

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155103	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/06/2012
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NAME OF PROVIDER OR SUPPLIER  IRONWOOD HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1950 RIDGEDALE RD SOUTH BEND, IN46614
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F0000	<p>This visit was for the Investigation of Complaints IN00101538 and IN00101816.</p> <p>Complaint IN00101538 - Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00101816 - Substantiated. Federal/State deficiencies related to the allegations are cited at F 157, F 166, F 323, F 498 and F 514.</p> <p>Survey dates: January 5 and 6, 2012</p> <p>Facility number: 000042 Provider number: 155103 AIM number: 100291540</p> <p>Survey team: Sandra Haws RN TC Susan Bruck RN</p> <p>Census bed type: SNF/NF: 138 Total: 138</p> <p>Census payor type: Medicare: 12 Medicaid: 109 Other: 17 Total: 138</p>	F0000		

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>Sample: 5</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 1/11/12 by Suzanne Williams, RN</p>				

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F0157 SS=D	<p>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 a family member had been notified of the resident falling and receiving a large hematoma to her forehead, for 1 of 4 residents reviewed for family notification in a sample of 5. Resident #B</p>	F0157	<p>Resident B assessed and chart reviewed. Family notified of any condition changes.</p> <p>Chart review of current in house residents with falls in the past 30 days completed to ensure family notification.</p>	01/20/2012			

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	<p>Findings include:</p> <p>Resident # B's record was reviewed on 1/5/12 at 12:30 p.m. The resident's record indicated diagnoses of, but not limited to, dementia, disorder of bone cartilage, organic psychotic condition, and osteoporosis.</p> <p>Nurses note dated 12/25/11 at 5:30 p.m. indicated "This nurse heard res (resident) yell out "help" from her room. Came to res's room found her on the floor on her side beside the bed. Helped res to wc (wheelchair). Found 4 cm hematoma to (R) (right) side of forehead...Dr.(doctor)/ POA (Power of Attorney) nx (notified)...."</p> <p>Progress note dated 12/28/11 at 1:30 p.m. indicated " At approx (approximately) 12:15 p.m. (name) wife of POA wanted to speak with this writer. She expressed that she was upset because "the nurse lied about notifying the POA when (Resident # D) fell and what else is she lying (sic) about...." The note written by the Director of Nursing continued saying "...I called (LPN # 4) to ask if she called the POA. She said she did not call because (LPN # 5) called. I said why did you document that you notified the POA when in fact you did not...then I called (LPN # 5) and asked if she called the POA and she said no, she called Hospice...."</p>		<p>Families were notified appropriate.</p> <p>Licensed Supervisory Nurses will be re-educated on family notification with each fall by the District Education and Training Director (DETD).</p> <p>Unit managers/designee will audit 24 hour report sheets and accident/incident reports for any falls for appropriate family notification daily (Monday thru Friday) x 2 weeks, then 3 times a week x 2 weeks, then weekly for 2 months, and then monthly. Any identified trends from the UM/designee audits will be taken to QA monthly for 3 months and then quarterly thereafter to determine if further education and/or further monitoring is needed. Any identified non-compliance will result in one on one re-education including progressive disciplinary action up to and including termination.</p>		

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F0166 SS=D	<p>During an interview with the Director of Nursing on 1/5/12 at 2:00 p.m., she indicated the nurse documented she notified the resident's family member when in fact she did not.</p> <p>The facility's policy and procedure was reviewed on 1/6/12 at 11:05 a.m. The policy titled "Notification of Resident Change in Condition" dated 1/06 indicated "...2. Notify the Physician and family or legal representative immediately if there is a significant change in condition, regardless of the time."</p> <p>This Federal tag relates to Complaint # IN00101816.</p> <p>3.1-5(a)(2)</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>Based on interview and record review, the facility failed to ensure a resident's family's grievance had been addressed and resolved in a timely manner related to the resident's comforter, Christmas tree and stuffed missing from her room, for 1 of 5 residents reviewed with a grievance in a sample of 5. (Resident # B)</p> <p>Findings include:</p>	F0166	<p>Resident #B grievance addressed and resolved. Value of items to be replaced.</p> <p>Review of grievances for the past 60 days note they have been addressed and resolved.</p> <p>Staff re-educated on the grievance process by the DETD.</p>	01/20/2012

