

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155363	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/23/2014
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NAME OF PROVIDER OR SUPPLIER PROFESSIONAL CARE REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 404 W WILLOW RD DALE, IN 47523
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: September, 17, 18, 19, 22, 23, 2014</p> <p>Facility number: 000254 Provider number: 155363 AIM number: 100266270</p> <p>Survey team: Sylvia Scales, RN TC Terri Walters, RN (9/17, 9/18, 9/22, 9/23) Amy Wininger, RN (9/17, 9/18, 9/19, 9/23) Dorothy Watts, RN</p> <p>Census bed type: SNF/NF: 39 Total: 39</p> <p>Census payor type: Medicare: 2 Medicaid: 33 Other: 4 Total: 39</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. -3.1</p>	F000000	<p>F000</p> <p>This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal law.</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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F000225 SS=D	<p>Quality review completed on October 1, 2014 by Jodi Meyer, RN</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of</p>			

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	<p>the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview, and record review, the facility failed to report an allegation of sexual abuse in a timely manner, in that, an allegation of sexual abuse was reported the following day to the state board of health for 1 of 3 allegations of abuse reviewed. (Resident # 36)</p> <p>Findings Include:</p> <p>1. On 9/22/14 at 3:27 P.M., the facility provided the investigation into the allegation of sexual abuse of Resident #36. It included an untimed witness statement dated 11/7/13. The witness statement included "...when I came around the corner I seen (sic) (name Resident #36) against the wall, (name Resident #31) standing in front of her, with his hands down (name Resident # 36)'s pants.... (Resident #36 name) asked me to take her to her room so I took her hand and led her that way with (Resident #31 name) following..."</p> <p>Another witness statement dated 11/7/13 at 7:30 P.M., included, "...(name of CNA) was motioning me to come down and she told me that she had seen (name Resident #31)'s hands down (name Resident #36)'s pants. I reported it to</p>	F000225	<p>F225</p> <p>It is the policy of this facility that all allegations that meet the definition of abuse and substantiated violations will be reported to State agencies "Immediately" meaning as soon as possible but not to exceed 24 hours after discovery of an incident, in the absence of a shorter time-frame requirement. In regards to the allegation of sexual abuse to Resident #36 by Resident #31 on 11/7/2013 an initial report was sent into the Indiana State Department of Health by the previous Administrator dated 11/8/2013.</p> <p>Other reportable incidents reviewed revealed no deficiency in timely reporting. Facility residents have the potential to be affected by the timeliness of reportable incidents. In order to enhance currently compliant operations, staff will be re-educated on the need to immediately report abuse allegations following their occurrence to the Administrator and re-educated on the reportable incident time-frame requirement in order to ensure the alleged deficient practice does not occur. Identified non-compliance will result in 1:1 re-education with repeat non-compliance resulting in progressive disciplinary process per policy. A Quality Assurance program was implemented under the</p>	10/22/2014

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	<p>(name of nurse).</p> <p>2. On 9/22/14 at 3:27 P.M., the facility provided an untimed, Indiana State Department of Health, Health Care Quality and Regulatory Commission "Incident Report Form" Initial report dated 11/8/13, was reviewed. It included, "Incident Date: 11/7/13 Incident time: 7:30 p.m."</p> <p>3. An untitled policy dated April 2013 was provided on 9/22/14 at 4:14 P.M., it included on page 1.1.7 Section A. "2. Report the incident immediately to the Administrator and DON/designee, who will immediately report any allegations of mistreatment, neglect, abuse, including injuries of unknown source, and misappropriation of resident property to applicable state and other agencies." "a. 'Immediately' means as soon as possible, but not to exceed 24 hours after discovery of incident, in the absence of a shorter state time frame requirement."</p> <p>4. During an interview on 9/23/14 at 10:24 A.M., The Health Facility Administrator indicated, the incident on 11/7/13 had occurred prior to her coming to the facility. She indicated any allegation of abuse is to be reported immediately to the Administrator and it was the responsibility of the</p>		<p>supervision of the Facility Administrator to monitor and verify timeliness of reportable abuse allegations. Audits will be completed on reportable incidents weekly for 4 weeks then 2x/month for one month then monthly. Audit findings will be reviewed by the Quality Assurance Team monthly upon completion for review and recommendations. These systemic changes will be completed 10/22/2014.</p>				

