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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 09/27/2013 |
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| NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260 |
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| F000000 | <p>This visit was for the Investigation of Complaints IN00134786, IN00134870, IN00135979 and IN00136352</p> <p>Complaint: IN00134786 Unsubstantiated due to lack of evidence.</p> <p>Complaint: IN00134870 Substantiated. Federal/State deficiencies related to the allegations are cited at F282, F312, F323 and F328.</p> <p>Complaint: IN00135979 Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00136352 Federal/State deficiencies related to the allegations are cited at F 157, F 282, F309 and F323.</p> <p>Survey dates: September 25, 26 & 27, 2013</p> <p>Facility Number: 000195 Provider Number: 155298 AIM Number: 100267690</p> <p>Survey Team: Mary Jane G. Fischer RN</p> | F000000 | <p>This plan of correction is the centers credible allegation of compliance. Preparation and or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is provided by the provisions of the state and federal law. We respectfully request desk review in lieu of return visit.</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>Census Bed Type: SNF/NF: 81 Total: 81</p> <p>Census Payor Type: Medicare: 10 Medicaid: 64 Other: 7 Total: 81</p> <p>Sample: 7</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed by Tammy Alley RN on October 1, 2013.</p> | | | |

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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 a physician was notified, in that when a resident had physician orders for a specific medication, the nursing staff failed to</p> | F000157 | It is the practice of Pyramid Point to ensure physicians are notified when a resident has orders for a specific medication that is not covered by a Payor source in order for physician to intervene | 10/25/2013 | | | |

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| | <p>inform the physician the medication was not covered by a Payor source and thus not given to the resident, and the need for physician intervention required for an alternate medication for 1 of 7 sampled resident's. (Resident "B").</p> <p>Findings include:</p> <p>The record for Resident "B" was reviewed on 09-26-13 at 1:15 p.m. Diagnoses included, but were not limited to, gastro-esophageal reflux disease, dementia, cerebral vascular accident, congestive heart failure, schizophrenia and delusions. These diagnoses remained current at the time of the record review.</p> <p>The resident had physician orders, dated 09-11-13 for Pantoprazole (a medication used to decrease gastric acid), 40 mg (milligrams) by mouth every day at 6:00 a.m.</p> <p>A review of the medication administration record indicated nurses initials which were circled on September 12, 14, 17, 18, 19, 20, 21, 22, 23, 24, 25 and 26, 2013. During an interview on 09-27-13 at 11:00 a.m., the Director of Nurses verified the nurses initial the medication record and then circle their initials</p> | | <p>with an alternative medication. What corrective actions will be taken for those residents who have been found to have been affected by this alleged deficient practice? The physician for Resident B was notified of the non-covered medication on 9-27-13 as stated in the 2567. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action will be taken? An audit will be conducted of current residents Medication Administration Record (MAR) to ensure the residents physicians have been notified of any medication not available due to non-covered status. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not reoccur? Licensed nurses (LN) have been re-educated on expectation for notification of physicians for unavailability of meds due to non-covered status. Pharmacy notifications of non-covered meds will be routed to DON/designee to ensure non-medications are changed to equivalent covered medication or authorization given to bill facility for the medication as appropriate. How the corrective action will be monitored to ensure the alleged deficient practice does not reoccur? The DON/designee will monitor the</p> | | | | |

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| | <p>when the resident did not receive or the resident refused a medication.</p> <p>During an interview on 09-27-13 at 11:00 a.m., the Director of Nurses indicated the medication prescribed "was not covered." "The pharmacy did not send that medication it's not paid for by [Payor source indicated]. I usually sign the form and send it back to pharmacy and then we, the facility, pay for it. The physician was not notified until today that the resident had not been getting the medication."</p> <p>Review of the facility policy titled "Change of Condition" when to report to the MD/NP/PA [medical doctor, nurse practitioner, physician assistant], on 09-27-13 at 12:00 p.m., and undated indicated the nursing staff should notify the physician either "immediately (Notify the attending or on-call MD, NP or PA on call as soon as possible, non-immediate (notify the attending or on-call MD, NP or PA no later than the next work day, routine (notify the attending or on-call MD, NP or PA no later than the next regular visit or phone or fax [facsimile] communication)."</p> <p>This Federal tag relates to Complaint IN00136352.</p> | | <p>residents MARs 2 x weekly x 4 weeks and then monthly x 2 months and then quarterly until a pattern of substantial compliance is maintained to ensure medications are available as ordered. Results of these audits will be presented to the facility QA&A committee monthly X 3 months and then quarterly until a pattern of substantial compliance is maintained with a subsequent plan developed and implemented as necessary.</p> | | |

