

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155323	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/02/2016
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NAME OF PROVIDER OR SUPPLIER  LAKEVIEW VILLAGE SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960
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F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaint IN00201429.</p> <p>This visit was in conjunction with the Recertification and State Licensure Survey and the Investigation of Complaint IN00200373.</p> <p>This visit resulted in an Extended Survey-Immediate Jeopardy.</p> <p>Complaint IN00201429 - Substantiated. Federal/State deficiencies related to the allegations are cited at F281 and F309.</p> <p>Survey dates: May 23, 24, 25, 26, 27, and 31, 2016.</p> <p>Extended survey dates: June 1 and 2, 2016</p> <p>Facility number: 000216 Provider number: 155323 AIM number: 100267580</p> <p>Census bed type: SNF/NF: 37 Total: 37</p> <p>Census payor type: Medicare: 4</p>	F 0000	Submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies This plan of correction is prepared and submitted because of requirements under state and federal law. Please accept this plan of correction as our credible allegation of compliance.	

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 0281 SS=J Bldg. 00	<p>Medicaid: 31 Other: 2 Total: 37</p> <p>Sample: 6</p> <p>These deficiencies reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 32883 on 6/6/16.</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. Based on record review and interview the facility failed to ensure professional standards of quality care were followed related to lack of a thorough assessment by a licensed staff member prior to moving a resident after a fall, administration of an oral medication to a resident with an altered mental status,</p>	F 0281	I. The facility interviewed the nurse on duty, responsible to care for the resident following the incident in question. The nurse has been given verbal 1 on 1 re-education related to not following the facilities Fall Emergency, First Aid Policy II. As other residents could be affected, the following corrective actions	06/21/2016

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	<p>and failure to ensure emergency medical treatment services were sought immediately after a fall in which the resident hit her head resulting in two subdural hemorrhages resulting in death for 1 of 6 residents reviewed for accidents. (Resident #B) (LPN #1)</p> <p>Finding includes:</p> <p>Resident #B's closed record was reviewed on 5/26/16 at 11:33 a.m. The resident's diagnoses included, but were not limited to hypertension, epilepsy, and chronic obstructive pulmonary disease.</p> <p>Review of the resident's Admission Minimum Data Set assessment dated 4/12/16 indicated the resident had a Brief Interview of Mental Status score of 14 out of 15, which indicated the resident was cognitively intact.</p> <p>Review of the Nurse's Note, dated 5/21/16 at 10:05 p.m. and written by LPN #1 indicated Resident #B was yelling and the CNAs had gone to the resident's room and found the resident lying on the floor beside her bed. The note indicated LPN #1 entered the room and observed "...obvious bld (blood) on floor under res (resident's) head. Res (resident) was yelling help me, help me. CNA's assisted res (resident) to bed..." The note</p>		<p>shall be taken. Nursing staff shall be inserviced <b>prior to beginning their next tour of duty</b> on the following policies/procedures applicable to their respective roles:</p> <ul style="list-style-type: none"> <li>·Fall Emergency (specific duties of <u>nursing assistant</u> and <u>licensed nurse</u> reviewed)</li> <li>·Change in Resident Condition/Emergency Transfer to Acute Care Hospital</li> <li>·Neurological Assessment</li> <li>·Medication Administration- with the following added to step #19</li> </ul> <p><b>·NOTE* Should a resident exhibit difficulty in swallowing and/or lethargic, oral medication must not be administered.</b></p> <ul style="list-style-type: none"> <li>·Abuse Policy, page 3 which states the following: "It is the responsibility of every employee of this facility to not only report abuse situations, but also suspicion of abuse and unusual observations and/or circumstances, to his/her supervisor. If it is the employee's supervisor the employee is reporting, the employee must notify another facility supervisor or the facility Administrator." III. As a measure to ensure ongoing compliance, the DON shall be contacted immediately following any resident fall. The events of the fall and immediate actions taken by the nurse shall be reviewed with the nurse to confirm immediate appropriate action(s) taken and resident</li> </ul>				