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F000226 SS=D	<p>Administrator to come to the facility and report the incident immediately. She indicated, at that time, she was unable to provide a statement showing what time the initial report was sent.</p> <p>3.1-28 (c)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview, and record review, the facility failed to ensure a complete and thorough investigation was completed and/or documented for an allegation of sexual abuse, in that, the facility documentation was lacking evidence that a follow up investigation and/or resident interviews had been conducted for 1 of 3 allegations reviewed. (Resident #36)</p> <p>1. On 9/22/14 at 3:27 P.M., the facility provided the investigation into the allegation of sexual abuse of Resident #36. It included an untimed witness statement dated 11/7/13. The witness statement included "...when I came around the corner I seen (name Resident #36) against the wall, (name Resident #31) standing in front of her, with his</p>	F000226	<p>F226</p> <p>It is the policy of this facility that allegations of abuse will be reviewed and investigated. In reference to the allegation of sexual abuse to Resident #36 by Resident #31 on 11/7/2013; Additional reportable incidents reviewed revealed documented individual resident interviews. The follow-up report submitted to ISDH for the incident was dated 11/12/13 and indicated that "other residents on the hall were interviewed and no other incidents were reported". All facility residents have the potential to be affected by the investigation procedures following abuse allegations. In order to enhance currently compliant operations, staff will be re-educated on the reporting of abuse allegations to the Administrator immediately as well as</p>	10/22/2014

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	<p>hands down (name Resident #36)'s pants.... (Resident #36 name) asked me to take her to her room so I took her hand and led her that way with (Resident #31 name) following..."</p> <p>Another witness statement dated 11/7/13 at 7:30 P.M., included, "...(name of CNA) was motioning me to come down and she told me that she had seen (name Resident #31)'s hands down (name Resident #36)'s pants. I reported it to (name of nurse)."</p> <p>2. On 9/22/14 at 3:27 P.M., the facility provided the investigative documentation for an allegation of sexual abuse that had occurred 11/7/14. The documentation included, an untimed, initial incident report dated 11/8/13. It included "CNA (certified nursing assistant) reports that she found resident (name) in the hallway near the back door and Resident (name) had his hands 'down her pants.' Residents were immediately separated. "</p> <p>A follow-up report dated 11/12/13. It included, " ...Other residents on the hall were interviewed and no other incidents were reported..."</p> <p>Two staff witness statements dated 11/7/13. No documentation provided of any resident interviews.</p>		<p>on the reportable incident investigation procedure in order to ensure the alleged deficient practice does not occur. Identified non-compliance will result in 1:1 re-education with repeat non-compliance resulting in progressive disciplinary process per policy. A Quality Assurance program was implemented under the supervision of the Facility Administrator to monitor and verify investigation documentation on reportable abuse allegations. Audits will be completed on reportable incidents weekly for 4 weeks then 2x/month for one month then monthly. Audit findings will be reviewed by the Quality Assurance Team monthly upon completion for review and recommendations. These systemic changes will be completed 10/22/2014.</p>				

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F000314 SS=G	<p>3. During an interview on 9/23/14 at 10:24 A.M., The Health Facility Administrator(HFA) indicated, the incident on 11/8/14 had occurred prior to her coming to the facility. She further indicated it was the expectation of the company that all allegation of abuse are to be reported immediately to the HFA, and it was then the responsibility of the HFA to come to the facility and report the incident immediately and start an investigation. She further indicated that during the investigation all interviewable residents would be interviewed, and those interviews were to be documented. The HFA indicated documentation that resident interviews were conducted was lacking.</p> <p>4. An untitled policy dated April 2013, was provided on 9/22/14 at 4:14 P.M. It included on page 1.1.6 Section A, " Investigation...3. Complete investigation summaries and final outcome questions. a. Attach supplemental documentation." 3.1-28(a)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without</p>			