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| | 3.1-5(a) | | | |

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| F000282 SS=D | <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to ensure resident plans of care were followed for 3 of 7 sampled resident's. (Resident's "G", "B" and "F").</p> <p>Findings include:</p> <p>1. The record for Resident "G" was reviewed on 09-27-13 at 2:45 p.m. Diagnoses included, but were not limited to edema, congestive heart failure, hypertension and depressive disorder. These diagnoses remained current at the time of the record review.</p> <p>A review of the resident's plan of care, originally dated 02-20-13, indicated the resident had a "self care deficit related to cerebral vascular accident, bilateral weakness, dependent for bed mobility, personal hygiene and bathing."</p> <p>During an observation on 09-27-13 at 2:25 p.m., with the Director of Nurses in attendance the resident was laying in bed. The resident's bilateral feet</p> | F000282 | <p>It is the practice of Pyramid Point to ensure resident plans of care are followed. What corrective actions will be taken for those residents who have been found to have been affected by this alleged deficient practice? Resident G has been referred to the podiatrist. The physician for Resident B has been notified of the non-covered medication. The fall risk careplan for Resident F has been reviewed and updated to include current interventions and the interventions verified to be in place. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action will be taken? A sweep of current residents will be completed to determine need for podiatry referral and referrals made as appropriate. An audit will be conducted of current residents Medication Administration Record (MAR) to ensure the residents physicians have been notified of any medication not available due to non-covered status. An audit will be conducted of current residents fall risk careplans to ensure interventions are current and available. What measures</p> | 10/25/2013 | | | |

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| | <p>were elevated and dressing could be observed on the resident's foot. The resident left foot - great toe had a long and thick surface with jagged edges.</p> <p>The Director of Nurses spread each of the resident's toes apart. Between each toe on the left foot was an abundance of a black, thick drainage/substance. Between the 2nd and 3rd toes on the right foot was also a black thick substance.</p> <p>2. The record for Resident "B" was reviewed on 09-26-13 at 1:15 p.m. Diagnoses included, but were not limited to, gastro-esophageal reflux disease, dementia, cerebral vascular accident, congestive heart failure, schizophrenia and delusions. These diagnoses remained current at the time of the record review.</p> <p>The resident had physician orders, dated 09-11-13 for Pantoprazole (a medication used to decrease gastric acid), 40 mg (milligrams) by mouth every day at 6:00 a.m.</p> <p>A review of the medication administration record indicated nurses initials which were circled on September 12, 14, 17, 18, 19, 20, 21, 22, 23, 24, 25 and 26, 2013. During</p> | | <p>will be put in place into place or what systemic changes will be made to ensure that the alleged deficient practice does not reoccur?Nursing staff have been re-educated on expectations for making appropriate referrals for podiatry needs, ensuring non-covered medications are addressed to ensure availability and ensuring fall careplans are updated and interventions in place. How the corrective action will be monitored to ensure the alleged deficient practice does not reoccur? The DON/designee will monitor the residents MARs 2 x weekly x 4 weeks and then quarterly until a pattern of substantial compliance is maintained to ensure medications are available as ordered, complete assessments of 10 residents feet for weekly X 4 weeks and then quarterly until a pattern of substantial compliance is maintained and review fall risk careplans for residents with fall risk score of 10 or greater x 4 weeks and then quarterly until a pattern of substantial compliance is maintained. These audits will then decrease to monthly x 2 months. Results will be submitted to the facility QA&A committee monthly x 3 months and then quarterly until a pattern of substantial compliance is maintained subsequent plan developed and implemented as necessary.</p> | | |

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| | <p>an interview on 09-27-13 at 11:00 a.m., the Director of Nurses verified the nurses initial the medication administration record and then circle their initials when a resident did not receive or the resident refused a medication.</p> <p>During an interview on 09-27-13 at 11:00 a.m., the Director of Nurses indicated the medication prescribed "was not covered." "The pharmacy did not send that medication it's not paid for by [Payor source indicated]. I usually sign the form and send it back to pharmacy and then we, the facility, pay for it. The physician was not notified until today that the resident had not been getting the medication."</p> <p>3. The record for Resident "F" was reviewed on 09-26-13 at 9:15 a.m. Diagnoses included, but were not limited to, dementia, hypertension, diabetes and peripheral vascular disease. These diagnoses remained current at the time of the record review.</p> <p>The annual MDS (Minimum Data Set) assessment, dated 07-11-13, indicated the resident had severe cognitive impairment and had impairments to both upper and lower extremities and balance problems.</p> | | | |

