

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155206	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/14/2013
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NAME OF PROVIDER OR SUPPLIER BROWNSBURG HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1010 HORNADAY RD BROWNSBURG, IN 46112
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey Dates: March 5, 6, 7, 8, 11, 12, 13, and 14, 2013.</p> <p>Facility Number: 000113 Provider Number: 155206 AIM Number: 100287670</p> <p>Survey Team: Heather Lay, RN - TC Lori Brettnacher, RN (3/5, 3/6, 3/7, 3/11, 3/12, 3/13, and 3/14, 2013)</p> <p>Census Bed Type: SNF: 1 SNF/NF: 89 Total: 90</p> <p>Census Payor Type: Medicare: 8 Medicaid: 64 Other: 18 Total: 90</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed on 03/21/2013 by Brenda Nunan, RN.</p>	F000000	Submission of this plan of correction shall not constitute or be construed as an admission by Brownsburg Healthcare that the allegations contained in the survey report are accurate or reflect accurately the provisions of nursing care and services to the residents of Brownsburg Healthcare.	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F000223 SS=B	<p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on interview and record review, the facility failed to ensure residents were free from verbal abuse for 2 of 4 residents reviewed for abuse (Resident #109 and # 33).</p> <p>Findings included:</p> <p>1. Resident #109's record was reviewed on 3/11/13 at 3:03 P.M. The record indicated she had diagnoses, which included but were not limited to, congestive heart failure and depression. A 12/13/12, quarterly minimum data assessment tool (MDS), indicated, Resident #109 was alert, oriented, and had a BIMS (Brief Interview Mental Status) of 15/15.</p> <p>During an interview on 3/6/2013 at 2:44 P.M., Resident #109 indicated she had been treated roughly by staff. She stated, "[Certified Nursing Assistant (CNA) named]. They let her go. She was too rough with</p>	F000223	<p>It is the facility policy to ensure that all residents are free from abuse/involuntary seclusion. All residents have the potential to be affected by this practice. Resident #109 stated a C.N.A. was rough with her and that she feared retribution. Resident #33's daughter stated the LPN retaliated against her mother verbally when she questioned her about toileting. Both incidents were investigated and both employees were suspended then terminated per facility abuse policy. Both incidents were reported to the appropriate agencies. Any concerns about rudeness, mistreatment, retaliation or abuse of any type are taken seriously and immediately investigated with resident safety being the first concern. Nursing and facility staff have been inserviced on abuse beginning 3/16/13 and quarterly, as well as upon employment. A specific emphasis was put on what verbal abuse is and that there is zero tolerance for abuse of any type. The Administrator and</p>	04/13/2013	

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	<p>everyone. She always yelled at [roommate named]."</p> <p>During an interview on 3/11/2013 at 3:12 P.M., the Administrator indicated she was aware of the allegation. At this time she was asked to provide documentation of the investigation regarding the alleged abuse.</p> <p>On 3/12/2013 at 9:30 A.M., the facility's investigation report regarding the above allegation was reviewed. This report dated 1/4/2013, indicated, on 1/4/13, Resident #109 reported CNA #19 and CNA #20 were being rude, sarcastic, and acted as if they did not want to take care of her. She alleged both CNAs were verbally abusive and feared retribution from them. The report indicated Resident #109 reported the CNAs were also rude and disrespectful to other residents. This investigation further indicated Resident #109's daughter was interviewed and reported CNA #19 had been very verbally disrespectful to the residents.</p> <p>2. On 3/8/13 at 11:30 A.M., Resident #33's record was reviewed. Diagnoses included, but were not limited to, a-fib, aaa (abdominal aortic aneurysm), hypertension, diverticulosis, iddm (insulin</p>		DON will monitor and investigate every complaint of abuse made. Any concerns will be addressed monthly by the quality assurance committee.				

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	<p>dependent diabetes mellitus), gi (gastrointestinal) bleed, anemia, malnutrition, chf (congestive heart failure), Alzheimer, dementia with delusions, depression, insomnia, and constipation.</p> <p>On, 3/12/2013 at 9:30 A.M., the Administrator provided documentation which indicated an allegation of abuse to Resident #33. The documentation indicated, on 2/1/2013, Resident #33's daughter called the DON (Director of Nursing) to report she believed Licensed Practical Nurse (LPN) #17 [named], retaliated against her mother after she was asked questions regarding the toileting protocol for her mother. This report indicated Resident #33's daughter stated, '[LPN #17 named] was very rude like she didn't want to be bothered. [Nurse #17 named] went and got my mom and took her to the bathroom. I went to [sic] outside her door and heard her loudly saying to my mom, 'put your feet on the floor. We don't play around here. Just poop.' I felt like slapping [LPN #17 named] for the way she was treating mom. I feel like she was retaliating for me questioning her. So after that she got another aide and told her to get the aide who got mom up. She told me next time to get the aides.</p>			
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	<p>Mom did use the bathroom when [LPN #17 named] took her. I heard what [LPN #17 named] said. I was outside mom's door and it was wrong. I called all my siblings and they agree she was angry with me and retaliated by being mean to mom."</p> <p>An un-dated facility policy titled, "Resident Neglect, Abuse, and Misappropriation of Property Policy," provided by the Administrator on 3/6/2013 at 1:30 P.M., indicated, "...Residents will be free from ...verbal ... and mental abuse.... Verbal Abuse Defined as the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability.... Mental Abuse: Includes, but is not limited to , humiliation, harassment, threats of punishment, or deprivation....The company strictly prohibits any conduct causing or resulting in mistreatment, neglect, exploitation, or abuse of its residents...."</p> <p>3.1-27(a)(1)</p>				

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F000247 SS=D	<p>483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. Based on interview, and record review, the facility failed to ensure residents were given notice prior to having a change in roommates. This deficient practice affected 1 of 3 residents reviewed for notices being given prior to a roommate/room change (Resident #67).</p> <p>Findings include:</p> <p>Resident #67's record was reviewed on 3/14/2013 at 12:00 P.M. She was originally admitted to the facility on 12/10/2008 and readmitted on 8/30/2011. Resident #67 had diagnoses which included, but were not limited to, depression, dementia with paranoia, and hypertension.</p> <p>During an interview on 3/6/13 at 9:45 A.M., Resident #67 indicated she was not given notice prior to her roommate moving in with her [Resident #67]. During an interview on 3/12/2013 at 2:58 P.M., the Assistant Director of Nursing (ADON) was asked to provide documentation which indicated Resident #67 had been given notification prior to</p>	F000247	<p>It is the facility policy that every resident has the right to receive notice before the residents room or roommate is changed. All residents have the potential to be affected by this practice. Resident #67 stated she was not notified and her daughter couldn't remember for sure if she was notified of a roommate change for her mother. The resident record did not reflect any notification. An audit was done of all room and roommate changes made in the last 30 days. The audit showed all had been notified and documented. Inservicing was done on notification of room/roommate changes for nursing and social service staff. Social Service Director and DON will monitor all room/roommate changes and any concerns will be addressed monthly by the quality assurance committee.</p>	04/13/2013			

