a hospital admission. The history and physical, from the hospital admission dated 4/24/13, indicated Resident (B) could no longer take care of herself at home and had fallen 3 or 4 times. Resident (B) had a history of a previous Cerebral Vascular Accident (CVA) and had left-sided weakness. Resident (B)'s other diagnoses included, but were not limited to, carotid artery stenosis, chronic atrial fibrillation, hypertension, pulmonary</p>	F000323	<p>What corrective action will be accomplished for those residents found to have been affected the deficient practice? Resident B no longer resides at the facility but did rehab and returned home. How other residents having the potential to be affected by the sam deficient practice will be identified and what corrective actions will be taken? No other residents were affected. All newly admitted residents with fall histories have potential to be affected. What measures will be put into place or what systemic changes will be made to ensure that the deficien practice does not recur? New residents admitted to the facility will be reviewed for prior history of falls. If there is a history of falls, the facility will initiate on admission for 72 hours Standard of Care documentation which will address date, time, and shift. The nurse will assess if the resident is alert and oriented, able to use call light, forgetful, restless, disorientation, and any attempts of unassisted ambulation. If the resident demonstrates any deficits during the first 72 hours the family and physician will be notified and a determination will</p>	11/24/2013

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	<p>hypertension and osteoporosis.</p> <p>The pre-admission assessment, completed on 4/25/13, indicated Resident (B) had a fall, inability to ambulate, back pain, history of a CVA and left-sided weakness.</p> <p>The initial nursing assessment document, dated 4/27/13, indicated a diagnosis of a post fall and inability to ambulate. The safety consideration indicated Resident (B) had a fall within the past 30 days. The physical functioning indicated Resident (B) was an extensive assist with transferring, dressing, toilet use and personal hygiene.</p> <p>A side rail assessment form, dated 4/28/13, indicated Resident (B) was unable to get out of bed safely, forgetful and had a history of falls.</p> <p>On 4/29/13 at 7:16 a.m., Resident (B) got up to go to the bathroom and forgot to put on the call light. Resident (B) had an unwitnessed fall while ambulating to the bathroom. Resident (B) complained of pain in her left arm/elbow area. Resident (B) was sent to the local emergency room and was found to have a fractured left humerus. Resident (B) returned to the facility on 4/29/13. No</p>		<p>be made for the use of personal alarms at that time. In addition, the facility will review current residents that have personal body alarms, bed sentry and chair sentry alarms weekly to determine if alarms can be discontinued and to assure current use of residents requiring personal body alarms continue to meets the needs of the residents. How will the corrective action(s) be monitored to ensure the deficient practices will not recur, i.e., what quality assurance program will be put into place? Nursing management will conduct audits on the 72 hour admission fall history Standard of Care 5 times a week for 2 weeks; the 3 times a week for 2 weeks; and a for 2 weeks; then weekly for 8 weeks. A personal body alarm audit tool will be used for all residents indicating the need for these devices and will be reviewed weekly review weekly during the Fall Committee Meeting. The results will be submitted to the monthly Quality Assurance Committee for review to determine the need for further monitoring of documentation, physician notification, interventions and follow-up.</p>		

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	<p>preventative interventions were in place at the time of the fall.</p> <p>A health care plan problem, dated 4/29/13, indicated Resident (B) had sustained a fall and fracture of her left humerus. Approaches for this problem included bed and chair electronic alarms, call light in reach and anticipate resident's needs.</p> <p>During an interview on 10/25/13 at 12:00 p.m., the Administrator indicated a side rail assessment was completed on admission and also quarterly. She indicated the facility relied on the hospital for information related to residents who may be a fall risk. She indicated the facility also completed a fall risk assessment on admission. She indicated the use of a personal alarm device was based on the individual and not an actual score, but an alarm would be used if there was a history of falls.</p> <p>The facility failed to provide any additional information related to a fall policy.</p> <p>This Federal tag relates to Complaint IN00138421.</p> <p>3.1-45(a)(2)</p>				

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F000514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to ensure resident records were complete and accurate in regard to quarterly fall risk assessments for 1 of 4 residents reviewed for complete and accurate records. (Resident C)</p> <p>Findings include:</p> <p>The clinical record for Resident (C) was reviewed on 10/25/13 at 10:40 a.m.</p> <p>The clinical record indicated Resident (C) was admitted to the facility on 4/24/08. Resident (C) had diagnoses that included, but were not limited to, chronic ischemic heart disease, diabetes mellitus, gout, hypertension and depression.</p>	F000514	<p>What corrective actions will be accomplished for those residents found to be affected by the deficient practice? Resident C was not affected by the fall assessment. A fall assessment was completed on 10/28/2013 for Resident C. A fall assessment audit was done on 10/28/2013 to review for all residents. 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. Fall Risk Assessment will be done upon admission, re-admission, significant, quarterly and annually, and after a fall. What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur? Fall Risk Assessment will be done upon</p>	11/24/2013	

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	<p>During record review, the last fall risk assessment was dated January 2013. No additional documented fall risk assessments were noted for April, July or October.</p> <p>During an interview on 10/25/13 at 12:00 p.m., the Administrator indicated the facility completed a fall risk assessment on admission, quarterly and as needed.</p> <p>During an interview on 10/25/13 at 5:00 p.m., the Assistant Director of Nursing indicated they were unable to find any additional fall risk assessments for Resident (C). She indicated the resident had not had any falls this year.</p> <p>The facility failed to provide any additional information related to a fall policy.</p> <p>3.1-50(f)(2)</p>		<p>admission, re-admission, significant change, quarterly and annually, and after a fall. How the corrective action (2) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? A weekly Fall Meeting is conducted to review events for 4 weeks for each resident occurrence. The Fall Committee reviews circumstances leading to fall; appropriate interventions to prevent reoccurrences; cognition status, medical status, therapy needs, equipment, position devices, personal alarms, medication reviews, and care plan updates. The Fall Committee reports to the monthly Quality Assurance Committee the previous months' activity on an ongoing basis. Any trends or significant issues results in a plan of action that is monitored until the Interdisciplinary Team deems no longer necessary.</p>		