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| | <p>The resident's plan of care originally dated 02-18-13 indicated the resident was at risk for falls related to dementia. Interventions to this plan of care included Assess toileting needs, provide/reinforce use of assistive devices - wheelchair, pressure sensor pad in bed and wheelchair, mat at bedside when in bed, check continence every two hours and turn and reposition every two hours.</p> <p>The physician order dated 02-18-13 instructed the nursing staff to provide a wheelchair and bed alarm.</p> <p>Review of a "Report of incident - actual or suspected fall, dated 06-18-13 at 10:15 p.m., indicated the resident had an unwitnessed fall from bed during self transfer in the resident's room. "Functional level prior to fall: dependent." "Possible Contributing Factors: equipment issue of failure, sliding or positioning issue, restlessness or anxiousness." The document indicated the resident was "unable to communicate what occurred." "Mental status: lethargic." The progress notes indicated "06-18-13 at 10:45 [p.m.] Res. [resident] found on floor on left side of bed. No apparent injuries observed.</p> | | | |

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| | <p>Resident non verbal. Neurochecks are WNL [within normal limits]. All ROM [range of motion] for res. are WNL. No s/s [signs or symptoms] of adverse effects from fall."</p> <p>"Intervention / Updates" included Sensor alarm in bed and wheelchair, non skid footwear and floor mat next to bed." A handwritten entry indicated "Bed Alarm."</p> <p>The resident already had an existing physician order for a bed/wheelchair alarm.</p> <p>During an interview on 09-27-13 at 11:00 a.m., the fall report was reviewed with the Director of Nurses. The Director of Nurses indicated she was unaware if the resident had the bed alarm available at the time of the fall to alert the nursing staff of unassisted ambulation or transfer.</p> <p>This Federal tag relates to Complaint IN00134870 and IN00136352.</p> <p>3.1-35(g)(2)</p> | | | | | | |

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| F000309 SS=D | <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview the facility failed to ensure a complete assessment for injuries of a resident when a resident had fallen and was in stated pain for 1 of 1 resident reviewed for pain in sample of 7. (Resident "A").</p> <p>Findings include:</p> <p>The record for Resident "A" was reviewed on 09-25-13 at 10:30 a.m. Diagnoses included, but were not limited to, dementia, hypertension, depression, and restless leg syndrome. These diagnoses remained current at the time of the record review.</p> <p>The resident was admitted to the facility from a local area hospital. A review of the hospital transfer papers, dated 09-03-13, alerted the facility the resident had a history of falls and remained at risk for additional falls, confusion with short term memory problems, unsteady gait with impaired</p> | F000309 | <p>It is the practice of Pyramid Point to ensure a complete assessment for each fall resident with a fall is completed. What corrective actions will be taken for those residents who have been found to have been affected by this alleged deficient practice Resident A-No longer resides at facility How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action will be taken? Residents who experience a fall have the potential to be affected. What measures will be put in place into place or what systemic changes will be made to ensure that the alleged deficient practice does not reoccur? Licensed nurses (LN) have been re-educated on the thorough completion of the facility Report of Incident SBAR – Actual or Suspected Fall. This form includes the components necessary to document a thorough and complete assessment of the resident who experiences a known or suspected fall. Copies of the</p> | 10/25/2013 | |

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| | <p>balance in which she would side step to regain balance with mild path deviation.</p> <p>At the time of admission, the facility indicated the resident was at risk for falls and injuries related to psychotropic medication and cardiovascular medications, dementia, cognitive impairment, and weakness.</p> <p>The admission "Fall Risk Assessment," dated 09-03-13 assessed the resident's fall risk at a "10" - in which a score of "10 or greater identified the resident as a High Risk for falls."</p> <p>The Physical Therapy Initial Assessment, dated 09-04-13 indicated the resident had cognitive impairment and had functional deficits in balance, and was a high risk for falls.</p> <p>The Occupational Therapy Initial Assessment, dated 09-04-13, indicated the resident had underlying impairment which included oriented to self and required cues/redirection for safety on multiple occasions during the evaluation. "Fall risk."</p> <p>During an interview on 09-27-13 at</p> | | <p>report will be forwarded to the DON/designee for review for accuracy and completeness of the report. How the corrective action will be monitored to ensure the alleged deficient practice does not reoccur? The DON/designee will review the Report of Incident SBAR – Actual or Suspected Fall the next business day following the event as a part of the IDT Walking Rounds daily X 4 weeks, then monthly X 2 months and then quarterly until a pattern of substantial compliance is maintained. Results of reviews will be submitted to the facility QA&A Committee monthly X 3 months and then quarterly until a pattern of substantial compliance is maintained with a subsequent plan developed and implemented as necessary.</p> | | |