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	<p>receiving a new roommate. During an interview with the DON (Director of Nursing), Administrator, and ADON, on 3/14/2013 at 12:22 P.M., the DON indicated Resident #67 received a new roommate on 1/18/2013 and was not given notice prior to the change.</p> <p>An un-dated policy titled, "Room Availability and Room Move Policy," provided by the Administrator on 3/14/2013, indicated, "...it is the policy of the facility to call family member of residents prior to the move to discuss room moves. The receiving roommate will also be told about the incoming roommate prior to the move. Their family may be contacted should the resident be unable to understand the situation...."</p> <p>3.1-3(v)(2)</p>			

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F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, record review, and interview, the facility failed to develop appropriate fall prevention interventions for a 1 of 5 residents reviewed for accidents [Resident #44] and failed to develop a comprehensive care plan for 1 of 1 resident reviewed for hospice [Resident #79].</p> <p>Findings include:</p> <p>1. Resident #44 was observed on 3/5/2013 at 10:00 A.M. She had bruising to most of the right side of</p>	F000279	It is the facility policy that every resident have a comprehensive care plan developed that includes measurable objectives and timetables. All residents have the potential to be affected by this practice. The care plan for resident #44 has been reviewed and updated to reflect individualized interventions for her care. Resident #79's care plan has been reviewed and updated with Hospice interventions that reflect accurately the days that the Hospice nurse and aide are in the facility and the care that they provide when they are in the facility. Beginning 3/16/13 and	04/13/2013	

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	<p>her face and sutures to her right forehead.</p> <p>Resident #44's record was reviewed on 3/11/2013 at 8:55 A.M. Diagnoses included, but were not limited to, hypertension, arthritis, debility, Alzheimer's dementia with agitation, hallucinations, insomnia, difficulty with walking, chronic pain, and depression. Resident #44 was a limited assist of one person for bed mobility, an extensive assistance of one person for transfers, and had short and long term memory problems, not being able to recall information after five minutes.</p> <p>A current care plan, originally dated 8/4/2012, and reviewed on 11/5/12, indicated Resident #44 was a high risk for falls related to the following: history of fall with fracture, history of falls, medications, use of wheelchair for mobility, diagnoses of Alzheimer's type dementia, forgets to call for assist at times, osteoporosis. A goal listed was for Resident #44 to be free from fall related injuries. Interventions to meet this goal included: assist with transfers, assure proper footwear, emphasize use of safe technique and observe for compliance, encourage use of assistance device, explain call light</p>		<p>ongoing, nursing staff have been inserviced on care plans and the importance of appropriate individualized interventions for each resident as well as putting the interventions on the C.N.A. assignment sheets to provide accurate knowledge for staff to provide care. DON/designee will monitor changes to care plans and assignment sheets daily through review of physician orders, daily review of interventions instituted through behavior meetings, fall meetings and 24 hour report information. Any concerns will be addressed monthly by the quality assurance committee.</p>		

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	<p>and assess resident's ability to use, frequently remind her to call for staff and wait for staff assistance, fall risk assessment every three months and as needed, keep articles of need within easy reach, bed at lowest level, and make sure staff was aware of patient's fall risk.</p> <p>A current care plan originally dated 8/14/2012, and last reviewed/updated on 2/2/12, indicated Resident #44 had long and short term memory deficits with difficulty making decision. She could not remember after five minutes. She could not state the details of her life information such as the town she had lived in for nearly 50 years. She had poor decision making as evidenced by her lack of safety awareness.</p> <p>A nurse's note dated 12/9/2013-3:00 A.M., indicated, "Found resident laying on floor next to bed wedged between w/c (wheelchair) and bed laying on her right side, (had recently been toileted) when asked what happened she stated she was trying to get herself out of bed (she has a hx (history) of this behavior). Right shoulder 1 cm (centimeter) X 1 CM, faint blue bruise, zero swelling, ROM (range of motion) WNL (within normal limits), MAE (moves all extremities),</p>			

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	<p>PERRL (Pupils equal, round, and reactive to light). Notified MD (medical doctor), 151/80 (blood pressure), P (pulse) 86, R (respirations) 16, T (temperature) 97.7, O2 (oxygen saturation) 96%, speech clear; reminded to use call light. Moved w/c. Will cont. (continue) to monitor."</p> <p>The record indicated interventions of encouraging the resident to ask for assistance and use the call light were added to the care plan after a fall with injury on 12/9/12. The record indicated the resident had been assessed to have short/long term memory deficits.</p> <p>During an interview on 3/11/2013 at 11:06, LPN #1 indicated the efficacy of encouraging Resident #44 to use the call light was dependent on her mental status. She indicated Resident #44's mental status varied from periods of lucidness to periods of confusion.</p> <p>A nurse's note dated 12/20/12 -10:30 P.M., indicated, "Resident was found sitting on floor in middle of room. Stated she was trying to get to w/c to go to bathroom....Has abrasion on left elbow. Cleansed with NS (normal saline) and bandage applied. Had c/o</p>						

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	<p>(complained) of pain while abrasion was being applied. Back is slightly red on right side. Stated, 'I hit my head a little bit.' MD notified. Family is aware. Resident is resting in bed at present time. Will be f/u (follow up) fall with neuros [neurological status checks] for next 72 hours."</p> <p>Documentation was lacking to indicated the facility immediately revised and implemented fall prevention interventions.</p> <p>A nurse's note dated 12/28/2013 -1:30 A.M., indicated, "Resident was found on the floor at her bedside by staff. Res (resident) stated, 'I was trying to get up to go to the bathroom.' Res. denies hitting her head and denies pain r/t (related to) fall. She said, 'I slid out of my bed.' V/S (vitals) -B/P (blood pressure) 152/79, P 87, R 20, Neuros WNL. Res was helped by staff back into bed. Reminded res to use call light when needing help. Call light within reach. MD faxed. Will notify family in A.M. Neuro sheet started. Will cont. to observe." The record lacked documentation Resident #44 was taken to the bathroom and did not indicated interventions other than reminding the resident with short/long term memory deficits to use her call light.</p>			

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	<p>A nurse's note dated 3/1/2012-11:10 P.M., indicated, "Writer and QMA (Qualified Medication Aide) heard yelling. Went down hallway found res lying on right side. Res lifted head noted lg (large) amount of blood on floor. Upon further assessment resident noted to have laceration upon right eye. Noted bruising to right eye as well. Res c/o right hip pain upon palpation. Applied light pressure to laceration and informed res that we were going to call Dr (doctor) to see if we could send her to E.R. (emergency room) for right hip pain and laceration. Res left on floor. Another nurse called POA (power of attorney (POA named) and informed her of res fall. Stated, 'Send to (hospital named). 911 called at this time."</p> <p>A hospital note, dated 3/3/2013, indicated, Resident #44 was seen in the emergency room for a facial laceration which required seven sutures and a contusion to her right hip from a fall.</p> <p>During a telephone interview on 3/13/2013 at 10:53 A.M., LPN #4 indicated, Resident, #44 was in a regular bed rather than a low bed .</p> <p>During a telephone interview on</p>			

