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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155775 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 04/12/2016 |
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| NAME OF PROVIDER OR SUPPLIER CUMBERLAND POINTE HEALTH CAMPUS | STREET ADDRESS, CITY, STATE, ZIP CODE 1051 CUMBERLAND AVE WEST LAFAYETTE, IN 47906 |
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| F 0000 Bldg. 00 | <p>This visit was for the Investigation of Complaint IN00196894.</p> <p>Complaint IN00196894 - Substantiated. Federal/State deficiencies related to the allegations are cited at F323.</p> <p>Survey dates: April 11 & 12, 2016</p> <p>Facility number: 000547 Provider number: 155775 AIM number: 100267440</p> <p>Census bed type: SNF/NF: 38 SNF: 27 Residential: 58 Total: 123</p> <p>Census payor type: Medicare: 9 Medicaid: 19 Other: 37 Total: 65</p> <p>Sample: 6</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p> | F 0000 | <p>Cumberland Pointe Health Campus 1051 Cumberland Avenue West Lafayette, IN 47906 Survey Event ID: BFVV11 The submission of this POC does not indicate an admission by Cumberland Pointe Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Cumberland Pointe Health Campus. This facility recognized it's obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities (for Title 18/19 programs). To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</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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| F 0323 SS=D Bldg. 00 | <p>Quality Review was completed by 21662 on April 13, 2016.</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to provided ordered interventions to prevent falls for 2 of 3 residents reviewed for falls (Residents C and G).</p> <p>Findings include:</p> <p>1. The record of Resident C was reviewed on 04/11/16 at 11:00 a.m. Diagnoses included, but were not limited to, osteoarthritis, osteoporosis, obesity, congestive heart failure, and chronic obstructive pulmonary disease.</p> <p>A Quarterly MDS (Minimum Data Set) Assessment, dated 02/07/2016, indicated Resident C required extensive assistance for transfers and bed mobility.</p> <p>A care plan, dated 02/09/2016, indicated Resident C was at risk for falling related to decreased mobility and not using the call light to call for help.</p> | F 0323 | CORRECTIVE ACTION:1. On 3-30-16 during the morning clinical meeting the 3-29-16 fall event documentation of Resident C was reviewed that included the notes related to the mat not being on the floor and pressure alarm not being plugged in. The Director of Health Services (DHS) initiated an investigation immediately due to the charting indicating the fall interventions were not in place. The Nursing Unit Manager verified on 3-30-16 that the resident's interventions of the alarm and mat were in place and were functioning. The DHS met with the charge nurse working at the time of the fall as well as the CNA who worked the evening shift on 3-29-16. The CNA acknowledged he did not share the resident's refusal of the mat with the charge nurse. The DHS completed counseling and education with the CNA regarding the importance of prompt reporting to the nurse of any fall interventions refused. On 4-01-16 non-skid strips were placed on the carpet under the bedside mat | 05/02/2016 | | | |

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| | <p>A Physician's Order, dated 10/06/2015, indicated to have a mat at bedside, check position every shift.</p> <p>A Physician's Order, dated 10/07/2015, indicated pressure alarm to bed, check function every shift.</p> <p>A Nursing Progress Note, dated 03/30/2016, indicated Resident C was heard to say "oh." Staff found Resident C lying on the floor beside her bed, face down. The pressure alarm was not plugged in and the bedside mat was not in place.</p> <p>During an interview on 04/12/2016 at 1:35 p.m., The Director of Health Services indicated, based on her investigation, the alarm was working when CRCA (Certified Resident Care Assistant) #1 left for the evening. The alarm box was on the floor and somehow came unplugged. She indicated the alarm box should not have been on the floor. She also indicated the bedside mat was refused by the resident, and should have been reported to the nurse.</p> <p>During an interview on 04/12/2016 at 3:35 p.m., Resident C indicated she did not remember the bed alarm going off when she fell. She also indicated she did not want the mat beside the bed at the</p> | | <p>to increase the resident's feeling of safety and she was willing to allow the mat to remain in place.</p> <p>2. On 2-26-16 the Nursing Unit Manager became aware of the resident's fall that day and the dycem not being placed in the wheelchair as indicated in the care plan. On 2-26-16 the Nursing Unit Manager completed in-service education with the nurses working the shift the fall occurred to ensure they checked the placement of his dycem every shift and replaced if missing.</p> <p>IDENTIFY OTHER RESIDENTS:An audit was completed by the Nursing Unit Managers for all HC residents and no other residents were found to have been affected.</p> <p>MEASURES/SYSTEMIC CHANGES:An in-service for all nursing staff was initiated on 3-31-16 to ensure awareness of and proficiency with safety policies and procedures, including fall interventions and proper reporting of any resident refusals of the interventions. Once weekly beginning the week of April 25, 2016 and through May the Nursing Unit Managers will conduct an audit for all HC residents to ensure all fall interventions including alarms, mats, etc. are in place. This audit will be conducted by the Nursing Unit Managers twice weekly in June and then monthly in July, August and September. Any resident found without the proper</p> | | |

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| | <p>time because it felt like it slid when she stepped on it, causing her to feel unsafe. Resident C indicated she had told the aides the reason for not wanting to use it. She indicated she had been refusing the mat for a while, but started using it after her fall because staff fixed the mat to make it feel like it was more secure.</p> <p>During an interview on 04/12/2016 at 3:50 p.m., CRCA #1 indicated Resident C was capable of transferring herself from bed to wheelchair if a wheel chair was in place beside her bed. She often transferred herself in the middle of the night to go to the bathroom. CRCA #1 indicated Resident C did not want the mat next to the bed because she felt like it slid beneath her feet. He indicated the mat had not been in use for approximately a week and he did not notify the nurse of Resident C's refusal, but he should have done so.</p> <p>2. The record of Resident G was reviewed on 04/12/16 at 10:00 a.m. Diagnoses included, but were not limited to, muscle weakness, dementia, and history of falls.</p> <p>A Quarterly MDS Assessment, dated 01/15/2016, indicated Resident G required extensive assistance with bed mobility and transfers.</p> | | <p>fall interventions in place will be immediately corrected and then reported to the DHS or designee for further training and counseling. MONITORING CORRECTIVE ACTIONS: The DHS will receive and review all audit results for the safety audits as well as any corrective actions required. Should any negative trends be noted during the audit cycle the frequency of audits will be increased till compliance is achieved. All audit results will be reported to the QA Committee each month through September.</p> | | |

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| | <p>A care plan, dated 10/17/2015, indicated Resident G had a history of falling related to dementia with poor safety awareness.</p> <p>A Physician's Order, dated 12/28/2015, indicated Dycem to wheel chair seat, check placement every shift.</p> <p>A Fall Circumstance Form, dated 02/26/2016, indicated Resident G slid from his wheelchair in the bathroom while attempting to self transfer. Dycem was not in the wheelchair at the time of the fall.</p> <p>During an interview on 04/12/2016 at 2:40 p.m., the Director of Health Services and Unit Manager #2 indicated the nurse on duty at the time of the fall failed to place the Dycem in the wheelchair. Unit Manager #2 indicated the nurse was the person ultimately responsible for ensuring the intervention was in place.</p> <p>A current policy, titled "Falls Management Program Guidelines," dated June 2015, provided by the Executive Director on 04/11/2016 at 11:00 a.m., indicated..."b. Careplan interventions should be implemented that address the resident's risk factors...."</p> <p>This Federal tag relates to complaint</p> | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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| | IN00196894. 3.1-45(a)(2) | | | | |