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	<p>pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview, and record review, the facility failed to ensure effective interventions were provided for a dependent resident, in that, a resident admitted without a pressure ulcer later developed a pressure ulcer for 1 of 1 resident who met the criteria for review of pressure ulcers. This practice of failed interventions resulted in Resident #23 experiencing a deep tissue injury wound that progressed to a stage 3 pressure ulcer. (Resident #23)</p> <p>Findings include:</p> <p>During an observation on 09/22/14 at 12:13 P.M., Resident #23 was in the dining room sitting in her wheelchair with her left foot elevated.</p> <p>The clinical record of Resident #23 was reviewed on 09/19/14 at 2:15 P.M. The record indicated the diagnoses of Resident #23 included, but were not limited to, fracture of left hip on 1/6/14, depression, diabetes mellitus, dementia.</p>	F000314	<p>F314It is the policy of this facility that the Braden Risk Assessment and Skin Integrity Assessment: Prevention and Treatment Care Plan be utilized. All residents are assessed on admission and weekly for four weeks then quarterly, and with a significant change of condition utilizing these same assessment tools. It is also the policy of this facility that when risk level is identified, appropriate interventions be put into place in order to decrease risk. Resident #23 has been reassessed and has appropriate interventions in place to minimize risk of alteration in skin integrity. Care plan updated to reflect current status. A review of the C.N.A. assignment sheet was performed to verify that all measures are appropriately communicated to the C.N.A.'s A facility wide audit was performed to identify any residents who are at increased risk for skin breakdown. No new previously unidentified residents were noted at this time. In order to enhance currently compliant operations, all nurses and C.N.A.'s will be re-educated on prevention of pressure ulcers. A Quality Assurance program was</p>	10/22/2014

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	<p>The Admission Assessment for Resident #23 dated 01/10/14 (Returned from hospital after L hip fracture) read as follows, "...Psychiatric:...some memory loss...SKIN: some edema..." Documentation as to the location of the edema was lacking.</p> <p>The Physician's Order dated 1/10/14 read as follows: "...pressure reduction boots and assess skin under the boot, and skin to joint above and below the boot every shift...mechanical lift for transfers"</p> <p>The Admission MDS (Minimum Data Set) assessment dated 02/09/14 indicated Resident #23 experienced cognitive impairment, required the extensive assistance of two plus staff for bed mobility (how resident moves to and from lying position, turn side to side, and position body while in bed or alternate sleep furniture), was at risk for the development of pressure ulcers, and had no pressure ulcers upon readmission from the hospital.</p> <p>A Braden Risk Assessment dated 01/16/14 indicated Resident #23 "...Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently..." and was a moderate risk</p>		<p>implemented under the supervision of the DON to monitor and verify the facility skin breakdown interventions and utilization of the yellow dot program. The charge nurse on each hall will perform a skin sweep weekly. The charge nurses will perform a review of turning and repositioning every shift for two weeks then very shift twice for two weeks then randomly as defined by the DON or designee. Random rounds will be performed by the DON or designee five times a week for two weeks then twice a week for two weeks then weekly to monitor the turning and repositioning of residents on the yellow dot program. Progress will be reported at the monthly QAPI meeting.</p>	

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	<p>for the development of pressure areas.</p> <p>A Resident Lifting, Transferring and Repositioning Data Collection Form dated 1/9/14, read as follows, "...1. Resident's level of assistance:...Total Dependence...4. Resident's level of cooperation: Unpredictable or varies...resident whose behavior changes frequently should be considered "unpredictable", not cooperative or unable to follow simple commands...7...b. Repositioning...2 (staff) or 3 (staff) for repositioning in bed.</p> <p>A Skin Grid-Pressure report provided by the DON (Director of Nursing) on 09/22/14 at 2:40 P.M., included, but was not limited to, an entry dated 02/11/14 which indicated, "...Deep tissue... (suspected) DEEP TISSUE INJURY Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear)...1.8 X 1.2 X 0.1 cm (centimeters)...color B (black - [escar])..."</p> <p>A Skin Grid-Pressure report provided by the DON (Director of Nursing) on 09/22/14 at 2:40 P.M., read as follows, "...STAGING DESCRIPTIONS...UNSTAGEABLE</p>			

