

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155662	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/02/2012
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NAME OF PROVIDER OR SUPPLIER NURSING CARE AT HARTSFIELD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DR MUNSTER, IN 46321
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: March 26, 27, 28, 29, 30 and April 2, 2012</p> <p>Facility number: 010758 Provider number: 155662 Aim number: 200229550</p> <p>Survey team: Kathleen (Kitty) Vargas, RN, TC Lara Richards, RN Heather Tuttle, RN</p> <p>Census bed type: SNF: 85 SNF/NF: 16 Total: 101</p> <p>Census payor type: Medicare: 18 Medicaid: 9 Other: 74 Total: 101</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 4/4/12 Cathy Emswiller RN</p>	F0000	Preparation and/or execution of the plan of correction in general, or this corrective actions in particular, does not constitute an admission or agreement of Nursing Care at Hartsfield Village of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal laws.It is the intention of this facility that this plan of correction serves as the facility's credible allegation of compliance with all regulatory guidelines.	

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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F0166 SS=A	<p>483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>Based on record review and interview the facility failed to ensure they followed their Registration and Disposition of Complaints Policy related to documentation of a resolution for missing personal property for 1 of 3 residents reviewed for personal property of the 4 residents who met the criteria for personal property. (Resident #71)</p> <p>Findings include:</p> <p>During an interview with Resident #71 on 3/27/12 at 9:08 a.m., she indicated that she had lost a blouse last month and had reported the incident to the head of laundry services. The resident further indicated the property was still missing and she had not heard anything more about it.</p> <p>The record for Resident #71 was reviewed on 3/27/12 at 2:00 p.m. The resident had been identified in current March 2012 as being alert and oriented to person, place and time.</p> <p>Review of a Concern/Suggestion</p>	F0166	<p>1. Corrections from previous timeframes cannot be made. Resident #71 was not affected by this alleged deficient practice.2.Concern forms for missing personal property were reviewed back to 3-1-12. No other residents were affected by this alleged deficient practice. In all other situations, items were located and returned to the resident.3.Policy for Registration and Disposition of Complaints was reviewed and revised on 3-28-12 to include, a concern form will be initiated after a clothing items is missing for 36 hours. Department managers who finalize concern form were all re-educated on the policy and reminded that they must have a conclusion to each concern within 7 days per policy. Facility resolved Resident #71's concern regarding the missing blouse. Policy was given to each manager on 4-13-12.4.All concern forms will be given to the Administrator following completion. Administrator will review the completed form to assure a resolution of the concern/complaint was done and follow up had been made with the person filing the</p>	04/13/2012

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	<p>Report dated 2/27/12, completed by Resident #71, indicated she was missing a polka dot tan and black blouse. The Housekeeping and Laundry Supervisor as well as the Administrator had signed the report on 2/27/12 indicating they received this information. The action taken and results section indicated "checked in laundry and resident room. Also called (name of outside agency) to see if it was sent there. Will continue to look for it."</p> <p>Review of the current and undated Registration and Disposition of Complaints Policy provided by the Administrator indicated the date the resolution was reported to the person who made the initial complaint or to the resident will be documented on the form by the staff involved. Individual department directors will be responsible for documenting information regarding actions taken and the results, when requested by the Administrator. In the event the complaint is not resolved within seven days, the administrator will meet with the staff responsible for addressing the concern and/or the resident to determine the reason for delay.</p> <p>Interview with The Housekeeping and Laundry Supervisor on 3/28/12 at</p>		<p>concern/complaint. Any department manger not following policy will be re-educated. If patterns are found, the manger will be disciplined up to and including termination of employment per policy. Results of the concern forms will be recorded for compliance and brought to the QA Committee meeting quarterly for review and/or recommendations until compliance is assured.5.Administrator repnsible for compliance.</p>		

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	<p>10:00 a.m., indicated she had completed a Concern/Suggestion form for the resident on 2/27/12. She indicated the resident had told one of her laundry aides and she filled out the concern form and then brought the form to her. She further indicated she did not complete the Concern/Suggestion Report Form with her final resolution and documentation that the resident was notified of the resolution.</p> <p>Interview with the Administrator on 3/28/12 at 11:10 a.m., indicated The Housekeeping and Laundry Supervisor did not follow The Disposition of Complaints Policy regarding follow up and resolution to the resident regarding the missing blouse.</p> <p>3.1-7(a)(2)</p>				