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| | <p>1:50 p.m. licensed nurse #12 indicated she remembered completing the admission process on 09-03-13, for the resident and indicated a family member was concerned about the potential for the resident falling. "We took a mattress off of another bed and placed it on the floor next to her bed, then we took chairs and placed them on each side of the bed. We didn't put an alarm on at that time."</p> <p>The 09-04-13 "Interdisciplinary Assessment and Progress Note," indicated the resident was a fall risk and had a fall within the last 30 days. The Interdisciplinary Team indicated the "safety device" to be implemented included a pressure alarm, chair and bed alarm. "Res. [resident] has poor safety awareness - fall risk. Recent falls at home."</p> <p>The 09-06-13 Medicare Documentation Flow Sheet indicated the following:</p> <p>"1330 [1:30 p.m.] Continues to be cooperative with care. LOA [leave of absence] and back to MD [Medical Doctor] appointment with [family member]. No new orders per [name of physician]. Medicated upon return with 2 Tylenol 325 mg [milligrams]</p> | | | | | | |

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| | <p>tablets for c/o [complaints of] BLE [bilateral lower extremity] leg pain. Assist of one for transfers due to pain. Legs elevated while resting to decrease pain. Took all scheduled meds without problems. No adverse drug reactions noted form PO [by mouth] ATB [antibiotic] for UTI [urinary tract infection]."</p> <p>A subsequent report, dated 09-06-13 at 1410 (2:10 p.m.) indicated the resident had an unwitnessed fall from bed due to a self transfer. "Additional Circumstances - device removal." "Resident observed on knees on bedside mat holding on to w/c [wheelchair]." A nurses note dated 09-06-13, at 1440 (2:40 p.m.), indicated "Resident c/o left leg and left hip pain after being assisted onto toilet. [Family member] notified of fall and also informed that resident turning own alarm off. Had been observed by staff once back in bed." The report indicated the resident indicated the amount of pain she experienced was 7, with 10 being the worst, but lacked a full assessment of the resident's abilities or limitations and the pain.</p> <p>The resident was not transported to the local area hospital until 4:25 p.m., via ambulance.</p> | | | |

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| | <p>A review of the Hospital Emergency Room report, dated 09-06-13 indicated the resident's family member "states patient has fallen twice in past 24 hours was found down on both occasions with no witness of fall. Left extremity shortened - pain upon palpation of left lateral hip."</p> <p>The hospital x-ray report, dated 09-06-13 indicated the resident had a "left femoral neck fracture."</p> <p>During an interview on 09-26-13 at 2:55 p.m., a concerned family member indicated "We think she fell on Thursday [09-05-13] because it was hard for her to get up and down and then she fell again on Friday. They didn't even call 911 to have her taken to the hospital. I don't believe they really assessed her and I had to insist they call 911. When we got to the hospital we found out she had fractured her hip."</p> <p>This Federal tag relates to Complaint IN00136352.</p> <p>3.1-37(a)</p> | | | |

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| F000312 SS=D | <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, and record review the facility failed to ensure the completion of activities of daily living, in that when a resident was identified as dependent for care the nursing staff failed to clean between the resident's toes, for 1 of 5 resident's reviewed for foot care in a sample of 7. (Resident "G").</p> <p>Findings include:</p> <p>The record for Resident "G" was reviewed on 09-27-13 at 2:45 p.m. Diagnoses included, but were not limited to edema, congestive heart failure, hypertension and depressive disorder. These diagnoses remained current at the time of the record review.</p> <p>A review of the resident's plan of care, originally dated 02-20-13 indicated the resident had a "self care deficit related to cerebral vascular accident, bilateral weakness, dependent for bed mobility, personal hygiene and bathing.</p> | F000312 | <p>It is the practice of Pyramid Point to ensure completion of activities of daily living regarding cleaning between resident toes. What corrective actions will be taken for those residents who have been found to have been affected by this alleged deficient practice? Resident G has been referred to the podiatrist. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action will be taken? A sweep of current residents will be completed to determine need for podiatry referral and referrals made as appropriate. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not reoccur? Nursing staff have been re-educated on the performance of ADL care including cleaning between the toes of residents. How the corrective action will be monitored to ensure the alleged deficient practice does not reoccur? The DON/designee will complete assessments of 10 residents feet weekly X 4 weeks and then monthly x 2 months and then</p> | 10/25/2013 | | | |

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| | <p>During an observation on 09-27-13 at 2:25 p.m., with the Director of Nurses in attendance the resident was laying in bed. The resident's bilateral feet were elevated and dressing could be observed on the resident's foot. The resident left foot - great toe had a long and thick surface with jagged edges.</p> <p>The Director of Nurses spread each of the resident's toes apart. Between each toe on the left foot was an abundance of a black, thick drainage/substance. Between the 2nd and 3rd toes on the right foot was also a black thick substance.</p> <p>This Federal tag relates to complaint IN00134870.</p> <p>3.1-38(a)(2)(A) 3.1-38(a)(3)(A)</p> | | <p>quarterly until a pattern of substantial compliance is maintained to ensure ADL care including cleaning between toes is completed. Results of the assessments will be submitted to the facility QA&A committee monthly X 3 months and then quarterly until pattern of substantial compliance is maintained with a subsequent plan developed and implemented as necessary.</p> | | |