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	<p>Full thickness loss in which the base of the ulcer is covered by ...eschar (tan, brown, black) in the wound bed..."</p> <p>Physician's Orders from (hospital name) Wound Clinic dated 4/25/14 at 1400 (2:00 P.M.) read as follows, "...Stage 3 Pressure Ulcer to L (left) distal Achilles complicated by diabetes, HTN (hypertension, hx (history of COPD (chronic obstructive pulmonary disease) and lyphedema..."</p> <p>A Progress Note dated 2/11/2014 07:10 A.M., indicated "...Resident abed (in bed) without pressure relief boots in place...Pressure area 1.8 x (by) 1.2 x 0.1 cm (centimeters) to lt (left) Achilles Cleansed with wound cleaner et (and) skin prep applied...Provider Orders: Cleanse with wound cleaner et (and) apply skin prep bid x 2 weeks et reeval. (reevaluate)...Date Notified: 2/11/14...Time Notified: 09:25 AM...Nurses Notes: Additional Comments Resident instructed to leave boots in place while abed (in bed)..."</p> <p>A Nurse's Note dated 2/11/14 at 1:45 P.M. indicated, "...Total depend (dependent) with transfers...New area found on L (left) Achilles...N.O. (new orders) DC (discontinue) Teds (compression stockings). Apply skin prep</p>			

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	<p>BID x (times) 14 d (days) et (and) eval. 2 asst (assistance) with ADL's (activities of daily living)..."</p> <p>A Physician's Order dated 3/28/14 "...May be seen @ (at) Wound Clinic eval (evaluation) et (and) tx (treatment) L (left) ankle..."</p> <p>Care Plan Skin integrity Assessment: dated 1/10/14 read as follows "prevention and treatment plan of care ...moderate risk (13-14) ...protect heels...goal Will remain free of open areas...care plan dated 2/11/14 protect elbows and heels as needed. 10/9/13"</p> <p>A Physical Therapy Note dated 2/12/14 read as follows. "Education with staff about importance of donning foam boots when pt (patient) is in bed to avoid further skin breakdown on heel."</p> <p>During an interview on 9/22/14 at 4:15 P.M., Occupational Therapy Assistant #5 indicated a physical therapist would educate staff if they noticed a resident was not wearing protective boots or if a staff member made a referral indicating the resident was not wearing their foam boot.</p> <p>During an interview on 9/23/14 at 10:10 A.M., the Director of Nursing (DON)</p>						

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F000323 SS=G	<p>indicated Resident #23 was at risk of developing a pressure ulcer upon returning from the hospital. The DON further indicated Resident #23 found the foam boots uncomfortable and would remove them herself. The DON indicated Resident #23 would reach down and loosen the straps and remove her right boot, then use her right foot to push down on the left boot until it was off her foot. The DON indicated she had educated Resident #23 about keeping the boots on. No new interventions were added to the care of Resident #23 when the staff were made aware the resident was removing her own protective boots</p> <p>3.1-40(a)(1)</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.</p> <p>A. Based on observation, interview, and record review, the facility failed to ensure services were provided to prevent falls, in that, a resident identified as being a risk to fall experienced a fall for 1 of 3 residents, who met the criteria for review of falls. This deficient practice resulted in Resident #36 experiencing a left wrist fracture. (Resident #36)</p>	F000323	F323It is the policy of this facility to strive to provide an environment that is free from hazards over which the center has control and to provide supervision and assistance devices to each resident as appropriate to prevent avoidable accidents. Resident #36 has been reassessed and has appropriate interventions in place	10/22/2014