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F0282 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 observation, record review and interview, the facility failed to ensure Physician Orders were followed related to transfers, and care plans were not followed related to monitoring non pressure areas of bruising. This affected 1 of 3 residents reviewed for accidents of the 6 who met the criteria for accidents and for 2 of 3 residents reviewed for non pressure related skin conditions of the 3 who met the criteria for non pressure related skin conditions. (Residents #66, #79 & #100)</p> <p>Findings include:</p> <p>1. On 3/26/2012 at 12:04 p.m., Resident #79 was observed with bruises noted to the right arm and the left arm that were red/purple in color. There was one yellow faded bruise noted to the left arm.</p> <p>On 3/27/12 at 9:30 a.m., Resident #79 was observed with a bruise to the top of her right hand that was red/purple in color and bruises to the</p>	F0282	<p>#1 & 21. Corrections for previous timeframes cannot be made. Residents #79 and #100 were not affected by this alleged deficient practice. On 3-28-12, skin assessments were conducted on both residents #79 and #100 families and physicians were notified of findings. Both residents denied any mistreatment. On 3-29-12 the residents were offered geri sleeves or long sleeve to wear for comfort and/or any added protection for skin. 2. All residents may have been affected by this alleged deficient practice. All residents were assessed head to toe with their weekly shower/skin audit the week of 4-9-12 and no residents were negatively affected by this alleged deficient practice. 3. The policy entitled Resident Rounds will be reviewed with the nurses and aides via in-service training on 4-17-12, 4-26-12 and 4-27-12 and ongoing. During the training we will also review the expectations for following the care plans. Residents will be observed daily for any injuries or bruises and the bruises will be monitored weekly for healing. The C.N.A. assignment sheets indicate to monitor residents skin for bruising</p>	05/02/2012

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	<p>top of her left hand that were red/purple in color.</p> <p>On 3/27/12 at 1:53 p.m., the resident was observed in bed. There were three bruises that were red/purple in color noted to her left arm and the top of her left hand. The resident's right arm and hand were observed covered by the blankets.</p> <p>On 3/28/12 at 8:30 a.m., the resident was observed sitting in a wheelchair eating breakfast. There were bruises observed to both arms and to the top of both hands that were red/purple in color.</p> <p>On 3/28/12 at 11:20 a.m., the resident was observed in bed, with her eyes closed. Both of her arms and hands were observed on the top of the bed linens. The resident had red/purple bruises to both of her arms and hands.</p> <p>The record for Resident #79 was reviewed on 3/28/12 at 9:20 a.m. The resident's diagnoses included, but were not limited to, diabetes, hypothyroidism, stroke, and anemia.</p> <p>Review of orders on the current March 2012 Physician Order Sheet indicated the resident was receiving</p>		<p>or injury and to report any findings to the nurse. A nurse will complete a weekly skin check with showers using a shower skin sheet. If a bruise is identified, the nurse will follow the accident/incident policy and start a weekly bruise monitoring tool entitled Admission/Weekly Bruise Assessment. The bruise will be monitored for healing weekly.4.Unit managers/designee will review the shower skin sheets/bruise monitoring tools 5 times per week to assure compliance with skin assessments and monitoring. The unit manager/designee will also make rounds daily 5 days per week to observe for any new visible bruises. Bruises identified will be communicated to nurses for follow up action. Results will be brought to DON/ADON weekly for review. DON will bring weekly skin report to QA Committee meeting quarterly for review and/or recommendations.5.DON responsible for compliance.#31Corrections for previous timeframes cannot be made for resident #66 following resident accident on 1-3-12. C.N.A. was counselled after interview with resident. Staff member was re-educated via in-service training for transfers on 1-4-12 and again for formal training with therapy on 2-22-12. Resident plan of care was reviewed and 2 person transfer remained appropriate. 2.All</p>	