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	<p>indicated no scalp laceration was noted but there was a small amount of blood coming from the resident's left ear canal. LPN #1 then called the on call Physician and obtained an order to send the resident to the Emergency Room for evaluation and treatment. LPN #1 further indicated "...911 notified for transfer. Phoned dtr (daughter) x2, no answer."</p> <p>Review of the Nurse's Note, dated 5/21/16 at 10:40 p.m. and written by LPN #1 indicated "Ambulance medics x 3 here for transfer. Left facility without incident."</p> <p>Review of a Post Fall Investigation form dated 5/21/16 indicated Resident #B was found on the floor beside her bed at 10:05 p.m. The form indicated the resident exhibited signs/symptoms of confusion, exhibited a decline in cognitive function, and indicated the resident was unable to answer or tell staff what had happened. The form indicated a narcotic analgesic had last been given at 10:30 p.m.</p> <p>Review of a written statement from Nurse Consultant #1 regarding the investigation of the resident's fall on 5/21/16 indicated she had interviewed LPN #1 regarding the fall. LPN #1 had indicated staff heard the resident calling for help, entered the resident's room and</p>		<p>well-being. A nurse failing to follow appropriate steps per facility policies shall be re-educated immediately and corrective action taken including disciplinary action up to and including termination, if warranted. IV. As a means of quality assurance, the Administrator and DON shall review together each fall on the next business day following the fall to confirm appropriate steps were taken in response to the fall/incident. Any concerns identified and corrective actions taken shall be documented/logged.</p> <p>Trends/patterns of care provided by licensed nurses shall be monitored to ensure corrective action is taken. Continued review of each fall and any corrective actions taken shall be reported to the Quality Assurance Committee during monthly meetings. This review process shall continue indefinitely to confirm appropriate immediate action taken in response to resident falls. Please note the facility is requesting IDR for this citation with IDR Rationale F281 &amp; F309 that will be emailed to ISDH as the file is too large and will not allow for upload on the gateway system, accompanied by staff Affidavit's and POC signature page. Completion Date: 6/3/16</p>		

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	<p>found the resident on the floor near her bed. LPN #1 indicated the resident was repeating "help me, help me." LPN #1 indicated the resident had managed to get herself to a sitting position with her back against the bed and would not stay still while LPN #1 was assessing her. LPN #1 indicated she completed the assessment and did not suspect "...hip or other skeletal or back injury based on res (resident) own efforts to get up et (and) assessment..." At that time the resident was assisted up off the floor. LPN #1 indicated bleeding was noted in the resident's ear canal and she then sent the resident to the hospital. LPN #1 indicated the approximate time of the fall was 10:15 p.m.</p> <p>Review of the Neurological Check Flowsheet, dated 5/21/16 for the initial assessment indicated the resident's blood pressure was 158/84, pulse 84, and respirations 20. The resident's level of consciousness was charted as awake and alert. The assessment area for pupil size/response had been left blank.</p> <p>Review of the Nursing Home to Hospital Transfer Form, dated 5/21/16 at 10:30 p.m. indicated the resident had last received pain medication, Norco (hydrocodone-acetaminophen, a narcotic pain medication) 7.5-325 milligrams on</p>			

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	<p>5/21/16 at 10:30 p.m.</p> <p>Review of the hospital ED (emergency department) Physician Progress Note, dated 5/21/16 at 11:53 p.m. indicated the resident had come in with altered mental status after a fall out of bed. The note indicated the resident had been put back in bed, had blood in her left ear, and pin point pupils. The note indicated the resident had emesis twice and had a blood pressure of 242/120. It indicated the resident had a chest x-ray completed at 12:09 a.m. that indicated early RLL (right lower lobe) infiltrate which was "...likely aspiration..." The impression and plan indicated, " 1. Acute right parietal &amp; (and) temporal subdural hematomas... 2. Acute hypertensive emergency... 3. Acute AMS (altered mental status)...4. Acute cervical strain...5. Acute fall."</p> <p>A hospital imaging CT (computerized tomography (a scan of the body that produces images of internal organs) result of the head/brain was completed on 5/21/16 at 11:59 p.m. The findings included "...There are 2 new subdural hemorrhages. One right temporal which measures 17 mm (millimeters) diameter and one right parietal which measures 15 mm..." The impression indicated "1. Acute appearing right subdural</p>			