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	<p>Resident # B's record was reviewed on 1/5/12 at 12:30 p.m. The resident's record indicated diagnoses of, but not limited to, dementia, disorder of bone cartilage, organic psychotic condition, and osteoporosis.</p> <p>During an interview with the Administrator on 1/5/12 at 1:40 p.m. regarding the resident's comforter, Christmas tree and stuffed animal missing, she indicated they have put out a reward for the missing items. The Administrator supplied a form titled "Resident Concern Report" dated 10/6/11. The form indicated "Name and telephone No. of person (s) filing concern." The name listed was the resident's POA (Power of Attorney) on behalf of Resident #B. The form continued to indicate "Nature of concern...Res (resident) is missing her 3-4 foot tall LED Christmas tree and stuffed lion that makes noises when it's tail is pulled. Missing blanket."</p> <p>The resident's personal inventory failed to include the comforter, lion or the Christmas tree. During continued interview with the Administrator regarding the above missing items, she indicated the resident did have the items. The staff failed to add them to the</p>		<p>Administrator will review new grievances daily during Morning Meeting and assign report to appropriate department head for investigation and follow-up. Administrator will monitor grievances daily for one month, and then weekly for 2 months, and then monthly thereafter for resolution. Any identified trends from the Administrator's follow-up will be taken to QA monthly for 3 months and then quarterly thereafter to determine if further education and/or further monitoring is needed. Any identified non-compliance will result in one on one re-education including progressive disciplinary action up to and including termination.</p>		

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	<p>inventory list when they were brought in. The Administrator indicated she had the pillow sham that matched the comforter to help identify it.</p> <p>Another Resident Concern report indicated "Administrator spoke with (POA name) son re: missing items 10/12/11 not found by housekeeping or nursing staff, will continue searching."</p> <p>During an interview with the resident's POA on 1/5/12 at 1:45 p.m., he stated the Christmas tree has been missing since March 2011. He stated when he asks the facility about it, they keep putting him off. The POA further indicated he had attended a care conference and they told him they could not find the missing items. The POA indicated the base of the Christmas tree was there but not the tree. He indicated he has addressed this as far back as March 2011 with no results. The POA stated he had to purchase another tree for Resident #B. He indicated there is at least \$100.00 in value missing and he feels nothing has been done to replace them.</p> <p>The facility's policy and procedure titled "Concern- Resident/Family" revised on 10/09 indicated "...If a grievance/concern is not resolved, additional options are available that may include, but are not</p>				

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F0323 SS=G	<p>limited to: Caring Partner (as determined by center), Regional Staff, Area Staff, Caring Plus...State and Federal regulation(s) shall supersede this procedure as applicable." The resident did not receive the above options.</p> <p>This Federal tag relates to Complaint IN00101816.</p> <p>3.1-7(a)(2)</p> <p>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>Based on observation, interview and record review, the facility failed to ensure residents were protected from falls resulting in fractures for 2 residents, and for 1 resident who received a 4 cm (centimeter) hematoma (raised bruising) to her forehead. This deficient practice affected 3 of 5 residents with falls in a sample of 5. (Residents # D, #B and #F)</p> <p>Findings include:</p> <p>1. During initial tour on 1/5/12 at 9:15 am of the 500 hall, accompanied by LPN # 6, Resident # D was observed resting in bed with her eyes closed. During an interview with LPN # 6 at this time, she</p>	F0323	Resident B, D, F fall risk re-assessed, care plans, and CNA sheets reviewed to reflect residents current status. A one time audit of current in house residents with falls in the past 30 days were reassessed. Care plans and CNA sheets updated to reflect current status. Nursing staff will be re-educated on the Fall/Injury Management-Post Fall or Injury policy and procedure, CNA sheets, resident transfer needs and care. Review of appropriate use of lifts will be provided by the District Educator and Training Director (DETD). Unit managers/designee will audit 24 hour reports, Accident/Incident reports, and care plans for thoseresidents	01/20/2012	