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	<p>Aspirin 325 mg (milligrams) 1 tablet daily.</p> <p>Review of the current Plan of Care dated 2/24/12, indicated the resident was at risk for complications associated with aspirin therapy. The Nursing approaches were to observe for adverse reactions such as bruising and to observe the skin with each encounter for bruising/skin tear.</p> <p>Review of nursing progress notes dated 3/1-3/22/12 (last documented), indicated there was no evidence of any type of bruising on the resident's arms.</p> <p>Interview with LPN #2 on 3/28/12 at 2:20 p.m., indicated the Certified Nursing Assistant (CNA) had come up to her earlier in the day and informed her the resident had bruises to her arms and to the top of her hands. She further indicated that the she did not receive any information in report regarding the bruises to the arms and hands from the oncoming nurse and/or shift, nor was there any information in the resident's chart regarding the bruising. LPN #2 indicated there was no documentation on the 24 hour report indicating the resident had any bruising to either one of her hands or arms.</p>		<p>residents requiring assistance for transfers may have been affected by this alleged deficient practice, but following interview with several alert and oriented residents, no other residents were affected by not following transfer orders.3.In-service training for nurses and aides will be done on 4-17-12, 4-26-12 and 4-27-12 and on-going regarding following physician orders for transfer status. Each resident's order for transfer status is in print on the C.N.A. assignment sheets, as well as, the nurses report sheet for monitoring. All assignment/report sheets were updated to include transfer status orders. C.N.A. responsible for not following physician ordered transfer is no longer employed by this facility.4.During resident rounds, the nurse will be observing resident transfers and reporting any non-compliance to unit manager/designee for corrective action. The unit manager/designee will observe 5 transfers weekly and report compliance to to DON weekly for review and/or recommendations. Any staff found noncompliant will be counselled up to and including termination of employment. DON will bring a summary of findings to QA committee meetings quarterly for tracking, trending and/or recommendations.5.DON responsible for compliance.</p>		

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	<p>2. On 3/26/2012 at 11:14 a.m., Resident #100 was observed with a bruise to the top of his right hand.</p> <p>On 3/27/12 at 1:51 p.m., the resident was observed sitting in a lazy boy chair recliner in his room. There was a red/purple bruise to the top of his right hand.</p> <p>On 3/28/12 at 8:30 a.m., the resident was observed up in the wheelchair in the main dining room. The resident was noted with a bruise to the top of his right hand.</p> <p>The record for Resident #100 was reviewed on 3/28/12 at 8:54 a.m. The resident's diagnoses included, but were not limited to, coronary artery disease, anemia, and hypothyroidism.</p> <p>A Physician Order dated 3/20/12, indicated the resident was receiving coumadin (a medication that thins the blood) 6 milligrams (mg) on Monday, Wednesday, Friday and Sunday and 5 mg on Tuesday, Thursday, and Saturday.</p> <p>Review of the current plan of care dated 1/22/12, indicated the resident was at risk for complications associated with NSAID (non steroidal</p>						

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	<p>anti-inflammatory drugs) and Anticoagulant (blood thinning) Therapy. The Nursing Interventions were to observe for adverse reactions such as bruising and to observe the skin with each encounter for bruising/skin tears.</p> <p>Nursing progress notes dated 3/20/12-3/27/12, indicated there was no documentation regarding any bruising to the resident's right hand. The last documented nursing progress note was 3/27/12 at 3:00 a.m., and there was no evidence of any type of bruising to the top of the resident's right hand.</p> <p>Interview with LPN #3 on 3/28/12 at 2:17 p.m., indicated she was unaware of the bruising to the top of the resident's right hand. She further indicated that her CNA (Certified Nursing Assistant) had not informed her of any type of bruising to the top of the right hand and that the midnight nurse did not inform her of any type of bruising to his hand.</p> <p>3. The record for Resident #66 was reviewed on 1/27/12 at 1:55 p.m. The resident had diagnoses that included, but were not limited to, history of colon resection, hypothyroidism, and spinal stenosis.</p>						

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	<p>There was a nursing note dated 1/3/12 at 7:45 p.m. that indicated, "CNA (Certified Nursing Assistant) made nurse aware that resident fell in her room. Upon entering the room resident was on her back with head propped up with chair in front of bathroom door. ROM (range of motion) wfl (within functional limits) . . . no visible injuries, states has no new pains . . . When asked what happened stated her leg gave out et (and) she was lowered to the floor. When asked if she was being transferred by 2 or 1 assist, resident states 1 assist . . . MD (physician) notified. Son notified et requested for follow up action d/t (due to) CNA not transferring her properly."</p> <p>The Fall Risk Assessments were reviewed. The Fall Risk Assessment, completed on 12/27/11, indicated the resident's fall risk was a score of 19, a total score greater than 10 represents a "High Risk." The Fall Risk Assessment note dated 12/27/11, indicated, "score of (19) ambulatory with restorative uses a r/w (rolling walker). 2 assists for transfers, seeks assist. hx (history) of falls, 1/4, 6/6, 10/20, 11/2, 11/27 of 2011. High risk, bolster sheet to bed."</p> <p>The Physician Order Sheet dated</p>						