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| F000323 SS=G | <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 two residents ("A" and "F"), received supervision and assistive devices, in that when resident's were identified with cognitive impairment and poor safety awareness, the nursing staff failed to ensure the integrity of the alarm to alert the nursing staff of unassisted ambulation or movement by the resident's.</p> <p>Resident "A" was transported to the local area hospital for evaluation and treatment, after she was found by the nursing staff, laying on the floor, adjacent to her bed. The hospital determined the resident's fall resulted in a fractured hip.</p> <p>In addition, the facility failed to ensure the nursing staff used a gait belt to ambulate a dependent resident, which resulted in the resident falling to the floor after losing her balance, while being ambulated.</p> <p>This deficient practice affected 3 of 5</p> | F000323 | <p>It is the practice of Pyramid Point to ensure residents received supervision and assistive devices and to use gate belts to ambulate a dependent resident. What corrective actions will be taken for those residents who have been found to have been affected by this alleged deficient practice? Resident A no longer resides at facility Resident B & F fall risk care plan has been updated to include current interventions and the interventions verified to be in place. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action will be taken? Residents requiring assistance with ambulation/transfers and/or with alarms to alert staff of attempts of unassisted ambulation/transfer have the potential to be affected. What measures will be put in place or what systemic changes will be made to ensure that the alleged deficient practice does not reoccur? LN have been re-educated on the thorough completion of the Report of Incident SBAR – Actual or</p> | 10/25/2013 | | | |

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| | <p>resident's reviewed for falls in a sample of 7. (Resident's "A", "B", and "F").</p> <p>Findings include:</p> <p>1. The record for Resident "A" was reviewed on 09-25-13 at 10:30 a.m. Diagnoses included, but were not limited to, dementia, hypertension, depression, and restless leg syndrome. These diagnoses remained current at the time of the record review.</p> <p>The resident was admitted to the facility from a local area hospital. A review of the hospital transfer papers, dated 09-03-13, alerted the facility the resident had a history of falls and remained at risk for additional falls, confusion with short term memory problems, unsteady gait with impaired balance in which she would side step to regain balance with mild path deviation.</p> <p>At the time of admission, the facility indicated the resident was at risk for falls and injuries related to psychotropic medication and cardiovascular medications, dementia, cognitive impairment, and weakness.</p> | | <p>Suspected Fall including completion of the section signifying the presence and functioning of alarms and other interventions at the time of the event. Nursing staff have been re-educated on the use of gait belts use when transferring or ambulating residents requiring assistance. How the corrective action will be monitored to ensure the alleged deficient practice does not reoccur? The DON/designee will review the Report of Incident SBAR – Actual or Suspected Fall the next business day following the event as a part of the IDT Walking Rounds daily X 4 weeks, then monthly X 2 months and then quarterly until a pattern of substantial compliance is maintained. DON/designee will observe gait belt use for ambulation or transfer of 5 residents whom need assistance weekly x 4 weeks and then monthly x 2 months and then quarterly until a pattern of substantial compliance is maintained. Results of reviews will be submitted to the facility QA&A Committee monthly X 3 months and then quarterly until a pattern of substantial compliance is maintained with a subsequent plan developed and implemented as necessary.</p> | | | | |

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| | <p>The admission "Fall Risk Assessment," dated 09-03-13 assessed the resident's fall risk at a "10" - in which a score of "10 or greater identified the resident as a High Risk for falls."</p> <p>The Physical Therapy Initial Assessment, dated 09-04-13, indicated the resident had cognitive impairment and had functional deficits in balance, and was a high risk for falls.</p> <p>The Occupational Therapy Initial Assessment, dated 09-04-13, indicated the resident had underlying impairment with included oriented to self and required cues/redirection for safety on multiple occasions during the evaluation. "Fall risk."</p> <p>During an interview on 09-27-13 at 1:50 p.m. licensed nurse #12 indicated she remembered completing the admission process on 09-03-13, for the resident and indicated a family member was concerned about the potential for the resident falling. "We took a mattress off of another bed and placed it on the floor next to her bed, then we took chairs and placed them on each side of the bed. We didn't put an alarm on at that time."</p> | | | | | | |