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	<p>indicated Resident # D sustained a fall with a fracture to her right hip. She indicated the resident transferred with a mechanical lift (Hoyer) with two person assistance.</p> <p>Residents # D's record was reviewed on 1/5/12 at 12:15 p.m. The resident's record indicated diagnoses of, but not limited to, dementia, seizure disorder, schizoaffective disorder, osteoporosis, depression, history of left femur fracture, and history of a right hip fracture.</p> <p>Resident #D's significant change MDS (minimum data set) assessment dated 11/17/11, indicated the resident had problems with her cognition. The resident needed total assistance with transfers with 2 staff assisting and extensive assistance with eating, dressing and bathing.</p> <p>Physician's Order dated 11/22/11 indicated "Clarification Hoyer lift for transfers."</p> <p>Review of the "Nursing Assistant Worksheet" on 1/5/12 at 1:00 p.m. indicated Resident #D transferred with a Hoyer lift with two staff.</p> <p>Nurse note dated 12/13/11 at 7:30 p.m. indicated "incident in shower room, and resident lowered to floor, no apparent</p>		<p>experiencing falls daily (Monday thru Friday) x 2 weeks, then 3 times a week x 2 weeks, then weekly for 2 months, and then monthly. Addendum: Unit managers/designee will audit staff lifts 3 lifts daily for 2 weeks, then 3 lifts 3 times a week for 2 weeks, and then 3 lifts weekly for 2 months, and then 3 lifts monthly. Any identified trends from the UM/designee audits will be taken to QA monthly for 3 months and then quarterly thereafter to determine if further education and/or further monitoring is needed. Any identified non-compliance will result in one on one re-education including progressive disciplinary action up to and including termination.</p>	

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	<p>injuries noted...."</p> <p>A statement written by LPN # 8 dated 12/13/11 at 7:30 p.m. indicated " "...last night (Resident #D) fell out of the Hoyer lift with (CNA # 2) transferring her by herself...."</p> <p>A form titled "Witness Investigations Statement" dated 12/13/11 at 7:30 p.m. written by (CNA # 2), indicated "after the resident was seated in the chair, I took the hooks off and noticed she was on the edge of the chair not seated that good. She proceeded to slide off. I couldn't pull the resident so I lowered her to the floor and called for help to help me with the resident."</p> <p>A "Witness Investigation Statement" dated 12/13/11 at 7:30 p.m., indicated: "Resident told this nurse that after shower CNA was pushing machine and she fell off of machine onto floor. No other staff member present." The nurse who wrote the statement was not able to be identified.</p> <p>A "Witness Investigation Statement" written by an unidentified LPN dated 12/13/11 at 7:30 p.m., indicated "... when (CNA # 2) was asked why she didn't have that second person during transfer, (CNA # 2) stated: 'q (every) body was busy but</p>			

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	<p>(CNA #3) looked in on me."</p> <p>Nurse note dated 12/14/11 at 2:38 a.m., indicated "...upon assessment resident with complaints of increased pain to (R) (right) hip, during ROM (Range of Motion) resident yelling out in pain. (Doctor name) paged with return call, updated on change in condition, N.O. (new order) received to X-ray (R) hip...."</p> <p>Nurse note dated 12/14/11 at 8:30 a.m. indicated "PRN (as needed) Tylenol (a medication given to relieve pain) given due to complaints right hip discomfort rated "7"... Right hip fracture... N.O. direct admit to (hospital name)...." The resident's record indicated the pain scale was from 1-10 with 10 indicating severe pain.</p> <p>A form titled "Discharge Summary" dated 12/16/11 indicated ..." Right hip reveals evidence of an old fracture with questionable acute new fracture." "HOSPITAL COURSE: The patient was admitted... She was on a Hoyer lift and they dropped her. I would prefer not to do that again. I will discharge her to the care of the home, follow her there, see how she does and hopefully make this resolved in regards to further hospitalization and hopefully she will not fall again...."</p>			