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	<p>January 2012 indicated the resident's Activity level for transfers was,"All transfers: use 2 assists."</p> <p>The investigation for the fall on 1/3/12 was reviewed. It indicated, "Review of the Incident Accident Investigation of unknown origin conclusion of investigation, staff CNA did not follow current nsg (nursing) order for transfer, CNA counseled, res (resident) interviewed and stated she even told the CNA to go get another aide." The investigation was signed by the DON on 1/4/12.</p> <p>Interview with the Director of Nursing (DON) on 3/28/12 at 10:06 a.m., indicated the resident had Physician's Orders to be transferred with 2 staff members and the CNA transferred the resident with only one assist. She indicated the CNA did not follow the physician's orders for transfer assistance.</p> <p>3.1-35(g)(2)</p>			

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F0309 SS=E	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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 observation, record review, and interviews, the facility failed to ensure each resident with non pressure related skin conditions related to bruising were assessed, monitored and documented for 3 of 3 residents reviewed for non pressure related skin conditions of the 3 residents who met the criteria for non pressure related skin conditions. (Resident's #79, #84, & #100)</p> <p>Findings include:</p> <p>1. On 3/26/2012 at 12:04 p.m., Resident #79 was observed with bruises noted to the right arm and the left arm that were red/purple in color. There was one yellow faded bruise noted to the left arm.</p> <p>On 3/27/12 at 9:30 a.m., Resident #79 was observed with a bruise to the top of the right hand that was red/purple in color and bruises to the top of the left hand that were</p>	F0309	<p>1. Corrections for previous timeframes cannot be made. Residents #79, #84 and #100 were not affected by this alleged deficient practice. On 3-28-12 skin assessments were done for residents #79 and #100 and families and physicians were notified. Both residents denied mistreatment. On 3-29-12 a skin assessment was done for residents #84 and physician and family were notified. Resident denied any mistreatment. 2. All residents may have been affected by this deficient practice. All residents were assessed head to toe with their weekly showers the week of 4-9-12 and no residents were negatively affected by this alleged deficient practice. 3. The policy entitled Admission Assessment and Resident Rounds will be reviewed with the nurses on 4-17-12, 4-26-12 and 4-27-12 via in-service training. The expectations for assessments and measurement of bruises upon admission will be reviewed via policy. The tool entitled Admission/Weekly Bruise Assessment will be used to note</p>	05/02/2012			

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	<p>red/purple in color.</p> <p>On 3/27/12 at 1:53 p.m., the resident was observed in bed. There were three bruises that were red/purple in color noted to her left arm and to the top of her left hand. The resident's right arm and hand were observed covered by the blankets.</p> <p>On 3/28/12 at 8:30 a.m., the resident was observed sitting in a wheelchair eating breakfast. There were bruises observed to both arms and to the top of both hands that were red/purple in color.</p> <p>On 3/28/12 at 11:20 a.m., the resident was observed in bed, with her eyes closed. Both of her arms and hands were observed on the top of the bed linens. The resident had red/purple bruises to both of her arms and hands.</p> <p>The record for Resident #79 was reviewed on 3/28/12 at 9:20 a.m. The resident's diagnoses included, but were not limited to, diabetes, hypothyroidism, stroke, and anemia.</p> <p>Review of the Annual Minimum Data Set Assessment (MDS) dated 2/22/12, indicated the resident was alert and oriented and able to make</p>		<p>the baseline assessment for bruises identified upon admission and the nurses will be responsible for weekly monitoring of the healing process. The expectations for daily resident rounds by the nurses will be enforced.4.Unit managers/designee will review the shower skin sheets/bruise monitoring tools 5 times per week to assure compliance with skin assessments and monitoring. The unit manager/designee will also make rounds daily 5 days per week to observe for any new visible bruises. Bruises identified will be communicated to nurses for follow up action. Results will be brought to DON/ADON weekly for review. Results of the weekly skin condition reports will be brought to QA Committee meeting quarterly for tracking, trending and/or recommendations.5.DON responsible for compliance.</p>	