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	<p>3/13/2013 at 11:11 A.M., LPN #4 indicated, "I don't remember if the bed was in the low position [prior to fall with laceration] because I was focused on her and the blood on the floor."</p> <p>During a telephone interview on 3/13/2013 at 1:15 P.M., CNA/QMA #3 indicated, the bed was not in the low position the night of the fall. CNA/QMA #3 indicated Resident #44 was able to raise the bed from the low position.</p> <p>During an interview on 3/13/2013 at 12:28 P.M., the DON indicated Resident #44 was in a regular bed and had orders to keep the bed in the lowest position. The DON indicated Resident #44 was capable of raising the bed from the low position. She indicated the intervention of a stationary low bed had not been added to the care plan and had not been implemented prior to the fall with injury on 3/1/13.</p> <p>During an interview on 3/13/2013 at 11:38 A.M., the Administrator was asked to provide the facility's current policies related to falls. A policy titled, "Fall Follow-Up" dated 10-13-2004 was included in the policies provided. This policy indicated, "Purpose: To</p>						

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	<p>investigate falls in an effort to define the etiology of the fall and to see that appropriate interventions are in place to remove or control the causative factors as much as possible..."</p> <p>2. On 3/12/13 at 3:30 P.M., Resident #79's record was reviewed. Diagnoses included, but were not limited to, dementia with agitation, depression, asthma, hypertension, difficulty walking, and Parkinson's disease.</p> <p>A facility hospice care plan, dated 10/2/12, included, but was not limited to. "Resident [#79] admitted to hospice care... Resident's wishes will be followed and resident will be kept comfortable... Assure resident [Resident #79] that needs will be met, Hospice certified nursing assistant [CNA] to provide care and hygiene per facility policy, Hospice registered nurse [RN] will educate patient and family per facility policy, Hospice will provide calendar of care per facility policy, Will not do weekly weights as weight loss is anticipated..."</p> <p>There was no documentation of a coordinated hospice care plan for Resident #79.</p> <p>On 3/12/13 at 3:42 P.M., in an interview, LPN #22 indicated she was</p>			

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	<p>not aware of a care plan for Resident #79.</p> <p>On 3/13/13 at 2:15 P.M., in an interview with the Director of Nursing [DoN] and Hospice RN #21, they indicated the facility and hospice agency used a coordinated care plan in the past; however, the coordinated care plan was no longer used between the facility and hospice. The DoN and Hospice RN #21 indicated revision would be made to Resident #79's care plan to coordinate care between hospice and the facility.</p> <p>3.1-35(a)</p>			

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F000282 SS=G	<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 observation, interview, and record review, the facility failed to ensure services were provided in accordance with residents' written plans of care to prevent injuries and/or falls for 3 of 5 residents reviewed for falls/injuries (Resident #44, #25, and #1) and failed to ensure medications were administered per physician's orders for 1 of 10 residents reviewed for medications administration (Resident # 33).</p> <p>Findings include:</p> <p>1. Resident #44's record was reviewed on 3/11/2013 at 8:55 A.M. Her diagnoses included, but were not limited to, hypertension, arthritis, debility, Alzheimer's dementia with agitation, hallucinations, insomnia, difficulty with walking, chronic pain, and depression. Resident #44 was a limited assist of one person for bed mobility, an extensive assistance of one person for transfers, and had short and long term memory problems, not being able to recall</p>	F000282	<p>It is the facility policy that services provided or arranged by the facility be provided by qualified persons in accordance with the written plan of care. All residents have the potential to be affected by this practice. Care plans for residents #44 and #1 were reviewed and updated to reflect individualized interventions in regards to falls and toileting schedules. A fall follow-up investigation tool is used to review each fall and intervention. A 30 day look back audit was done on residents with falls and injuries to review and update interventions and toileting schedules to more individualize the interventions. The fall follow-up investigation is started with each fall, and each fall is reviewed Monday through Friday by the interdisciplinary team to ensure that all interventions are appropriate and that the fall is fully reviewed. Any concerns will be addressed monthly by the quality assurance committee. Resident #25 received a laceration to her leg. Her care plan has been reviewed and updated to accurately reflect her transfer requirements, as well as her skin fragility. This information</p>	04/13/2013	

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	<p>information after five minutes.</p> <p>A nurse's note dated 3/1/2012-11:10 P.M., indicated, "Writer and QMA (Qualified Medication Aide) heard yelling. Went down hallway found res lying on right side. Res lifted head noted lg (large) amount of blood on floor. Upon further assessment re noted to have laceration upon right eye. Noted bruising to right eye as well. Res c/o right hip pain upon palpation. Applied light pressure to laceration and informed res that we were going to call Dr (doctor) to see if we could send her to E.R. (emergency room) for right hip pain and laceration. Res left on floor. Another nurse called POA (power of attorney (POA named) and informed her of res fall. Stated, 'Send to (hospital named). 911 called at this time."</p> <p>A hospital note, dated 3/3/2013, indicated, Resident #44 was seen in the emergency room for a facial laceration which required seven sutures and a contusion to her right hip from a fall.</p> <p>During a telephone interview on 3/13/2013 at 10:53 A.M., LPN #4 indicated the pressure alarm was not working when Resident #44 fell out of</p>		<p>has been placed on the nurse aide assignment sheets. An audit was done of transfer status of all residents by the Director of Rehab and Director of Nursing. The Director of Rehab and Director of Nursing review the transfer status of all newly admitted residents and any residents with a change in mobility/ambulation. Any concerns will be addressed monthly by the quality assurance committee. Resident #33 received an unnecessary medication that had been discontinued. The LPN was disciplined and re-educated on transcription of physician orders, correct procedure for re-writes and checking of all orders written since previous month re-write. DON/designee will monitor monthly re-writes and daily physician orders for accuracy in transcription. Any concerns will be addressed monthly by the quality assurance committee.</p>		

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	<p>bed on 3/1/2013. "</p> <p>During a telephone interview on 3/13/2013 at 1:15 P.M., CNA/QMA #3 indicated the bed was not in the low position. She further indicated she was aware Resident #44 could raise the bed herself and confirmed the alarm was not working when she fell out of bed on 3/1/2013.</p> <p>A current care plan, originally dated 8/4/2012, and reviewed on 3/5/2013, indicated Resident #44 was a high risk for falls related to the following: history of fall with fracture, history of falls, medications, use of wheelchair for mobility, diagnoses of Alzheimer's type dementia, forgets to call for assist at times, and osteoporosis. A current goal listed was for Resident #44 to be free from fall related injuries. Interventions included to meet this goal included, but were not limited to: explain call light and assess resident's ability to use, frequently remind her to call for staff and wait for staff assistance, keep articles of need within reach, toilet her with AM/PM care, after lunch, in the evening as needed, offer to toilet every two hours, and after supper, pressure alarm in bed,, and use of a low bed.</p>						

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	<p>A current care plan originally dated 8/14/2012, and last reviewed/updated on 2/2/12, indicated, Resident #44 had long and short term memory deficits with difficulty making decision. She could not remember after five minutes. She could not state the details of her life information such as the town she had lived in for nearly 50 years. She had poor decision making as evidenced by her lack of safety awareness.</p> <p>Resident #44 was observed on the following dates and times:</p> <p>Resident #44 was observed on 3/5/2013 at 10:00 A.M. She had bruising to most of the right side of her face and sutures to her right forehead.</p> <p>3/12/2013-8:50 A.M., 11:10 A.M., and, 11:20 A.M. sitting in a wheel chair (w/c), in her room. The call light was positioned in the middle of the low bed and was not within reach of Resident #44.</p> <p>On 3/12/2013, from 11:10 A.M. to 1:15 P.M. (during constant observation), staff entered her room twice to provide fluids to her room mate but did not offer to take Resident #44 to the restroom or</p>						