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	<p>B. Based on observation, interview, and record review, the facility failed to ensure a resident received adequate supervision and/or interventions were properly implemented and/or provided to prevent falls for a resident identified as being a high risk for falls for 1 of 3 residents who met the criteria for review of falls. (Resident #26). Findings include:</p> <p>A 1. On 09/17/15 at 8:30 A.M., Resident #36 was observed in a hallway, sitting in a wheelchair. Resident #36 was observed, at that time, to have a bruise under the left eye and a cast to the left upper extremity.</p> <p>During an interview 09/17/14 at 8:40 A.M. LPN #11 indicated Resident #36 had attempted to stand and ambulate independently, experienced a fall, and broke her arm sometime in the previous 10 days.</p> <p>The clinical record of Resident #36 was reviewed on 09/17/14 at 1:00 P.M. The record indicated the diagnoses of Resident #36 included, but were not limited to, dementia and/or history of falls.</p>		<p>to minimize risk of falling. Care plan updated to reflect current status. Resident 26 has been reassessed and has appropriate interventions in place to minimize risk of alteration in skin integrity. Care plan updated to reflect current status. A review of falls involving current facility residents occurring within the facility in 2014 will be performed by the DON to identify if any other residents affected. Care plans/ C.N.A. assignment sheets will be reviewed and updated as needed. In order to enhance currently compliant operations, nursing personnel will be re-educated on fall prevention and management. A Quality Assurance program was implemented under the supervision of the DON to monitor and verify that fall safety interventions are implemented as careplanned. The DON or designee will make rounds to evaluate the safety interventions are being implemented five times a week for two weeks then weekly to monitor the implementation of the safety interventions. Progress will be reported at the monthly QAPI meeting.</p>		

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	<p>The Annual MDS (Minimum Data Set) assessment dated 04/26/14 indicated Resident #36 experienced severe cognitive impairment, balance deficits, and no behaviors. The MDS further indicated Resident #36 required the extensive assistance of two staff for transfers and had a history of falls.</p> <p>A Fall /Injury Assessment: Prevention and Management Care plan dated 05/02/14 for Fall/Injury Risk included, but was not limited to, an intervention dated 05/02/14 for "... general supervision..." The revised care plan dated 06/26/14 identified a new intervention of, "... increased supervision..."</p> <p>The most recent Quarterly MDS assessment dated 07/12/14 indicated Resident #36 experienced severe cognitive impairment, balance deficits, and behaviors. The MDS further indicated Resident #36 required the extensive assistance of two staff for transfers and had a history of falls.</p> <p>A Physician's Progress note dated 07/16/14 indicated, "...She does have a history of dementia...recently she had increased falls..."</p> <p>A Nurse's note dated 09/03/14 at 12 :00</p>			

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	<p>P.M., indicated, "Spoke to therapy re: resident significant decline in ambulation. Resident shaky (sic) and walking with knees bent..."</p> <p>A Nurse's note dated 09/03/14 at 9:30 P.M., indicated, "Resident up and down all evening. Would not lie or sit over 5-10 minutes at time. Res toileted and redirect numerous times. Resident has spoken jibberish (sic) frequently. ..."</p> <p>A Nurse's note dated 09/04/14 at 5:45 P.M., indicated, "Res lying sideways in bed, attempted to kick nurse when attempting to give medications..."</p> <p>A Nurse's note dated 09/04/14 at 8:00 P.M., indicated, "... Resident agitated..."</p> <p>A Nurse's note dated 09/09/14 at 4:00 A.M. indicated, "Res has been up pacing/wandering in halls since beginning of shift. Res states I don't know what to do, I am afraid, looking for her sons. attempts to redirect resident unsuccessful. Resident given snack, warm milk, books to read. 1 on 1 care. Resident also given Tylenol for general discomfort. Res very restless staff will assist res (resident) to bed but she gets up within 1-2 minutes. Resident does the same when sitting in lobby-staff will get her to sit down-but she gets up within 1-2</p>			

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	<p>minutes. unable to keep resident attention with any activity. Wanderguard (a door-locking device) is in place and functioning. no exit seeking noted."</p> <p>A Nursing note dated 09/09/14 at 2:55 P.M., indicated, "...This nurse setting (sic) at nurses (sic) station, heard noise in front lobby. Looked up and saw resident lying on floor on her stomach. Head turned to the right side and touching the wallboard..."</p> <p>A Care Conference Note dated 09/10/14 indicated, "Resident was assisted to the lounge area with 1 CNA. Seated in a chair moments later the resident got up out of chair. Lost her balance and fell...noticeable malformation of the left wrist. NP (Nurse Practitioner) notified ... anti-anxiety medication administered after after (sic) pain med, distraction, diversion and 1-1 was unsuccessful..."</p> <p>A FNP (Family Nurse Practitioner) Progress note dated 09/11/14 displaced left dist (distal) radius fx (fracture). Closed reduction with left arm cast placement. Elevate as much as possible..."</p> <p>During an interview on 09/18/14 at 10:30 A.M., RN #10 indicated Resident #36 experienced a recent fall and incurred a</p>			