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	<p>decisions. The resident needed extensive assist with bed mobility and transfers with two person assist, she needed extensive assistance with personal hygiene, and was totally dependent on staff for toileting.</p> <p>Review of the current Plan of Care dated 2/24/12, indicated the resident was at risk for complications associated with aspirin therapy. The Nursing approaches were to observe for adverse reactions such as bruising, and to observe the skin with each encounter for bruising/skin tear.</p> <p>Review of nursing progress notes dated 3/1-3/22/12 (last documented), indicated there was no evidence of any type of bruising on the resident's arms.</p> <p>Review of the monthly summary Nursing sheet dated 3/14/12, indicated the resident had no bruises.</p> <p>Review of the shower skin audit sheet dated 3/21/12, indicated the resident had no bruises to either one of her arms or hands.</p> <p>Review of the shower skin audit sheet dated 3/28/12, indicated the resident had a bruise to the right and left arms with no measurements noted.</p>				

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	<p>Review of orders on the current March 2012 Physician Order Sheet, indicated the resident was receiving Aspirin 325 mg (milligrams) 1 tablet daily.</p> <p>On 3/28/12 at 2:45 p.m., LPN #2 measured all of the resident's bruises that were on her arms and hands. The measurements were as follows:</p> <p>left forearm 3 centimeters (cm) by 3 cm purple left top of hand 3 cm by 2 cm purple left top of thumb 2 cm by 2 cm purple left forearm yellow/purple 4 cm by 3 cm</p> <p>top of right hand 3 cm by 3 cm purple top of right hand outer aspect 2 cm by 2 cm purple top of right hand fading light blue 2 cm by 2 cm #1 top of right hand fading 2 cm by 2 cm light blue #2 top of right thumb 3 cm by 3 cm purple</p> <p>Interview with LPN #2 on 3/28/12 at 2:20 p.m., indicated the CNA (Certified Nursing Assistant) had come up to her earlier in the day and informed her the resident had bruises to her arms and to the top of her</p>						

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	<p>hands. She further indicated that the she did not receive any information in report regarding the bruises to the arms and hands from the oncoming nurse and/or shift, nor was there any information in the resident's chart regarding the bruising. LPN #2 indicated there was no documentation on the 24 hour report indicating the resident had any bruising to either one of her hands or arms.</p> <p>2. On 3/26/2012 at 11:14 a.m., Resident #100 was observed with a bruise to the top of his right hand.</p> <p>On 3/27/12 at 1:51 p.m., the resident was observed sitting in a lazy boy chair recliner in his room. There was a red/purple bruise to the top of his right hand.</p> <p>On 3/28/12 at 8:30 a.m., the resident was observed up in a wheelchair in the main dining room. The resident was noted with a bruise to the top of his right hand.</p> <p>The record for Resident #100 was reviewed on 3/28/12 at 8:54 a.m. The resident's diagnoses included, but were not limited to, coronary artery disease, anemia, and hypothyroidism.</p>			

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	<p>A Physician Order dated 3/20/12, indicated the resident was receiving coumadin (a medication that thins the blood) 6 milligrams (mg) on Monday, Wednesday, Friday and Sunday and 5 mg on Tuesday, Thursday, and Saturday.</p> <p>Review of the admission Minimum Data Set (MDS) assessment dated 1/22/12, indicated the resident was understood and understands, with a BIMS score of 14, indicating the resident was alert and oriented. The resident required extensive assist with bed mobility, transfers, dressing and personal hygiene.</p> <p>Review of the current plan of care dated 1/22/12 indicated the resident was at risk for complications associated with NSAID (non steroidal anti-inflammatory drugs and Anticoagulant (blood thinning) Therapy. The Nursing Interventions were to observe for adverse reactions such as bruising and to observe the skin with each encounter for bruising/skin tears.</p> <p>Review of the shower skin audit sheet dated 3/20/12, indicated the resident's skin was intact and there were no areas of bruising noted.</p>			

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	<p>Nursing progress notes dated 3/20/12-3/27/12, indicated there was no documentation regarding any bruising to the resident's right hand. The last documented nursing progress note was 3/27/12 at 3:00 a.m., and there was no evidence of any type of bruising to the top of the resident's right hand.</p> <p>Interview with LPN #3 on 3/28/12 at 2:17 p.m., indicated she was unaware of the bruising to the top of the resident's right hand. She further indicated that her CNA had not informed her of any type of bruising to the top of the right hand and that the midnight nurse did not inform her of any type of bruising to his hand. The LPN indicated the normal procedure when finding a bruise was to assess the bruise and document in the nursing progress notes the size and the location of the bruise. LPN #3 then measured the bruise in which it measured 2 cm by 1.8 cm.</p> <p>Interview with The Staff Development Director on 3/28/12 at 2:41 p.m., indicated nursing staff were to document in the nurses notes the size and location of the bruises and fill out an incident report, they would be monitored on a daily basis. She indicated that the resident's family</p>			