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| | <p>The 09-04-13 "Interdisciplinary Assessment and Progress Note," indicated the resident was a fall risk and had a fall within the last 30 days. The interdisciplinary team indicated the "safety device" to be implemented included a pressure alarm, chair and bed alarm. "Res. [resident] has poor safety awareness - fall risk. Recent falls at home."</p> <p>The 09-06-13 Medicare Documentation Flow Sheet indicated the following:</p> <p>"1330 [1:30 p.m.] Continues to be cooperative with care. LOA [leave of absence] and back to MD [Medical Doctor] appointment with [family member]. No new orders per [name of physician]. Medicated upon return with 2 Tylenol 325 mg [milligrams] tablets for c/o [complaints of] BLE [bilateral lower extremity] leg pain. Assist of one for transfers due to pain. Legs elevated while resting to decrease pain. Took all scheduled meds without problems. No adverse drug reactions noted form PO [by mouth] ATB [antibiotic] for UTI [urinary tract infection]."</p> <p>A subsequent report, dated 09-06-13 at 1410 (2:10 p.m.) indicated the</p> | | | |

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| | <p>resident had an unwitnessed fall from bed due to a self transfer. "Additional Circumstances - device removal." "Resident observed on knees on bedside mat holding on to w/c [wheelchair]." A nurses note dated 09-06-13, at 1440 (2:40 p.m.), indicated "Resident c/o left leg and left hip pain after being assisted onto toilet. [Family member] notified of fall and also informed that resident turning own alarm off. Had been observed by staff once back in bed." The report indicated the resident indicated the amount of pain she experienced was 7, with 10 being the worst, but lacked a full assessment of the resident's abilities or limitations.</p> <p>A review of the Hospital Emergency Room report, dated 09-06-13 indicated the resident's family member "states patient has fallen twice in past 24 hours was found down on both occasions with no witness of fall. Left extremity shortened - pain upon palpation of left lateral hip."</p> <p>The hospital x-ray report, dated 09-06-13 indicated the resident had a "left femoral neck fracture."</p> <p>During an interview on 09-26-13 at 2:55 p.m., a concerned family</p> | | | |

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| | <p>member indicated "We think she fell on Thursday [09-05-13] because it was hard for her to get up and down and then she fell again on Friday. They didn't even call 911 to have her taken to the hospital. I don't believe they really assessed her and I had to insist they call 911. When we got to the hospital we found out she had fractured her hip."</p> <p>During an interview on 09-27-13 at 11:00 a.m., the fall report was reviewed with the Director of Nurses. The Director of Nurses indicated the resident frequently "turned off the device" and the "nurses were aware of it."</p> <p>When further interviewed that if the nursing staff was aware of the resident turning off the device, what interventions did the nurses put in place so the resident was unable to deactivate the device and ensure the audible alarm alerted the nursing staff of unassisted ambulation. The Director of Nurses indicated she thought the nurses placed the device under the resident's bed. When questioned where the device was located at the time of the fall, the Director of Nurses indicated she was unsure, "but it must have been within reach."</p> | | | |

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| | <p>2.) The record for resident "F" was reviewed on 09-26-13 at 9:15 a.m. Diagnoses included, but were not limited to, dementia, hypertension, diabetes and peripheral vascular disease. These diagnoses remained current at the time of the record review.</p> <p>The annual MDS (Minimum Data Set) assessment, dated 07-11-13 indicated the resident had severe cognitive impairment and had impairments to both upper and lower extremities and balance problems.</p> <p>The resident's plan of care originally dated 02-18-13, indicated the resident was at risk for falls related to dementia. Interventions to this plan of care included assess toileting needs, provide/reinforce use of assistive devices - wheelchair, pressure sensor pad in bed and wheelchair, mat at bedside when in bed, check continence every two hours and turn and reposition every two hours.</p> <p>The physician order dated 02-18-13 instructed the nursing staff for a wheelchair and bed alarm.</p> <p>Review of a "Report of incident -</p> | | | | |

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| | <p>actual or suspected fall, dated 06-18-13 at 10:15 p.m., indicated the resident had an unwitnessed fall from bed during self transfer in the resident's room. "Functional level prior to fall: dependent." "Possible Contributing Factors: equipment issue of failure, sliding or positioning issue, restlessness or anxiousness." The document indicated the resident was "unable to communicate what occurred." "Mental status: lethargic." The progress notes indicated "06-18-13 at 10:45 [p.m.] Res. [resident] found on floor on left side of bed. No apparent injuries observed. Resident non verbal. Neurochecks are WNL [within normal limits]. All ROM [range of motion] for res. are WNL. No s/s [signs or symptoms] of adverse effects from fall." "Intervention / Updates" included Sensor alarm in bed and wheelchair, non skid footwear and floor mat next to bed." A handwritten entry indicated "Bed Alarm."</p> <p>During an interview on 09-27-13 at 11:00 a.m., the fall report was reviewed with the Director of Nurses. The Director of Nurses indicated she was unaware if the resident had the bed alarm available at the time of the fall to alert the nursing staff of unassisted ambulation or transfer.</p> | | | |