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	<p>ensure the call light was in reach. At 11:49 A.M., staff pushed her down the hall to the dining area. At 11:50 A.M., she was positioned at the dining room table. At 12:34 P.M., Resident #44 was served lunch. From 12:34 p.m. to 1:15 p.m., Resident #44 was observed at the dining room table eating lunch.</p> <p>Review of a Bowel and Bladder assessment dated 3/12/13, indicated Resident #44 was to be on a every two hour toileting schedule.</p> <p>Review of the CNA assignment sheet indicated Resident #44 should be taken to the bathroom every two hours.</p> <p>During an interview on 3/12/2013 at 12:33 P.M., CNA #2 was asked how she knew what care the residents were to be provided. She replied, "Well, I've worked her for a long time but I do move around." She pulled out her assignment sheet and indicated it should be on the assignment sheet and if it wasn't she would ask someone. The CNA assignment sheet failed to reflect Resident #44's current toileting schedule.</p> <p>During an interview on 3/12/2013 at</p>						

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	<p>12:45 P.M., CNA #2 was asked when Resident #44 was last taken to the bathroom. She stated, "I took her after breakfast at 10:00 A.M. I know I am late. She will stay continent most of the time during the day if you take her to the bathroom."</p> <p>2. On 3/5/12 at 10:00 A.M., an ISDH [Indiana State Department of Health] facility self reported incident, dated 10/29/12, included, but was not limited to, "Date of Alleged [incident]: 10/25/12... Brief Description of Incident: Resident [#25] noted by CNA [Certified Nursing Assistant] #23 to have laceration on back of right calf... Type of Injury: Back of right calf laceration 7.5 cm long by 1/2 inches deep (received 15 stitches in ER [emergency room])... Immediate Action Taken: Resident assessed... MD [medical doctor] and family notified... Resident sent to ER for evaluation... Preventive Measures Taken: Monitor stitches for s/s [signs and symptoms] of infection... Remove per orders... Ensure no sharp edges on chair, bed, etc..."</p> <p>On 3/12/13 at 10:29 A.M., Resident #25's record was reviewed. Diagnoses included, but were not</p>						

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	<p>limited to, hypothyroidism, sepsis syndrome, macular degeneration, atrial fibrillation, peripheral vascular disease, hypertension, edema, dementia, constipation, osteoporosis, depression, falls, and anemia.</p> <p>A "Focus Charting" dated 10-9-12 through 10-15-12, included, but was not limited to, "Activities of Daily Living... Transfers: Extensive assistance of 2 or more staff...</p> <p>A "Case Mix ADL Data Collection" dated 10/1/12 through 10/31/12, indicated Resident #25 required extensive assistance with transfers of 2 or more persons.</p> <p>A "Nurse's Notes" dated 10/25/12 at 8:15 P.M., included, but was not limited to, "Called to room by CNA [#23]... had just laid patient [Resident #25] down... noted 7.5 centimeter deep laceration to right lower lateral leg... transferred to ER..."</p> <p>A care plan, dated 10/25/12, included, but was not limited to, "History of skin laceration of unknown etiology... Current laceration right lower leg... Patient [Resident #25] will be free from lacerations... Remind staff to carefully monitor patient during movements/transfers... Monitor skin</p>						

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	<p>every shift..."</p> <p>On 3/12/13 at 11:30 A.M., the DoN [Director of Nursing] provided the facility's investigation of Resident #25's skin laceration. The investigation included, but was not limited to, "Incident Date; 10/25/12... Staff Involved: CNA #23 and Registered Nurse [RN] #24....Brief Description of Incident: CNA [#23] called nurse [RN #24] to room to report laceration on back of right calf... CNA [#23] was putting resident to bed and noted laceration... Patient [Resident #25] was being transferred from wheelchair to bed and laid down by CNA [#23]..."</p> <p>On 3/12/13 at 11:35 A.M., in an interview, the DoN indicated the facility was unable to find any sharp edges on Resident #25's personal care equipment. She indicated physical therapy checked her wheelchair and did not find any abnormalities [sharp edges].</p> <p>On 3/12/13 at 2:30 P.M., in an interview, CNA #23 indicated she was the only staff member transferring Resident #25 at the time of the incident on 10/25/12. CNA #23 indicated as soon as she assisted Resident #25 to a standing position,</p>			

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	<p>Resident #25 said, "My leg, my leg." At that time, CNA #23 indicated she observed a cut on Resident #25's right leg and called for assistance from RN #24. CNA #23 indicated she was not aware that Resident #25 was a 2 person assist with transfers.</p> <p>On 3/12/13 at 2:50 P.M., in an interview, CNA #25 indicated she provided care to Resident #25. She indicated Resident #25 required 2 staff members for all transfers.</p> <p>3. Resident #1 was observed without fall interventions [non-skid socks and call light within reach] on the following days:</p> <p>On 3/7/13 at 1:57 P.M., Resident #1 was observed at the bedside without non-skid socks. At that time, in an interview, CNA #26 indicated Resident #1 does try to ambulate without calling for assistance.</p> <p>On 3/11/13 at 3:00 P.M., Resident #1 was observed laying in bed. Resident #1 was easily awakened. She was observed without non-skid socks.</p> <p>On 3/12/13 at 2:55 P.M., Resident #1 was easily awakened while laying in bed. At that time, her call light was observed hanging on the wall.</p>			

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	<p>Resident #1 indicated she did not know where the call light was and could not find it. Resident #1 was observed without non-skid socks.</p> <p>On 3/11/13 at 2:37 P.M., Resident #1's record was reviewed. Diagnoses included, but were not limited to, hypertension, history of falls, hypothyroidism, osteoarthritis, syncope, and muscle weakness.</p> <p>A "Fall Care Plan Addendum" included, but was not limited to, "7/5/12 at 6:40 P.M.... Found on floor started to sit and chair moved and landed on floor... Chair removed and encouraged resident [Resident #1] to call for assistance... Encouraged to always use walker... 7/28/12 at 9:30 A.M.... Found on floor... trying to reach for closet when lost balance... 8/27/12 at 9:45 P.M.... [Resident #1] Stated was sitting on side of bed and reached for slippers on table and slid to floor... 9/29/12 at 6:45 P.M.... Staff heard resident [Resident #1] calling for help and found sitting on floor between bed and overbed table.... 1.5 cm skin tear to right parietal area and hematoma to same area... [bed at lowest position] 12/5/12 at 3:00 P.M.... Found on floor... slid off bed... 12/9/12 at 10:30 P.M.... Found on bathroom floor</p>			