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	<p>and Physician would have to be notified.</p> <p>Interview with The Unit Manager on the first floor on 3/28/12 at 2:35 p.m., indicated the nurses were required to measure bruises when they first see them, and then they would call the resident's doctor and family member. She further indicated if the bruise was a reportable then they would monitor the bruise more closely.</p> <p>3. Resident #84 was observed on 3/27/12 at 1:49 p.m., the resident was seated in a wheelchair. She had a short sleeved shirt on. There were bruises noted to her right and left arms. On the right arm there was a bruise noted on the inner elbow area, the forearm and near the wrist on the forearm. On the left arm there two bruises near the inner elbow area, a bruise near the thumb and on the forearm.</p> <p>Interview with the resident on 3/28/12 at 1:15 p.m., indicated she did not know how she got the bruises on her arms.</p> <p>The record for Resident #84 was reviewed on 3/29/12 at 9:55 a.m. The resident had diagnoses that included,</p>			

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	<p>but were not limited to pulmonary edema, congestive heart failure and hypertension.</p> <p>The form titled "Nurse Admission/Assessment Record" dated 2/28/12, indicated the resident had bruising on her right upper arm near the axilla, on the inner elbow area, on the forearm and on the back of her hand. There was also bruising on the left arm on the inner elbow area, the forearm and on the back of her hand. There were no measurements of any of the bruises on the assessment form.</p> <p>Review of the nursing progress notes dated 2/28/12 through 3/18/12 indicated there was no evidence the bruises were measured and assessed.</p> <p>The resident was discharged to the hospital on 3/18/12 and then readmitted to the facility on 3/22/12. The "Nurse Admission/Assessment Record" dated 3/22/12, indicated there were bruises on resident's right arm in the inner elbow area and on the forearm. It also indicated there was a bruise on the resident's left arm near the wrist. There were no measurements of the bruises noted on the admission record.</p>				

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	<p>Review of the nursing progress notes dated 3/22/12 through 3/25/12 indicated there was no evidence of measurements and/or assessments of the resident's bruises.</p> <p>The nurse's note dated 3/26/12 at 10:20 a.m., indicated, "bruise remains to left hand by thumb et (and) top of hand, purple in color. . .States she got in hospital from IV (intravenous)." There was no measurement of the bruise and there were no other entries in the nursing progress notes related to the other bruises noted on the resident's arms.</p> <p>Review of the form titled, "Shower Day Skin Audit" dated 3/26/12, indicated the resident had scattered bruises from hospital stay and PICC (peripheral intravenous central catheter) line and IV. There were x's marked on the right and left inner elbow areas of the form. There were no measurements of the bruises on the form.</p> <p>The resident was observed on 3/29/12 at 1:34 p.m. with LPN #1. LPN #1 indicated the resident had bruises on her right arm and measured the bruises. The bruise noted on the inner elbow area was</p>						

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	<p>1.5 cm (centimeters) by 4.6 cm in size and was purple in color. The bruise on the resident's right forearm was 3.8 cm x 4.4 cm in size and was blue/purple. The bruise on the outside of the resident's right forearm was red in color and was 6.8 cm x 5 cm in size.</p> <p>The resident was observed to have bruises on her left arm. LPN #1 measured the bruise on the inner elbow area. It was 1 cm x 5 cm in size and red in color. Another bruise near the inner elbow area was 2.2 cm x 4.4 cm in size and was red in color. The outer forearm had a bruise 3.2 cm x 3.5 cm in size and purple in color. There was a bruise on the left hand near the thumb that was 3.4 cm x 4 cm in size and dark purple in color.</p> <p>Interview with LPN #1 at that time, indicated there was no evidence of an assessment or of a measurement of any of the bruises noted on the resident's left and right arms. He indicated there should have been measurements of the bruises when they were first noted.</p> <p>Interview with LPN #1 on 3/29/12 at 9:49 a.m., indicated that when a bruise was noted, it was to be assessed and measured. It was then</p>						