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	<p>hematomas... "</p> <p>Review of the hospital Neurosurgery Staff Initial Consult, dated 5/22/16 at 12:57 a.m. indicated the resident had "...multiple episodes of emesis and hypertension on arrival. Patient altered and moaning and unable to provide any history..."</p> <p>Interview with Nurse Consultant #1 and Regional Director #2 on 5/27/16 at 1:41 p.m. indicated they were unaware of the extent of the resident's injury following the fall until the morning of 5/23/16 when the resident's daughter had come in to the facility and notified them the resident had passed away. They indicated once they had been made aware of the extent of the resident's injury, the incident was reported to the Indiana State Department of Health.</p> <p>Interview with CNA #1 on 5/31/16 at 12:37 p.m. indicated she had worked the evening shift on 5/21/16. She indicated she was charting at the Nurse's Station just after change of shift, around 10:00 p.m. She indicated the midnight shift CNA, CNA #2, had just started her rounds and found Resident #B on the floor in her room. CNA #2 came to the Nurse's Station and indicated to LPN #1 that she had found Resident #B lying on</p>						

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	<p>the floor in her room. CNA #1 indicated LPN #1 did not get up at first and CNA #2 had to tell LPN #1 a second time before LPN #1 followed CNA #1 and CNA #2 to Resident #B's room. CNA #1 indicated LPN #1 entered the room and immediately told CNA #1 and CNA #2 to get Resident #B up off the floor and put her in bed. CNA #1 indicated she and CNA #2 did not want to move the resident but did so because LPN #1 had told them to. CNA #1 indicated there was blood on the floor and in the resident's hair but she could not tell where the blood was coming from. CNA #1 indicated LPN #1 did not assess the resident prior to telling the CNA's to assist the resident off the floor and back into bed. CNA #1 indicated Resident #B was yelling "help me" the whole time. She further indicated the resident was usually alert and able to communicate with staff. CNA #1 indicated she then left the facility as her shift was over.</p> <p>Interview with CNA #2 on 5/31/16 at 2:12 p.m. indicated she had worked the midnight shift on 5/21/16. She indicated she had just come on shift and was starting her rounds when she noted Resident #B lying on the floor beside her bed with blood on the floor around her. She indicated she immediately went to</p>			

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	<p>notify LPN #1 and had to "coax" LPN #1 to come the resident's room with her and CNA #1. She indicated she observed blood coming out of the resident's ear and blood all over her gown and in her hair. CNA #2 indicated LPN #1 entered the room and told her and CNA #1 to put Resident #B back in bed. She indicated LPN #1 then left the room to get Resident #B a pain pill. She indicated she and CNA #1 were cleaning the blood out of the resident's hair trying to find out where the bleeding was coming from when the resident started vomiting. CNA #2 indicated the resident's face was swelling up, her eyes were bulging out, she wasn't swallowing properly, and she wasn't acting like her normal self. She indicated LPN #1 then came back to the resident's room with the pain pill and administered the pill to the resident. CNA #2 indicated she and CNA #1 had then rolled the resident over at which time CNA #2 scooped the pill out of the resident's mouth because she was fearful the resident would choke on it as the resident had not swallowed the pill yet. CNA #2 indicated the nurse then "assessed the resident, called the resident's daughter,</p>			

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	<p>waited around for a little while, and then called 911." CNA #2 estimated the time from when she found Resident #B on the floor until LPN #1 called the ambulance was about 40 minutes.</p> <p>Interview with Nurse Consultant #1 on 5/31/16 at 2:49 p.m. indicated she had completed the fall investigation for Resident #B's fall on 5/21/16. She indicated she had spoken to LPN #1 about the fall but had not spoken to CNA #1 and CNA #2. She indicated she probably should have interviewed CNA #1 and CNA #2 about the fall as they had found the resident lying on the floor and assisted her back to bed. She further indicated the resident should not have been moved off the floor and 911 should have been called immediately.</p> <p>A facility policy titled "Fall Emergency, First Aid", dated 10/2014, and received as current from Nurse Consultant #1 as current on 5/31/16 at 2:53 p.m. indicated, "...Any resident who sustains a fall will be assessed for injury at the time of the fall and will receive first aid treatments promptly...Procedure: Certified Nursing Assistant: 1. If a resident falls, call for nurse and stay with resident...3. Do not</p>			