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	<p>fractured left wrist. RN #10 further indicated, at that time, Resident #36 experienced agitation, confusion, and/or decreased safety awareness for several days prior to the fall.</p> <p>During an interview on 09/19/14 at 11:15 A.M. the HFA (Health Facilities Administrator) indicated a CNA had assisted Resident #36 to a stationary chair outside of the DON's office, served Resident #36 a snack, and turned away from Resident #36 and continued to pass snacks to the other residents in the dining room. The HFA then indicated she was walking from behind the nurse's station towards her office and a nurse was seated at the nurse's station. The HFA further stated, at that time, Resident #36 was "...extremely impulsive and high risk to fall..." and indicated no one could get to the resident in time to prevent the fall.</p> <p>During an interview on 09/19/14 at 2:00 P.M., the DON (Director of Nursing) indicated Resident #36 experienced a fall on 09/09/14 and further indicated, at that time, Resident #36 was not supervised closely enough in the dining room to prevent the fall.</p> <p>B1. On 9/17/14 at 10:30 A.M., Resident #26 was observed her room lying in bed.</p> <p>The clinical record for Resident #26 was</p>			

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	<p>reviewed on 9/19/14 at 8:34 A.M., diagnoses include, but were not limited to hypertension, congestive heart failure, and Alzheimer's dementia.</p> <p>The facility Interdisciplinary team notes included:</p> <p>Fall #1 occurred on 2/5/14, Resident found on restroom floor, she had been incontinent of bowel and bladder and had removed the clothing on her bottom half. The immediate intervention added was Imodium (an anti diarrheal medication).</p> <p>Fall # 2 occurred on 2/5/14, Resident found on restroom floor had been incontinent of bowel and bladder. Immediate intervention added was Imodium.</p> <p>Fall #3 occurred on 2/9/14, Resident was sitting in a glider rocker and slid with seat cushion to floor. The immediate intervention added was Resident #26 was not to be placed in the rocker anymore.</p> <p>Fall #4 occurred on 2/19/14 Resident fell out of glider rocker in dining room. The immediate intervention was staff education not to place Resident #26 in the rocker anymore and dycem was placed under seat cushion.</p>			

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	<p>Fall #5 2/27/14 Resident fell in room attempting to ambulate from wheel chair to a recliner without assistance. The immediate intervention was to add a self release seat belt to the wheel chair.</p> <p>Fall #6 occurred on 4/1/14. Resident #26 was found sitting on the floor in her room beside the bed. The immediate intervention was adding non skid strips to floor.</p> <p>The Nursing progress notes include:</p> <p>Fall #7 occurred on 7/10/14. Resident #26 found lying on side beside bed. The immediate intervention was to place a pillow under her right side.</p> <p>Fall #8 occurred on 8/31/14. Resident #26 was found lying on floor on her left side. The immediate intervention was to provide an electric bed so it could be placed in the lowest position.</p> <p>The care plans include, but were not limited to, an ADL (activities of daily living)/ MOBILITY CARE PLAN imitated 2/28/14 which indicated Resident #26 will transfer with one assist.</p> <p>A "FALL/INJURY ASSESSMENT: PREVENTION AND MANAGEMENT PLAN OF CARE" was imitated 2/28/14</p>			

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	<p>related to a history of falls, dementia and Alzheimer's. Interventions include, but were not limited to, increased supervision, educated resident/responsible party as needed and scheduled toileting all dated 2/28/14. Also included were low air loss mattress undated, pillow to right side while in bed added 7/11/14 and an electric bed dated 8/31/14.</p> <p>The Director of Nursing was interviewed on 9/22/14 at 9:20 A.M. in regards to the falls. She indicated Resident #26 was not on a toileting program at the time of the first fall because of her cognition. She indicated Resident #26 was at risk for falls. She indicated she was aware that Resident #26 had fallen twice out of the glider in the dining room and that staff were educated not to use it after the second fall. She further indicated that Resident #26 falls from bed were due to Resident #26 having decreased safety awareness and being able to get up from the bed.</p> <p>The Falls and Injuries Policy and Procedure provided by the ADON (Assistant Director of Nursing) on 09/19/14 at 8:31 A.M. indicated, "... provide an environment that is free from hazards over which the center has control and provides supervision... to each</p>			