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	<p>laying on her back, said she was trying to use the bathroom and slipped and fell in urine... Assisted to bed, put on non-skid socks... 1/26/13, no time... Resident [#1] was ambulating out of her room with walker and tipped her walker over sideways falling to the ground... 5 cm skin tear to left elbow... 2/7/13, no time... Found sitting on floor, she stated she was going to br [bathroom] and fell and hit her head... Has a bruise to right parietal area and skin tear to right elbow..."</p> <p>A fall care plan, dated 12/12/12, included, but was not limited to, "At risk for falls r/t [related to] medications, osteoarthritis, history of seizure, history of cerebral vascular accident, syncope, decrease in vision, pain, overall decline in activities of daily living, dementia, and history of falls... Will be free of fall related injury... Continue to encourage to ask for assistance... 7/10/12: Non-skid socks... 12/9/12: Pressure alarm in bed and chair... 8/28/12: Resident to wear non-skid footwear at all times..."</p> <p>4. On 3/8/13 at 11:30 A.M., Resident #33's record was reviewed. Diagnoses included, but were not limited to, atrial fibrillation, hypertension, diverticulosis, diabetes</p>				

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	<p>mellitus, anemia, malnutrition, congestive heart failure, dementia with delusions, depression, insomnia, and constipation.</p> <p>A "Monthly Vital Sign Record" indicated on 12/3/12, Resident #33's blood pressure was 97/62.</p> <p>A "History and Physical/MD Assessment" dated 12/19/12, indicated Resident #33's had a diagnosis of hypertension; however, blood pressure had been low and the plan was to discontinue the medication, Norvasc.</p> <p>A "Physician's Orders" dated 12/22/12, included, but was not limited to, "Discontinue Norvasc [blood pressure medication]..."</p> <p>The "Medication Administration Record [MAR]" dated 1/1/13 through 1/31/13 indicated the medication, Norvasc, had not been given. However, the MAR dated 2/1/13 through 2/28/13 and 3/1/13 through 3/8/13, indicated the discontinued medication, Norvasc had been given.</p> <p>There was no documentation in Resident #33's record of a physician's order to restart Norvasc.</p>			

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	<p>On 3/8/13 at 12:00 P.M., a current medication order [Norvasc] was requested for Resident #33.</p> <p>On 3/8/13 at 1:55 P.M. in an interview, the DoN indicated it was her nurse's [LPN #27] error. The DoN indicated that when LPN #27 didn't find the Norvasc in the medication drawer, she called the pharmacy and re-ordered it without checking for a current order. At that time, the DoN provided a "Medication Error Report" dated 3/8/13. The report included, but was not limited to, "What was physician's order... Norvasc 5 milligrams by mouth daily, was discontinued on 12/22/12... Reason for making error.. Medication was discontinued 12/22/12, not given in January 2013, given in February 2013 when re-write done [sic] incorrectly and sent to pharmacy... Could the error have endangered the life or welfare of the patient... Per the Nurse Practitioner... Blood pressure low and in normal range so discontinued medication... Blood pressure not low enough to endanger [Resident #33]... What precautions can you take to prevent similar error... Re-education of nurse [LPN #27] making error..."</p> <p>3.1-35(g)(2)</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, interview, and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 3 of 5 residents reviewed for accidents (Resident #44, #25, and #1).</p> <p>Findings include:</p> <p>1. Resident #44's record was reviewed on 3/11/2013 at 8:55 A.M. Her diagnoses included, but were not limited to, hypertension, arthritis, debility, Alzheimer's dementia with agitation, hallucinations, insomnia, difficulty with walking, chronic pain, and depression. Resident #44 was a limited assist of one person for bed mobility, an extensive assistance of one person for transfers, and had short and long term memory problems, not being able to recall information after five minutes.</p> <p>A current care plan, originally dated 8/4/2012, and reviewed on 3/5/2013, indicated Resident #44 was a high</p>	F000323	<p>It is the facility policy that the resident environment remains free of accident hazards. All residents have the potential to be affected by this practice. Residents #44 and #1's care plans have been reviewed and updated to reflect individualized interventions. Assignment sheets have been updated to reflect the changes that have been made to the plan of care (including toileting schedules and transfer requirements). Residents #25's care plan has been reviewed and updated to reflect individualized interventions accurately with the assignment sheet updated to reflect he changes. Beginning 3/16/13 and ongoing nursing staff have been educated to the importance of individualized interventions and putting them on the assignment sheets in order to give the staff the knowledge to provide proper care. Assignment sheets are updated daily by the unit managers and monitored by the DON/designee for changes in order or status. Interventions for residents who fall will be monitored by the DON/designee using a fall intervention</p>	04/13/2013			

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	<p>risk for falls related to the following: history of fall with fracture, history of falls, medications, use of wheelchair for mobility, diagnoses of Alzheimer's type dementia, forgets to call for assist at times, and osteoporosis. A current goal listed was for Resident #44 to be free from fall related injuries. Interventions included to meet this goal included, but were not limited to: explain call light and assess resident's ability to use, frequently remind her to call for staff and wait for staff assistance, keep articles of need within reach, toilet her with AM/PM care, after lunch, in the evening as needed, offer to toilet every two hours, and after supper, pressure alarm in bed,, and use of a low bed.</p> <p>A current care plan originally dated 8/14/2012, and last reviewed/updated on 2/2/12, indicated, Resident #44 had long and short term memory deficits with difficulty making decision. She could not remember after five minutes. She could not state the details of her life information such as the town she had lived in for nearly 50 years. She had poor decision making as evidenced by her lack of safety awareness.</p> <p>A nurse's note dated 12/20/12 -10:30</p>		<p>monitoring tool to ensure interventions are in place. The tool will be used daily for 30 days, weekly for 30 days, bi-weekly for 60 days then monthly for 60 days. Non-compliance by residents is documented and care planned. Any concerns will be addressed monthly by the quality assurance committee.</p>		

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	<p>P.M., indicated, "Resident was found sitting on floor in middle of room. Stated she was trying to get to w/c to go to bathroom....Has abrasion on left elbow. Cleansed with NS (normal saline) and bandage applied. Had c/o (complained) of pain while abrasion was being applied. Back is slightly red on right side. Stated, 'I hit my head a little bit.' MD notified. Family is aware. Resident is resting in bed at present time. Will be f/u (follow up) fall with neuros (neurological) for next 72 hours." Documentation was lacking which indicated the facility immediately revised and implemented fall prevention interventions.</p> <p>On 12/21/2013, Resident #44's fall care plan indicated due to the fall on 12/20/2012, an intervention was added to prevent her from sustaining fall related injuries. This intervention was for staff to toilet her with AM/PM care, after lunch, in the evening as needed, offer to toilet every two hours, and after supper.</p> <p>A nurse's note dated 12/28/2013 -1:30 A.M., indicated, "Resident was found on the floor at her bedside by staff. Res (resident) stated, 'I was trying to get up to go to the bathroom.' Res. denies hitting her head and denies pain r/t (related to) fall. She</p>						

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	<p>said, 'I slid out of my bed.' V/S (vitals) -B/P (blood pressure) 152/79, P 87, R 20, Neuros WNL. Res was helped by staff back into bed. Reminded res to use call light when needing help. Call light within reach. MD faxed. Will notify family in A.M. Neuro (neurological) sheet started. Will cont. to observe." The record lacked documentation Resident #44 was taken to the bathroom and did not indicate interventions other than reminding the resident with short/long term memory deficits to use her call light.</p> <p>A nurse's note dated 12/28/2012-9:15 A.M., indicated, the family was notified of the fall and the family suggested using an alarm. The DON was notified of the request. A pressure alarm to the bed to alert staff of unsafe movement and a mat at the bedside were added as interventions to Resident #44's fall care plan to meet the goal of preventing her from having fall-related injuries.</p> <p>A nurse's note dated 12/9/2013-3:00 A.M., indicated, "Found resident laying on floor next to bed wedged between w/c (wheelchair) and bed laying on her right side, (had recently been toileted) when asked what</p>				