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	<p>During an interview with the Director of Nursing on 1/5/12 at 12:40 p.m., she indicated all residents who are transferred with Hoyer lifts are to have two person assistance during transfers.</p> <p>2. Resident # B's record was reviewed on 1/5/12 at 12:30 p.m. The resident's record indicated diagnoses of, but not limited to, dementia, disorder of bone cartilage, organic psychotic condition, and osteoporosis.</p> <p>The resident's significant change MDS (minimum data set) assessment dated 12/13/11 indicated the resident's cognition was severely impaired, she transferred with assistance of 1 staff and needed extensive assistance with dressing and bathing with assistance of 1 staff.</p> <p>The resident's record indicated the resident had fallen on the following dates: 11/10/11, 11/21/11, 11/25/11,12/16/11, 12/21/11 and 12/25/11. The resident's plan of care, dated as last updated on 12/19/11, failed to indicate interventions had been put into place to prevent the falls.</p> <p>Nurses note dated 12/25/11 at 5:30 p.m. indicated "This nurse heard res (resident) yell out 'help' from her room. Came to res's room found her on the floor on her side beside the bed. Helped res to wc</p>				

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	<p>(wheelchair). Found 4 cm hematoma to (R) (right) side of forehead)...."</p> <p>During an interview with the Director of Nursing on 1/5/12 at 12:40 p.m., regarding a fall risk assessment, she indicated the care plan is used.</p> <p>Nurse note dated 12/26/11 at 2:15 p.m. indicated "F/U (follow-up) fall with neuro (neurological checks) cont (continue)...(R) (right) forehead/ eye remains bruised...."</p> <p>Nurse note dated 12/27/11 10:00 a.m. "...continues to have facial bruising, especially to eye area...."</p> <p>3. Resident F's record was reviewed on 1/5/12 at 3:00 p.m. The resident's record indicated diagnoses of, but not limited to, peripheral vascular disease, right femoral fracture, failure to thrive, end stage Alzheimer's dementia, and psychosis.</p> <p>Nurses note dated 9/2/11 at 10:00 p.m. indicated "...CNA leaving unit noted res on floor next to a chair. Had been sleeping in bed was wearing socks, floor was dry."</p> <p>Nurse note dated 9/2/11 at 10:45 p.m. indicated "...Res left on gurney 11 p (p.m.) with (ambulance service name), complains of pain with paramedic's assessment...."</p>			

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	<p>Nurse note dated 9/3/11 2:30 a.m. indicated "...Res admitted with rt (right) hip fx (fracture)...."</p> <p>A physician's form titled " History &amp; Physical" dated 9/3/11 indicated "... she did have a ground level fall and right hip pain...we are going to admit her...her x-ray does confirm a fractured right femoral neck with mild varus angulation...."</p> <p>The nurse notes indicated the resident had a fall in July 2011. The note indicated on 7/31/11 staff notified the physician of a fall. The resident's plan of care for falls failed to indicate an intervention had been put into place to prevent another fall from occurring.</p> <p>The facility's policy titled "Falls and Injuries"...Policy: Supervision, refers to an intervention and means of mitigation the risk of an accident. Centers are obligated to provide adequate supervision to prevent accidents. Adequate supervision is defined by the type and frequency of supervision, based on the individual residents assessed needs and identified hazards in the resident environment. Supervision may vary resident to resident and time to time for the same resident. The use of tools or items such as personal</p>				