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	<p>move resident. Leave in same position until the nurse examines resident...Licensed Nurse: 1. Respond immediately to call. 2. Do not move resident prior to completion of a thorough assessment...4. Assess resident from head to toe for any injuries...8. Assess for injury to head. If noted, begin neurologic checks immediately...11. After resident is thoroughly assessed and deemed to be free from injury, assist resident up. 12. Interview resident and any witnesses to the fall..."</p> <p>The 2015 Indiana State Board of Nursing Standards for the Competent Practice of Registered and Licensed Practical Nursing Rule 3. Licensed Practical Nursing: 848 IAC 2-3-3, Section 3 indicated "...nursing behaviors failing to meet the minimal standards of acceptable and prevailing licensed practical nursing practices, which could jeopardize the health, safety, and welfare of the public shall constitute unprofessional conduct. These behaviors include, but are not limited to the following: (1) Using unsafe judgement, technical skills, or inappropriate interpersonal behaviors in providing nursing care."</p> <p>An immediate jeopardy was identified on 5/31/16 at 5:35 p.m. The immediate</p>			

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	jeopardy began on 5/21/16 at 10:05 p.m. when a licensed facility staff member failed to thoroughly assess Resident #B before moving the resident after the resident had fallen, hit her head, and was bleeding from her left ear canal. The facility Administrator, Director of Nursing, Regional Consultant #1, Regional Consultant #2, and Nurse Consultant #1 were informed of the immediate jeopardy on 5/31/16 at 5:35 p.m. The immediate jeopardy was removed on 6/2/16 at 1:30 p.m. when through interviews and record reviews it was determined that the facility had implemented a plan of action to remove the immediate jeopardy and the steps taken removed the immediacy of the problem. Inservices had been completed with 19 of the 25 Nurses and CNAs on the following policies/procedures: Fall Emergency, Change in Resident Condition/Emergency Transfer to Acute Care Hospital, Neurological Assessment, Medication Administration, and Abuse. Interviews with the Nurses and CNAs indicated they were inserviced and knowledgeable of the above policies and procedures. Residents who had falls were reviewed by the Administrator and DON the day following the fall to confirm appropriate steps were taken in response to the fall/incident. The DON was notified of all falls immediately and			

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F 0309 SS=J Bldg. 00	<p>reviewed immediate actions taken were appropriate. Even though the facility's corrective action removed the immediate jeopardy, noncompliance remained at a lower scope and severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy.</p> <p>This Federal Tag relates to Complaint IN00201429. 3.1-35(g)(1)</p> <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 record review and interview, the facility failed to provide necessary care and services related to lack of a thorough assessment by a licensed staff member prior to moving a resident after a fall, administration of an oral medication to a resident with an altered mental status, and failure to ensure emergency</p>	F 0309	I. The facility interviewed the nurse on duty, responsible to care for the resident following the incident in question. The nurse has been given written and verbal 1 on 1 re-education related to not following the facilities Fall Emergency, First Aid Policy II. As other residents could be affected, the following corrective actions shall be taken. Nursing staff shall	06/21/2016

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	<p>medical treatment services were sought immediately after a fall in which the resident hit her head resulting in two subdural hemorrhages resulting in death. This affected 1 of 6 residents reviewed for accidents. (Resident #B)</p> <p>The immediate jeopardy began on 5/21/16 at 10:05 p.m. when a licensed facility staff member failed to thoroughly assess Resident #B before moving the resident after the resident had fallen, hit her head, and was bleeding from her left ear canal. The facility Administrator, Director of Nursing (DON), Regional Consultant #1, Regional Consultant #2, and Nurse Consultant #1 were informed of the immediate jeopardy on 5/31/16 at 5:35 p.m.</p> <p>Finding includes:</p> <p>Resident #B's closed record was reviewed on 5/26/16 at 11:33 a.m. The resident's diagnoses included, but were not limited to hypertension, epilepsy, and chronic obstructive pulmonary disease.</p> <p>Review of the resident's Admission Minimum Data Set assessment dated 4/12/16 indicated the resident had a Brief Interview of Mental Status score of 14 out of 15, which indicated the resident was cognitively intact.</p>				<p>be inserviced <b>prior to beginning their next tour of duty</b> on the following policies/procedures applicable to their respective roles:</p> <ul style="list-style-type: none"> <li>·Fall Emergency (specific duties of <u>nursing assistant</u> and <u>licensed nurse</u> reviewed)</li> <li>·Change in Resident Condition/Emergency Transfer to Acute Care Hospital</li> <li>·Neurological Assessment</li> <li>·Medication Administration- with the following added to step #19</li> </ul> <p><b>·NOTE* Should a resident exhibit difficulty in swallowing and/or lethargic, oral medication must not be administered.</b></p> <ul style="list-style-type: none"> <li>·Abuse Policy, page 3 which states the following: "It is the responsibility of every employee of this facility to not only report abuse situations, but also suspicion of abuse and unusual observations and/or circumstances, to his/her supervisor. If it is the employee's supervisor the employee is reporting, the employee must notify another facility supervisor or the facility Administrator." III. As a measure to ensure ongoing compliance, the DON shall be contacted immediately following any resident fall. The events of the fall and immediate actions taken by the nurse shall be reviewed with the nurse to confirm immediate appropriate action(s) taken and resident well-being. A nurse failing to</li> </ul>		