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	<p>happened she stated she was trying to get herself out of bed (she has a hx (history) of this behavior). Right shoulder 1 cm (centimeter) X 1 CM, faint blue bruise, zero swelling, ROM (range of motion) WNL (within normal limits), MAE (moves all extremities), PERRL [sic] (Pupils equal and reactive to light). Notified MD (medical doctor), 151/80 (blood pressure), P (pulse) 86, R (respirations) 16, T (temperature) 97.7, O2 (oxygen saturation) 96%, speech clear; reminded to use call light. Moved w/c. Will cont. (continue) to monitor."</p> <p>The record indicated interventions of encouraging the resident to ask for assistance and use the call light were added to the care plan after a fall with injury on 12/9/2012. The record indicated the resident had been assessed to have/short/long term memory deficits. Documentation was lacking which indicated the facility immediately revised and implemented appropriate fall prevention interventions.</p> <p>A nurse's note dated 3/1/2012-11:10 P.M., indicated, "Writer and QMA (Qualified Medication Aide) heard yelling. Went down hallway found res (resident) lying on right side. Res</p>				

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	<p>lifted head noted lg (large) amount of blood on floor. Upon further assessment noted to have laceration upon right eye. Noted bruising to right eye as well. Res c/o right hip pain upon palpation. Applied light pressure to laceration and informed res that we were going to call Dr (doctor) to see if we could send her to E.R. (emergency room) for right hip pain and laceration. Res left on floor. Another nurse called POA (power of attorney (POA named) and informed her of res fall. Stated, 'Send to (hospital named). 911 called at this time."</p> <p>A hospital note, dated 3/3/2013, indicated, Resident #44 was seen in the emergency room for a facial laceration which required seven sutures and a contusion to her right hip from a fall.</p> <p>During a telephone interview on 3/13/2013 at 10:53 A.M., LPN #4 indicated the pressure alarm was not working when Resident #44 fell out of bed on 3/1/2013. "</p> <p>During a telephone interview on 3/13/2013 at 11:11 A.M., LPN #4 indicated, "I don't remember if the bed was in the low position because I was focused on her and the blood on the</p>			

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	<p>floor."</p> <p>During a telephone interview on 3/13/2013 at 1:15 P.M., CNA/QMA #3 indicated, Resident #44 could raise her bed from the low position. She further indicated the bed was not in the low position and the alarm was not working at the time of the fall on 3/1/2013.</p> <p>During an interview on 3/13/2013 at 12:28 P.M., the DON indicated Resident #44 was in a regular bed and had orders to keep the bed in the lowest position. The DON indicated Resident #44 was capable of raising the bed from the low position. She indicated an intervention of a stationary low bed had not been added to the care plan and had not been implemented prior to the fall with injury on 3/1/2013.</p> <p>Resident #44 was observed on the following dates and times:</p> <p>Resident #44 was observed on 3/5/2013 at 10:00 A.M. She had bruising to most of the right side of her face and sutures to her right forehead.</p> <p>3/12/2013-8:50 A.M., 11:10 A.M., and, 11:20 A.M. sitting in a wheel chair</p>			

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	<p>(w/c), in her room. The call light was positioned in the middle of the low bed and was not within reach of Resident #44.</p> <p>On 3/12/2013, from 11:10 A.M. to 1:15 P.M. (during constant observation), staff entered her room twice to provide fluids to her room mate but did not offer to take Resident #44 to the restroom or ensure the call light was in reach. At 11:49 A.M., staff pushed her down the hall to the dining area. At 11:50 A.M., she was positioned at the dining room table. At 12:34 P.M., Resident #44 was served lunch. From 12:34 p.m. to 1:15 p.m., Resident #44 was observed at the dining room table eating lunch.</p> <p>Review of a Bowel and Bladder assessment dated 3/12/13, indicated Resident #44 was to be on a every two hour toileting schedule.</p> <p>Review of the CNA assignment sheet indicated Resident #44 should have been taken to the bathroom every two hours.</p> <p>During an interview on 3/12/2013 at 12:33 P.M., CNA #2 was asked how she knew what care the residents were to be provided. She replied,</p>						

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	<p>"Well, I've worked her for a long time but I do move around." She pulled out her assignment sheet and indicated it should be on the assignment sheet and if it wasn't she would ask someone. The CNA assignment sheet failed to reflect Resident #44's current toileting schedule.</p> <p>During an interview on 3/12/2013 at 12:45 P.M., CNA #2 was asked when Resident #44 was last taken to the bathroom. She stated, "I took her after breakfast at 10:00 A.M. I know I am late. She will stay continent most of the time during the day if you take her to the bathroom."</p> <p>During an interview on 3/13/2013 at 11:38 A.M., the Administrator was asked to provided the facility's current policies related to falls. A policy titled, "Fall Follow-Up" dated 10-13-2004, indicated, "Purpose: To investigate falls in an effort to define the etiology of the fall and to see that appropriate interventions are in place to remove or control the causative factors as much as possible."</p> <p>2. On 3/5/12 at 10:00 A.M., an ISDH [Indiana State Department of Health] facility self reported incident, dated 10/29/12, included, but was not limited to, "Date of Alleged [incident]:</p>						

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	<p>10/25/12... Brief Description of Incident: Resident [#25] noted by CNA [Certified Nursing Assistant] #23 to have laceration on back of right calf... Type of Injury: Back of right calf laceration 7.5 cm long by 1/2 inches deep (received 15 stitches in ER [emergency room])... Immediate Action Taken: Resident assessed... MD [medical doctor] and family notified... Resident sent to ER for evaluation... Preventive Measures Taken: Monitor stitches for s/s [signs and symptoms] of infection... Remove per orders... Ensure no sharp edges on chair, bed, etc..."</p> <p>On 3/12/13 at 10:29 A.M., Resident #25's record was reviewed. Diagnoses included, but were not limited to, hypothyroidism, sepsis syndrome, macular degeneration, atrial fibrillation, peripheral vascular disease, hypertension, edema, dementia, constipation, osteoporosis, depression, falls, and anemia.</p> <p>A "Focus Charting" dated 10-9-12 through 10-15-12, included, but was not limited to, "Activities of Daily Living... Transfers: Extensive assistance of 2 or more staff...</p> <p>A "Case Mix ADL Data Collection" dated 10/1/12 through 10/31/12,</p>			