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F0498 SS=G	<p>alarms can help monitor resident's activities but does not eliminate the need for staff vigilance and are not to be utilized in lieu of supervision...."</p> <p>This Federal tag relates to Complaint IN00101816.</p> <p>3.1-45(a)(2)</p> <p>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>Based on observation, interview and record review, the facility failed to ensure staff safely transferred a resident using a Hoyer lift with the required 2 staff assistance. This deficient practice resulted in a resident sustaining a fall and fracture resulting in hospitalization for 1 of 2 residents reviewed with Hoyer transfers in a sample of 5. (Resident # D)</p> <p>Findings Include:</p> <p>During initial tour on 1/5/12 at 9:15 a.m. of the 500 hall, accompanied by LPN # 6, Resident # D was observed resting in bed with her eyes closed. During an interview with LPN # 6 at this time, she indicated Resident # D sustained a fall with a fracture to her right hip. She indicated the</p>	F0498	<p>Resident D fall risk reassesses, care plans, and CNA sheets reviewed to reflect current status.</p> <p>A one time audit of current in house residents with falls in the past 30 days were reassessed. Care plans and CNA sheets updated to reflect current status. Review of employee files to ensure CNAs are able to demonstrate competency in skills and techniques to care for residents based on current care plans.</p> <p>Nursing staff will be re-educated on the appropriate use of lifts by the EDTD. New hires will be educated and competency validated prior to working assignment. New hires will be audited again at</p>	01/20/2012			

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	<p>resident transferred with a mechanical lift (Hoyer) with two person assistance.</p> <p>Residents # D's record was reviewed on 1/5/12 at 12:15 p.m. The resident's record indicated diagnoses of, but not limited to, dementia, seizure disorder, schizoaffective disorder, osteoporosis, depression, history of left femur fracture, and history of a right hip fracture.</p> <p>Physician's Order dated 11/22/11 indicated "Clarification Hoyer lift for transfers."</p> <p>Review of the "Nursing Assistant Worksheet" on 1/5/12 at 1:00 p.m. indicated Resident #D transferred with a Hoyer lift with two staff.</p> <p>Nurse note dated 12/13/11 at 7:30 p.m. indicated "incident in shower room, and resident lowered to floor, no apparent injuries noted...."</p> <p>A statement written by LPN # 8 dated 12/13/11 at 7:30 p.m., indicated, "...last night (Resident #D) fell out of the Hoyer lift with (CNA # 2) transferring her by herself...."</p> <p>A form titled "Witness Investigations Statement" dated 12/13/11 at 7:30 p.m., written by CNA # 2, indicated "after the</p>		<p>30 days for competency. Unit managers/designee will audit staff lifts 3 lifts daily for 2 weeks, then 3 lifts 3 times a week for 2 weeks, and then 3 lifts weekly for 2 months, and then 3 lifts monthly. Any identified trends from the UM/designee audits will be taken to QA monthly for 3 months and then quarterly thereafter to determine if further education and/or further monitoring is needed. Any identified non-compliance will result in one on one re-education including progressive disciplinary action up to and including termination.</p>		

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	<p>resident was seated in the chair, I took the hooks off and noticed she was on the edge of the chair not seated that good. She proceeded to slide off. I couldn't pull the resident so I lowered her to the floor and called for help to help me with the resident."</p> <p>A "Witness Investigation Statement" dated 12/13/11 at 7:30 p.m., indicated: "Resident told this nurse that after shower CNA was pushing machine and she fell off of machine onto floor. No other staff member present." The nurse who wrote the statement was not able to be identified.</p> <p>A "Witness Investigation Statement" written by an unidentified LPN, dated 12/13/11 at 7:30 p.m., indicated "...when (CNA # 2) was asked why she didn't have that second person during transfer, (CNA # 2) stated: 'q (every) body was busy but (CNA #3) looked in on me.'"</p> <p>Nurse note dated 12/14/11 at 2:38 a.m. indicated "...upon assessment resident with complaints of increased pain to (R) (right) hip, during ROM (Range of Motion) resident yelling out in pain. (Doctor name) paged with return call, updated on change in condition, N.O. (new order) received to X-ray (R) hip...."</p>				