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	<p>to be monitored for 24 hour follow up charting.</p> <p>Interview with the Director of Nursing on 3/29/12 at 9:50 a.m., indicated that bruises were to be assessed and measured when first noted.</p> <p>3.1-37(a)</p>				

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F0323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, record review and interview, the facility failed to ensure the residents were transferred with the proper amount of staff assistance to prevent falls. This affected 1 of 3 residents reviewed for accidents of the 6 residents who met the criteria for accidents. (Resident #66)</p> <p>Findings include:</p> <p>Resident #66 was observed on 3/28/12 at 10:30 a.m. Certified Nursing Assistant (CNA) #1 and CNA #2 transferred the resident from her recliner chair to the wheelchair. The CNAs used a mechanical lift to transfer the resident.</p> <p>The record for Resident #66 was reviewed on 1/27/12 at 1:55 p.m. The resident had diagnoses that included, but were not limited to, history of colon resection, hypothyroidism, and spinal stenosis.</p> <p>There was a nursing note dated</p>	F0323	<p>1Corrections for previous timeframes cannot be made. Resident #66 remains in the facility following resident accident on 1-3-12. C.N.A. was counselled after interview with resident. Staff was re-educated via in-service training for transfers on 1-4-12 and again for formal training with therapy on 2-22-12. Resident plan of care was reviewed and 2 person transfer remained appropriate. 2.All residents requiring assistance with transfers may have been affected by this alleged deficient practice, but following interview with several alert and oriented residents, no other residents had concern regarding consistent transfers as ordered by the physician.3.In-service training for nurses and aides will be done on 4-17-12, 4-26-12 and 4-27-12 and on-going regarding following physician orders for transfer status. Each resident's orders for transfer status is in print on the C.N.A. assignment sheets, as well as, the nurses report sheet for monitoring compliance during resident rounds. Nursing staff have been reminded the facility expectation to utilize the tools that</p>	05/02/2012

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	<p>1/3/12 at 7:45 p.m. that indicated, "CNA made nurse aware that resident fell in her room. Upon entering the room resident was on her back with head propped up with chair in front of bathroom door. ROM (range of motion) wfl (within functional limits) . . . no visible injuries, states has no new pains . . . When asked what happened stated her leg gave out et (and) she was lowered to the floor. When asked if she was being transferred by 2 or 1 assist, resident states 1 assist . . . MD (physician) notified. Son notified et requested for follow up action d/t (due to) CNA not transferring her properly."</p> <p>The Fall Risk Assessments were reviewed. The Fall Risk Assessment, completed on 12/27/11 indicated the resident's fall risk was a score of 19, a total score greater than 10 represents a "High Risk." The Fall Risk Assessment note dated 12/27/11, indicated, "score of (19) ambulatory with restorative uses a r/w (rolling walker). 2 assists for transfers, seeks assist. hx (history) of falls, 1/4, 6/6, 10/20, 11/2, 11/27 of 2011. High risk, bolster sheet to bed."</p> <p>The Physician Order Sheet dated January 2012 indicated the resident's Activity level for transfers was,"All</p>		<p>are already in place to communication physician order transfer status. All assignment/report sheets are up to date and include transfer status orders. C.N.A. responsible for not following physician ordered transfer is no longer employed by this facility.4.During resident rounds, the nurse will be observing resident transfers and reporting any non-compliance to unit manager/designee for corrective action. The unit manager/designee will observe 5 transfers weekly and report compliance to to DON weekly for review. Any staff found noncompliant will be counselled up to and including termination of employment. DON will bring a summary of findings to QA Committee meetings quarterly for tracking, trending and/or recommendations.5.DON responsible for compliance.</p>				

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	<p>transfers: use 2 assists."</p> <p>The Quarterly Minimum Data Set (MDS) completed on 3/21/12, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15. A score of 13-15 indicated the resident was cognitively intact. It also indicated the resident required extensive assistance of 2 staff members for transfers, and she was not steady when moving from a seated position, and was only able to stabilize with human assistance. She also had 2 or more falls since the prior assessment.</p> <p>The investigation for the fall on 1/3/12 was reviewed. It indicated, "Review of the Incident Accident Investigation of unknown origin conclusion of investigation, "staff CNA did not follow current nsg (nursing) order for transfer, CNA counseled, res (resident) interviewed and stated she even told the CNA to go get another aide." The investigation was signed by the DON on 1/4/12.</p> <p>Review of the Progressive Discipline form dated 1/4/12, provided by the DON on 3/28/12 at 11:00 a.m., indicated the date of the incident was 1/3/12, and the summary of the incident, "CNA (CNA's name)</p>			