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	<p>indicated Resident #25 required extensive assistance with transfers of 2 or more persons.</p> <p>A "Nurse's Notes" dated 10/25/12 at 8:15 P.M., included, but was not limited to, "Called to room by CNA [#23]... had just laid patient [Resident #25] down... noted 7.5 centimeter deep laceration to right lower lateral leg... transferred to ER..."</p> <p>A care plan, dated 10/25/12, included, but was not limited to, "History of skin laceration of unknown etiology... Current laceration right lower leg... Patient [Resident #25] will be free from lacerations... Remind staff to carefully monitor patient during movements/transfers... Monitor skin every shift..."</p> <p>On 3/12/13 at 11:30 A.M., the DoN [Director of Nursing] provided the facility's investigation of Resident #25's skin laceration. The investigation included, but was not limited to, "Incident Date; 10/25/12... Staff Involved: CNA #23 and Registered Nurse [RN] #24....Brief Description of Incident: CNA [#23] called nurse [RN #24] to room to report laceration on back of right calf... CNA [#23] was putting resident to bed and noted laceration... Patient</p>						

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	<p>[Resident #25] was being transferred from wheelchair to bed and laid down by CNA [#23]..."</p> <p>On 3/12/13 at 11:35 A.M., in an interview, the DoN indicated the facility was unable to find any sharp edges on Resident #25's personal care equipment. She indicated physical therapy checked her wheelchair and did not find any abnormalities [sharp edges].</p> <p>On 3/12/13 at 2:30 P.M., in an interview, CNA #23 indicated she was the only staff member transferring Resident #25 at the time of the incident on 10/25/12. CNA #23 indicated as soon as she assisted Resident #25 to a standing position, Resident #25 said, "My leg, my leg." At that time, CNA #23 indicated she observed a cut on Resident #25's right leg and called for assistance from RN #24. CNA #23 indicated she was not aware that Resident #25 was a 2 person assist with transfers.</p> <p>On 3/12/13 at 2:50 P.M., in an interview, CNA #25 indicated she provided care to Resident #25. She indicated Resident #25 required 2 staff members for all transfers.</p> <p>3. Resident #1 was observed without</p>						

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	<p>fall interventions [non-skid socks and call light within reach] on the following days:</p> <p>On 3/7/13 at 1:57 P.M., Resident #1 was observed at the bedside without non-skid socks. At that time, in an interview, CNA #26 indicated Resident #1 does try to ambulate without calling for assistance.</p> <p>On 3/11/13 at 3:00 P.M., Resident #1 was observed laying in bed. Resident #1 was easily awakened. She was observed without non-skid socks.</p> <p>On 3/12/13 at 2:55 P.M., Resident #1 was easily awakened while laying in bed. At that time, her call light was observed hanging on the wall. Resident #1 indicated she did not know where the call light was and could not find it. Resident #1 was observed without non-skid socks.</p> <p>On 3/11/13 at 2:37 P.M., Resident #1's record was reviewed. Diagnoses included, but were not limited to, hypertension, history of falls, hypothyroidism, osteoarthritis, syncope, and muscle weakness.</p> <p>A "Fall Care Plan Addendum" included, but was not limited to, "7/5/12 at 6:40 P.M.... Found on floor</p>			

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	<p>started to sit and chair moved and landed on floor... Chair removed and encouraged resident [Resident #1] to call for assistance... Encouraged to always use walker... 7/28/12 at 9:30 A.M.... Found on floor... trying to reach for closet when lost balance... 8/27/12 at 9:45 P.M.... [Resident #1] Stated was sitting on side of bed and reached for slippers on table and slid to floor... 9/29/12 at 6:45 P.M.... Staff heard resident [Resident #1] calling for help and found sitting on floor between bed and overbed table.... 1.5 cm skin tear to right parietal area and hematoma to same area... [bed at lowest position] 12/5/12 at 3:00 P.M.... Found on floor... slid off bed... 12/9/12 at 10:30 P.M.... Found on bathroom floor laying on her back, said she was trying to use the bathroom and slipped and fell in urine... Assisted to bed, put on non-skid socks... 1/26/13, no time... Resident [#1] was ambulating out of her room with walker and tipped her walker over sideways falling to the ground... 5 cm skin tear to left elbow... 2/7/13, no time... Found sitting on floor, she stated she was going to br [bathroom] and fell and hit her head... Has a bruise to right parietal area and skin tear to right elbow..."</p>			

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	<p>A fall care plan, dated 12/12/12, included, but was not limited to, "At risk for falls r/t [related to] medications, oosteroarthritis, history of seizure, history of cerebral vascular accident, syncope, decrease in vision, pain, overall decline in activities of daily living, dementia, and history of falls... Will be free of fall related injury... Continue to encourage to ask for assistance... 7/10/12: Non-skid socks... 12/9/12: Pressure alarm in bed and chair... 8/28/12: Resident to wear non-skid footwear at all times..."</p> <p>3.1-45(a)(1)</p>			

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F000333 SS=D	<p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. Based on record review and interview, the facility failed to ensure a resident's medication regimen was adequately monitored to prevent delivery of a discontinued blood pressure medication to a resident who experienced low blood pressure. This deficient practice affected 1 of 10 residents reviewed for significant medication errors medication use [Resident #33].</p> <p>Findings include:</p> <p>On 3/8/13 at 11:30 A.M., Resident #33's record was reviewed. Diagnoses included, but were not limited to, atrial fibrillation, hypertension, diverticulosis, diabetes mellitus, anemia, malnutrition, congestive heart failure, dementia with delusions, depression, insomnia, and constipation.</p> <p>A "Monthly Vital Sign Record" indicated on 12/3/12, Resident #33's blood pressure was 97/62.</p> <p>A "History and Physical/MD Assessment" dated 12/19/12, indicated Resident #33's had a</p>	F000333	<p>It is the policy of the facility that residents are free of any significant medication errors. All residents have the potential to be affected by this practice. Resident #33 received a medication that had been discontinued. The LPN received disciplinary action and was re-educated to checking re-writes and order transcription accuracy. The resident did not have any harm from the error. Inservicing was started on 3/16/13 for nursing staff and is ongoing re: order transcription and checking of re-writes for accuracy by two nurses. DON/designee will monitor re-writes monthly and daily physician orders for transcription accuracy. Any concerns will be addressed monthly by the quality assurance committee.</p>	04/13/2013	

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	<p>diagnosis of hypertension; however, blood pressure had been low and the plan was to discontinue the medication, Norvasc.</p> <p>A "Physician's Orders" dated 12/22/12, included, but was not limited to, "Discontinue Norvasc [blood pressure medication]..."</p> <p>The "Medication Administration Record [MAR]" dated 1/1/13 through 1/31/13 indicated the medication, Norvasc, had not been given. However, the MAR dated 2/1/13 through 2/28/13 and 3/1/13 through 3/8/13, indicated the discontinued medication, Norvasc had been given.</p> <p>There was no documentation in Resident #33's record of a physician's order to restart Norvasc.</p> <p>On 3/8/13 at 12:00 P.M., a current medication order [Norvasc] was requested for Resident #33.</p> <p>On 3/8/13 at 1:55 P.M. in an interview, the DoN indicated it was her nurse's [LPN #27] error. The DoN indicated that when LPN #27 didn't find the Norvasc in the medication drawer, she called the pharmacy and re-ordered it without checking for a current order. At that time, the DoN</p>			