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| | <p>3.) The record for Resident "B" was reviewed on 09-26-13 at 1:15 p.m. Diagnoses included, but were not limited to, dementia, cerebral vascular accident, congestive heart failure, schizophrenia and delusions. These diagnoses remained current at the time of the record review.</p> <p>The resident's MDS assessment, dated 06-14-13 indicated the resident had severe cognitive impairment, required supervision with toileting, and was only able to balance with the assistance of staff for walking or turning around.</p> <p>A review of the resident's MDS assessment, dated 07-30-13, indicated the resident had severe cognitive impairment, with problems related to balance to include "not steady, only able to stabilize with human assistance, with moving from a seated to a standing position, turning around, moving on and off toilet, and surface to surface transfer.</p> <p>The resident's original plan of care dated 06-07-13 indicated the resident was at risk for falls and injuries related to psychotropic medications, diuretic medications, unsteady gait, cognitive impairment, dementia and a</p> | | | | | | |

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| | <p>history of falls. Interventions included provide adequate lighting, observe for side effects of medication, provide/reinforce use of non-skid foot wear, pressure sensor pad in wheelchair, attempt to lay down after meals, and do not leave unattended when up in wheelchair."</p> <p>Review of the the IDT (interdisciplinary Team) Post Occurrence assessment and plan, dated 07-04-13 indicated the resident toileted "self at time of fall, resident had one sock on one off. Resident was in bathroom getting off the comode [sic] and fell to floor." Further review of the progress note indicated, "CNA [Certified Nurses Aide] took resident to the bathroom and resident fell." "CNA should not leave resident alone in the bathroom."</p> <p>A subsequent "Report of Incident - actual or suspected Fall," dated 08-20-13 at 4:10 p.m., indicated "Res. was walking in hallway, leaning forward with this staff at her side. Res. lost balance. I tried to prevent falling forward into face et [and] assisted resident to floor." "Intervention - gait belt to be used when ambulating if possible."</p> <p>During an interview on 09-27-13 at</p> | | | |

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| | <p>11:55 a.m., the fall report was reviewed with the Director of Nurses. The Director of Nurses indicated the staff member should always use a gait belt when transferring or ambulating a resident."</p> <p>During observation on 09-26-13 at 1:30 p.m. and then again on 09-27-13 at 2:30 p.m., the resident was left unattended in the Activity room.</p> <p>Review of the facility policy titled "Gait Belt, Use of," undated, and provided on 09-27-13 at 11:50 a.m., by the Director of Nurses, indicated the following:</p> <p>"Basic Responsibility - Nursing staff and Therapy staff."</p> <p>"Policy - It is the policy of this facility that staff will help control and balance (by using a gait belt) resident who require assistance with ambulation and transfer."</p> <p>"Purpose - To help control and balance resident during assisted transfer or ambulation."</p> <p>This Federal tag relates to Complaints IN00134870 and IN00136352.</p> | | | |

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| F000328 SS=E | <p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on observation, interview and record review the facility failed to ensure resident's received necessary care and services from qualified persons, in that when resident's, when resident's needed podiatry care the nursing staff failed to notify the podiatrist of the resident's need for 4 of 5 resident's reviewed for podiatry care in a sample of 7. (Resident's "B", "E", "D" and "G").</p> <p>Findings include:</p> <p>1. The record for Resident "B" was reviewed on 09-26-13 at 1:15 p.m. Diagnoses included, but were not limited to, dementia, cerebral vascular accident, congestive heart failure, schizophrenia and delusions. these diagnoses remained current at the time of the record review.</p> <p>The resident's MDS (minimum data</p> | F000328 | <p>It is the practice of Pyramid Point to ensure residents receive necessary care & services from Podiatrist. What corrective actions will be taken for those residents who have been found to have been affected by this alleged deficient practice? Residents B, E, D & G have been referred to and seen by podiatrist How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action will be taken? A sweep of current residents will be completed to determine need for podiatry referral and referrals made as appropriate. What measures will be put in place into place or what systemic changes will be made to ensure that the alleged deficient practice does not reoccur? Nursing staff have been re-educated on expectations for making appropriate referrals for podiatry needs. How the corrective action will be monitored to ensure the alleged deficient practice</p> | 10/25/2013 |