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	<p>transferred resident without the required assistance of another staff member (violation of transfer status) further violation will result in progressive disciplinary action leading to and including termination."</p> <p>Interview with the Director of Nursing (DON) on 3/28/12 at 10:06 a.m., indicated the CNA that transferred the resident on 1/3/12 was no longer employed by the facility. She indicated the resident was to be transferred with 2 staff members and the CNA transferred the resident with only one assist. She indicated the CNA was educated after the incident.</p> <p>3.1-45(a)(1)</p>			

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NAME OF PROVIDER OR SUPPLIER NURSING CARE AT HARTSFIELD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DR MUNSTER, IN 46321
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0329 SS=D	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure 1 of 10 residents who were reviewed for unnecessary medications had adequate indications for the use of an as needed (prn) anti-anxiety medication. (Resident #17)</p> <p>Findings include:</p> <p>The record for Resident #17 was reviewed on 3/27/12 at 2:47 p.m. The resident's diagnoses included, but</p>	F0329	<p>1. Correction for previous timeframes cannot be made. Residents #17 was not affected by this alleged deficient practice and remains in the facility without injury. Resident does have a diagnosis of anxiety as an indication for the use of ativan. Resident was removed from the stimulating dining room environment on 3-3-12 as a non-pharmalogical intervention to reduce anxiety, prior to receiving the anti-anxiety medication. 2.All residents with orders for PRN anti-anxiety medications have the</p>	05/02/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155662	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/02/2012
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	<p>were not limited to, dementia and dementia with psychosis.</p> <p>Review of the March 2012 Physician's Order Summary (POS), indicated the resident was to receive Ativan (an anti-anxiety medication) 0.5 milligrams (mg) three times a day as needed for anxiety.</p> <p>An entry in the nursing progress notes dated 3/3/12 at 8:20 p.m., indicated the resident received Ativan at 6:00 p.m. due to having hallucinations/delusions, and being verbally aggressive with his spouse and staff. Documentation indicated the resident had to be removed from the dining room. There was no documentation to indicate what interventions were attempted prior to giving the medication.</p> <p>Review of the March 2012 Medication Administration Record (MAR), indicated the medication was not signed out as being given on 3/3/12 at 6:00 p.m. Further, a "Prn Psychoactive Med Intervention" Sheet had not been completed.</p> <p>The 3/12 MAR, indicated the resident received the prn Ativan on 3/27/12 at 2:00 p.m., due to increased crying and agitation. There was no entry in</p>		<p>potential to be affected by this alleged deficient practice. Residents with the potential to be affected will be identified through a review of physician orders.3.Re-education of the nurse will be conducted following her return from FMLA. Nursing staff nurses will be re-educated through in-service training on facility policy and regulation regarding unnecessary drugs and medication administration on 4-17-12, 4-26-12 and 4-27-12 and on-going. The facility form entitled PRN Psychoactive Medication Intervention was reviewed and remains appropriate for use according to policy. Blank copies of this tool have been placed in the MAR as a reminder to the nurses for non-pharmalogical intervention options prior to administering PRN psychoactive medications.</p> <p>4.Unit manager/designee will monitor the Medication Administration Records weekly for 6 months for compliance with the use of non-pharmalogical interventions. The results will be brought by the DON to the QA Committee meeting quarterly from tracking, trending and recommendations.5.DON responsible for compliance.</p>		

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	<p>the nursing progress notes on 3/27/12 at 2:00 p.m. describing the behavior. Further, a "Prn Psychoactive Med Intervention" Sheet had not been completed.</p> <p>Interview with LPN #4 on 3/30/12 at 1:40 p.m., indicated when a resident received a prn psychoactive medication, interventions should be attempted prior to giving the medication, documentation should be completed on the MAR and the prn psychoactive med intervention sheet should also be completed.</p> <p>Interview with the Assistant Director of Nursing on 4/2/12 at 10:00 a.m., indicated an intervention sheet should have been completed prior to giving the Ativan on 3/3 and 3/27/12 as well as the behaviors being documented on 3/27/12.</p> <p>3.1-48(a)(4)</p>				