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	<p>provided a "Medication Error Report" dated 3/8/13. The report included, but was not limited to, "What was physician's order... Norvasc 5 milligrams by mouth daily, was discontinued on 12/22/12... Reason for making error.. Medication was discontinued 12/22/12, not given in January 2013, given in February 2013 when re-write done [sic] incorrectly and sent to pharmacy... Could the error have endangered the life or welfare of the patient... Per the Nurse Practitioner... Blood pressure low and in normal range so discontinued medication... Blood pressure not low enough to endanger [Resident #33]... What precautions can you take to prevent similar error... Re-education of nurse [LPN #27] making error..."</p> <p>3.1-25(b)(9) 3.1-48(c)(2)</p>			

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F000428 SS=D	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on record review and interview, the facility failed to ensure the licensed pharmacist properly reviewed and reported a medication irregularity for a 2 month time frame. This deficient practice affected 1 of 10 residents reviewed for unnecessary medication use [Resident #33].</p> <p>Findings include:</p> <p>On 3/8/13 at 11:30 A.M., Resident #33's record was reviewed. Diagnoses included, but were not limited to, atrial fibrillation, hypertension, diverticulosis, diabetes mellitus, anemia, malnutrition, congestive heart failure, dementia with delusions, depression, insomnia, and constipation.</p> <p>A "Monthly Vital Sign Record" indicated on 12/3/12, Resident #33's blood pressure was 97/62.</p>	F000428	<p>It is the facility policy that the drug regimen of each resident be reviewed at least once a month by a licensed pharmacist. All residents have the potential to be affected by this practice. Resident #33's record has been reviewed by the facility consultant pharmacist. The Pharmacist will continue with monthly medication regimen reviews and will pay special attention to any hand corrected items on the medical record. The pharmacist will check to see that the physician orders are corrected/updated the next month and recommend sending clarification orders to the pharmacy if needed. The DON/designee will also monitor by checking re-writes and daily physician orders for changes. Any concerns will be addressed monthly by the quality assurance committee.</p>	04/13/2013	

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	<p>A "History and Physical/MD Assessment" dated 12/19/12, indicated Resident #33's had a diagnosis of hypertension; however, blood pressure had been low and the plan was to discontinue the medication, Norvasc.</p> <p>A "Physician's Orders" dated 12/22/12, included, but was not limited to, "Discontinue Norvasc [blood pressure medication]..."</p> <p>The "Medication Administration Record [MAR]" dated 1/1/13 through 1/31/13 indicated the medication, Norvasc, had not been given. However, the MAR dated 2/1/13 through 2/28/13 and 3/1/13 through 3/8/13, indicated the discontinued medication, Norvasc had been given.</p> <p>There was no documentation in Resident #33's record of a physician's order to restart Norvasc.</p> <p>A "Pharmacy Medication Regimen Review" included the following dates: 12/11/12, 1/8/13, and 2/21/13. There was no review for the month of March, 2013. There was no documentation on the pharmacy review that Norvasc had been re-ordered for the month of February, 2013.</p>			

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	<p>On 3/8/13 at 12:00 P.M., a current medication order [Norvasc] was requested for Resident #33.</p> <p>On 3/8/13 at 1:55 P.M. in an interview, the DoN indicated it was her nurse's [LPN #27] error. The DoN indicated that when LPN #27 didn't find the Norvasc in the medication drawer, she called the pharmacy and re-ordered it without checking for a current order. At that time, the DoN provided a "Medication Error Report" dated 3/8/13. The report included, but was not limited to, "What was physician's order... Norvasc 5 milligrams by mouth daily, was discontinued on 12/22/12... Reason for making error.. Medication was discontinued 12/22/12, not given in January 2013, given in February 2013 when re-write done [sic] incorrectly and sent to pharmacy... Could the error have endangered the life or welfare of the patient... Per the Nurse Practitioner... Blood pressure low and in normal range so discontinued medication... Blood pressure not low enough to endanger [Resident #33]... What precautions can you take to prevent similar error... Re-education of nurse [LPN #27] making error..."</p> <p>On 3/12/13 at 3:00 P.M., the DoN</p>			

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	<p>provided the pharmacy policies and procedures manual.</p> <p>A "Requirements for Writing Medication Orders and Prescriptions" dated 1/08, included, but was not limited to, "Medication orders for residents shall be written on the Physician's Order Sheet located in the resident's chart..."</p> <p>A "New Medication Ordering" dated 1/08, included, but was not limited to, "When the physician writes a new order or the nurse receives a telephone order, the following procedure should be followed: All new orders should be written..."</p> <p>On 3/12/13 at 3:10 P.M., in an interview, the DoN indicated the pharmacy did not follow policy and procedure and should have requested a written order for Resident #33's medication and the error should have been found and reported on Resident #33's February and March, 2013 physician re-write.</p> <p>3.1-25(h)</p>				

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F000520 SS=E	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on interview and record review, the facility failed to identify staff non-compliance related to failure to implement individual resident interventions to prevent accidents that resulted in injury. In addition, the facility failed to have an adequate system in place to monitor the effectiveness of interventions and further modify interventions to prevent injury of a resident through the quality assurance protocol.</p>	F000520	It is the facility policy that a quality assurance committee meets at least quarterly to review issues and develop and implement appropriate plans of action to correct identified quality issues. All residents have the potential to be affected by this practice. It is the practice of the facility that the quality assurance committee will identify and implement appropriate interventions for deficient practices identified in the facility. All nursing staff have been inserviced on	04/13/2013	

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	<p>Findings include:</p> <p>On 3/14/13 at 11:10 A.M., in an interview, the Administrator indicated the Quality Assessment and Assurance Committee met monthly. She indicated the committee included herself, the Medical Director, the Director of Nursing, and department managers. She indicated the committee did not review accidents or resident falls on a monthly basis. The Administrator indicated injuries related to resident falls or accidents resulting from staff failure to follow a resident's plan of care had not been addressed during previous monthly Quality Assessment and Assurance Committee meetings.</p> <p>In addition, the Administrator indicated the interdisciplinary team [IDT], which included herself, the DoN [Director of Nursing], the Social Worker, and MDS [Minimum Data Set] Coordinator, were notified when a fall or accident had occurred in the facility. She indicated the incident was investigated after notification from the staff involved in the incident. However, the Administrator indicated the facility did not have a policy that identified the role of the interdisciplinary team in fall</p>		<p>implementation of appropriate individualized interventions and monitoring of the interventions to ensure they are in place and are effective. A policy has been put in place to identify the interdisciplinary team's roll in fall management. Medication errors will be reviewed monthly by the quality assurance committee. All licensed nursing staff have been inserviced on the facility policy for having two nurses check rewrites to ensure accuracy and safety of the residents. The interdisciplinary team reviews residents with falls, injuries, medication errors and behaviors on a daily basis to determine the root cause for the event and develop appropriate interventions. The care plan and assignments sheets are updated at the review meeting. Facility fall and injury tracking and the facility fall management policy and procedure and any medication errors will be reviewed monthly by the quality assurance committee for any trends and need for change. Any deficient practice related to falls/injuries/medication errors will have corrective action taken.</p>		

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	<p>management. The Administrator was unable to provide interdisciplinary team documentation for the residents who sustained injury from falls or accidents while in the facility.</p> <p>Further, the Administrator was unable to provide documentation of facility policies and procedures regarding fall management and accident prevention or documentation of a system used by the facility to prevent injury of a resident related to staff failure to implement interventions.</p> <p>3.1-52(b)(2)</p>			