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| | <p>set) assessment, dated 07-30-13 indicated the resident had severe cognitive impairment and required assistance with dressing.</p> <p>The record indicated the resident received podiatry services on 07-05-13. The podiatrist noted, "I treated Xerosis using a therapeutic lotion. Follow the medications and treat described as follows: Recommend apply lotion. Pt. [patient] should be treated in 61 days for foot care due to systemic condition or sooner, should inflammation, infection pain or ulcers arise."</p> <p>During an observation on 09-27-13 at 2:30 a.m., with the Director of Nurses in attendance, the resident's shoes and socks were removed. The resident right foot had thick yellow toe nail to the great toe, and long and jagged toe nail edges to the 2nd, 3rd, and 4th toe.</p> <p>The Director of Nurses indicated, "She needs to be seen by the podiatrist. I'll put her name on the list to be seen."</p> <p>2.) The record for Resident "D" was reviewed on 09-26-13 at 8:30 a.m. Diagnoses included, but were not limited to hypertension, depression,</p> | | <p>does not reoccur? The DON/designee will complete assessments of 10 residents feet weekly X 4 weeks and then monthly x 2 months and then quarterly until a pattern of substantial compliance is maintained to ensure foot care is provided and podiatry referrals made as appropriate. Results of the assessments will be submitted to the facility QA&A committee monthly X 3 months and then quarterly until pattern of substantial compliance is maintained with a subsequent plan developed and implemented as necessary.</p> | |

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| | <p>cerebral vascular accident, glaucoma and osteoporosis. These diagnoses remained current at the time of the record review.</p> <p>A review of the resident's MDS dated 08-15-13 indicated the resident required extensive assistance with dressing.</p> <p>The record indicated the resident had been seen by the podiatrist on 06-13-13. The podiatrist recommended, Pt. (patient) should be treated in 61 days for foot care due to systemic condition or sooner, should inflammation, infection pain or ulcers arise."</p> <p>During an observation on 09-27-13 at 2:05 p.m., with the Director of Nurses in attendance the resident's shoes and socks were removed. The resident's right foot was observed with a long and thick toe nail to the great toe as well as the 2nd toe. The resident's left foot had edema in which the skin to the top surface of the foot was shiny in appearance and the Director of Nurses identified as 3+ edema. All toe nails on the left foot were long, jagged and curved over the tip of the toe. The resident had deep indentations from the use of the compressions stockings. The</p> | | | |

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| | <p>Director of Nurses indicated the resident needed to be seen by the podiatrist, and the need to elevate the resident's legs due to the edema.</p> <p>3.) The record for Resident "E" was reviewed on 09-27-13 at 11:00 a.m. Diagnoses included, but were not limited to, cerebral vascular accident, neuropathy, arthritis and dementia with psychosis. These diagnoses remained current at the time of the record review.</p> <p>A review of the resident's MDS, dated 07-16-13 indicated the resident required extensive assistance with dressing.</p> <p>A podiatrist notation, dated 08-08-13 indicated "Pain noted all locations. Follow the medication and treatment described as follows: Staff to observe only. Recommend lotion feet after shower. Pt. should be treated in 61 days for foot care due to systemic condition or sooner should inflammation, infection, pain or ulceration arise."</p> <p>During an observation on 09-27-13 at 2:15 p.m., the resident's shoes and socks were removed. The right foot had thick toenails on the 2nd toe and then curled under the tip of the toe.</p> | | | |

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| | <p>The 3rd toe on the right foot had a long and jagged nail. The left foot had a thick yellow/white nail to the great toe and the other toe nails were long and jagged.</p> <p>The Director of Nurses indicated "I'm not sure when she was seen by the podiatrist but it looks like she needs to be seen again."</p> <p>4.) The record for Resident "G" was reviewed on 09-27-13 at 2:45 p.m. Diagnoses included, but were not limited to edema, congestive heart failure, hypertension and depressive disorder. These diagnoses remained current at the time of the record review.</p> <p>On 09-26-13 at 8:30 a.m., the Director of Nurses identified the resident with a facility acquired pressure ulcer to the left heel.</p> <p>During an observation on 09-27-13 at 2:25 p.m., with the Director of Nurses in attendance the resident was laying in bed. The resident's bilateral feet were elevated and dressing could be observed on the resident's foot. The resident left foot - great toe had a long and thick surface with jagged edges.</p> | | | |

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| | <p>The resident's record indicated the resident was last seen by the podiatrist on 07-05-13. The podiatrist indicated the resident received "wound care." "Symptomatic Nails - pain noted at all locations. Discolored noted at all locations. Onychogryphosis [abnormal hypertrophy and curving of the nails giving a clawlike appearance and onychomycosis [a fungal disease of the nails giving a white opaque thickened appearance. Assessment: [resident] has podiatric and systemic diagnoses of Onychomycosis and Onych-auxis-ogryphosis-olysis. Pt. [patient] soul be treated in 61 days for foot care due to systemic condition or sooner, should inflammation, infection pain or ulcers arise."</p> <p>The Director of Nurses indicated, "she should probably be seen by the podiatrist."</p> <p>This Federal tag relates to Complaint IN00134870.</p> <p>3.1-47(a)(7)</p> | | | |