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F000465 SS=E	<p>resident to prevent avoidable accidents...Hazards refer to elements of the resident environment that have potential cause of injury or illness. "Hazards over which the center has control" are hazards where reasonable efforts could influence the risk resulting in injury. "Free of accident hazards as much as possible" refers to being free of accident hazards over which the center has control...Supervision/Adequate Supervision...Adequate supervision is defined by the type and frequency of supervision, based on the individual resident assessed needs and identified hazards in the resident environment. Supervision may vary resident to resident and time to time for the same resident.</p> <p>3.1-45(a)(2)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation, and interview, the facility failed to ensure resident bathroom exhaust fans were functioning, a residents' bathroom was free of objectionable odors, the bathroom floor was clean and a resident was provided</p>	F000465	F465 It is the policy of this facility to maintain a clean, safe, and home-like atmosphere for the residents, staff, and visitors. The exhaust fans identified as not functioning have been repaired. A facility-wide audit has been conducted in order to identify any	10/22/2014			

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	<p>adequate lighting for 1 of 2 halls during 3 of 3 observations. (Rooms 21, 23, 26 and Resident #10)</p> <p>Findings include:</p> <p>Observations and interview for West hall:</p> <p>1. During observations on 9/18/14 at 10:47 A.M., 9/22/14 at 2:25 P.M. and 9/23/14 at 1:15 P.M., the bathroom in room 26 was observed to have a strong odor of urine and ammonia and the exhaust fan did not function. The entire floor of the bathroom was observed to have areas of dark marring and/or dirt, especially around the base of the commode.</p> <p>During observations on 9/18/14 at 11:20 A.M., 9/19/14 at 11:47 A.M. and 9/23/14 at 1:18 P.M., the bathrooms in rooms 21 and 23 did not have functioning exhaust fans.</p> <p>2. During an interview on 9/18/14 at 9:44 A.M., Resident #10 indicated he would like to read at night when he was in bed, but there was not enough light to do so. Resident #10 further indicated he requested more light, but he was told it was not possible because the facility's policy required nothing could be located over the head of the bed.</p>		<p>other exhaust fan issues and all identified issues have been resolved.</p> <p>The bathroom floor in room 26 has been replaced. A facility-wide audit of resident bathroom floors has been conducted in order to identify any additional flooring concerns with any identified problems corrected.</p> <p>Resident #10 has a reading light at bedside in order to provide additional lighting for reading when in bed. Interviewable residents within the facility were interviewed in order to identify any other patients potentially affected by the need for additional lighting. All residents of the facility have the potential to be affected by the alleged deficient practices. In order to enhance the facility's currently compliant operations, a Quality Assurance Program was implemented under the supervision of the Facility Administrator to monitor for and identify any further concerns. Audits will be repeated weekly x 4 weeks, 2x weekly x 2 months then monthly with finding taken to the Quality Assurance Team monthly for review and recommendations. These systemic changes will be completed 10/22/2014.</p>				

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	<p>3. A walk through with the Health Care Administrator (HCA) was conducted on 9/23/14 at 1:40 P.M. The (HCA) was made aware that the bathroom exhaust fans were not functioning in rooms 21 and 23. The bathroom in room 26 had an objectionable odor of urine and ammonia, a dirty marred floor and the exhaust fan did not work. The HCA was also made aware that Resident #10 voiced concern there was not enough light in his room for reading in bed.</p> <p>4. During an interview with the Housekeeping Supervisor (HS) in room 26 on 9/24/14 at 2:23 P.M., she indicated the strong urine and ammonia odor might have been caused by the toilet becoming detached from the floor. The HS further indicated the bathroom floor had been replaced, but it was still difficult to keep clean.</p> <p>During an interview on 9/24/14 at 2:55 P.M., the Maintenance Supervisor (MS) indicated he had repaired 2 bathroom exhaust fans and had ordered parts for the 3rd exhaust fan. MS further indicated he would look into a reading light for Resident #10's room.</p> <p>3.1-19(f) 3.1-19(f)(2)</p>			

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

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