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	<p>Nurse note dated 12/14/11 at 8:30 a.m. indicated "PRN (as needed) Tylenol (a medication given to relieve pain) given due to complaints right hip discomfort rated "7" ... Right hip fracture... N.O. direct admit to (hospital name)...." The resident's record indicated the pain scale was from 1-10 with 10 indicating severe pain.</p> <p>A form titled "Discharge Summary" dated 12/16/11, indicated "...Right hip reveals evidence of an old fracture with questionable acute new fracture." "HOSPITAL COURSE: The patient was admitted... She was on a Hoyer lift and they dropped her. I would prefer not to do that again. I will discharge her to the care of the home, follow her there, see how she does and hopefully make this resolved in regards to further hospitalization and hopefully she will not fall again...."</p> <p>During an interview with the Director of Nursing on 1/5/12 at 12:40 p.m., she indicated all residents who are transferred with Hoyer lifts are to have two person assistance during transfers.</p> <p>CNA #2 was hired to facility on 8/16/11. CNA #2 was trained on Hoyer use and technique. Review of form titled "SKILLS CHECK OFF/RETURN DEMONSTRATION INVACARE</p>				

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F0514 SS=D	<p>450/600 TOTAL LIFT" dated 8/18/11, indicated to use the number of staff required for the procedure. The skills check off/demonstration form was signed by CNA #2 on 8/18/11.</p> <p>This federal tag relates to Complaint IN00101816.</p> <p>3.1-14(i)</p> <p>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 accurately documented, related to inaccurate documentation concerning a family member being notified of a fall with injury, for 1 of 5 records reviewed for accurate documentation in a sample of 5. (Resident # B)</p> <p>Findings include:</p> <p>Resident # B's record was reviewed on 1/5/12 at 12:30 p.m. The resident's record</p>	F0514	<p>Resident #B chart reviewed and accurate.</p> <p>Chart review of current in house residents with falls in the past 30 days completed to ensure family notification. Families were notified appropriate with appropriate documentation.</p> <p>Licensed nurses will be re-educated on accurate documentation in residents records by the DETD.</p>	01/20/2012	

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	<p>indicated diagnoses of, but not limited to, dementia, disorder of bone cartilage, organic psychotic condition, and osteoporosis.</p> <p>Nurses note dated 12/25/11 at 5:30 p.m. indicated "This nurse heard res (resident) yell out "help" from her room. Came to res's room found her on the floor on her side beside the bed. Helped res to wc (wheelchair). Found 4 cm hematoma to (R) (right) side of forehead...Dr.(doctor)/ POA (Power of Attorney) nx (notified)...."</p> <p>Progress note dated 12/28/11 at 1:30 p.m. indicated " At approx (approximately) 12:15 p.m. (name) wife of POA wanted to speak with this writer. She expressed that she was upset because "the nurse lied about notifying the POA when (Resident # D) fell and what else is she lying (sic) about..." The note written by the Director of Nursing continued saying "...I called (LPN # 4) to ask if she called the POA. She said she did not call because (LPN # 5) called. I said why did you document that you notified the POA when in fact you did not...then I called (LPN # 5) and asked if she called the POA and she said no, she called Hospice...."</p> <p>During an interview with the Director of Nursing on 1/5/12 at 2:00 p.m., she indicated the nurse documented she</p>		<p>Unit managers/designee will audit 24 hour reports, Accident/Incident reports for those residents experiencing falls To ensure that accurate documentation of notification occurred daily (Monday thru Friday) x 2 weeks, then 3 times a week x 2 weeks, then weekly for 2 months, and then monthly. Any identified trends from the UM/designee audits will be taken to QA monthly for 3 months and then quarterly thereafter to determine if further education and/or further monitoring is needed. Any identified non-compliance will result in one on one re-education including progressive disciplinary action up to and including termination.</p>		

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	<p>notified the resident's family member when in fact she did not.</p> <p>This Federal tag relates to Complaint IN00101816</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>				