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	<p>Review of the Nurse's Note, dated 5/21/16 at 10:05 p.m. and written by LPN #1 indicated Resident #B was yelling and the CNAs had gone to the resident's room and found the resident lying on the floor beside her bed. The note indicated LPN #1 entered the room and observed "...obvious bld (blood) on floor under res (resident's) head. Res (resident) was yelling help me, help me. CNA's assisted res (resident) to bed..." The note indicated no scalp laceration was noted but there was a small amount of blood coming from the resident's left ear canal. LPN #1 then called the on call Physician and obtained an order to send the resident to the Emergency Room for evaluation and treatment. LPN #1 further indicated "...911 notified for transfer. Phoned dtr (daughter) x2, no answer."</p> <p>Review of the Nurse's Note, dated 5/21/16 at 10:40 p.m. and written by LPN #1 indicated "Ambulance medics x 3 here for transfer. Left facility without incident."</p> <p>Review of a Post Fall Investigation form dated 5/21/16 indicated Resident #B was found on the floor beside her bed at 10:05 p.m. The form indicated the resident exhibited signs/symptoms of confusion, exhibited a decline in cognitive function,</p>		<p>follow appropriate steps per facility policies shall be re-educated immediately and corrective action taken including disciplinary action up to and including termination, if warranted. IV. As a means of quality assurance, the Administrator and DON shall review together each fall on the next business day following the fall to confirm appropriate steps were taken in response to the fall/incident. Any concerns identified and corrective actions taken shall be documented/logged. Trends/patterns of care provided by licensed nurses shall be monitored to ensure corrective action is taken. Continued review of each fall and any corrective actions taken shall be reported to the Quality Assurance Committee during monthly meetings. This review process shall continue indefinitely to confirm appropriate immediate action taken in response to resident falls. Please note the facility is requesting IDR for this citation with IDR Rationale F281 &amp; F309 that will be emailed to ISDH as the file is too large and will not allow for upload on the gateway system , accompanied by staff Affidavit's and POC signature page. Completion Date: 6/3/16</p>				

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	<p>and indicated the resident was unable to answer or tell staff what had happened. The form indicated a narcotic analgesic had last been given at 10:30 p.m.</p> <p>Review of a written statement from Nurse Consultant #1 regarding the investigation of the resident's fall on 5/21/16 indicated she had interviewed LPN #1 regarding the fall. LPN #1 had indicated staff heard the resident calling for help, entered the resident's room and found the resident on the floor near her bed. LPN #1 indicated the resident was repeating "help me, help me." LPN #1 indicated the resident had managed to get herself to a sitting position with her back against the bed and would not stay still while LPN #1 was assessing her. LPN #1 indicated she completed the assessment and did not suspect "...hip or other skeletal or back injury based on res (resident) own efforts to get up et (and) assessment..." At that time the resident was assisted up off the floor. LPN #1 indicated bleeding was noted in the resident's ear canal and she then sent the resident to the hospital. LPN #1 indicated the approximate time of the fall was 10:15 p.m.</p> <p>Review of the Neurological Check Flowsheet, dated 5/21/16 for the initial assessment indicated the resident's blood</p>			

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	<p>pressure was 158/84, pulse 84, and respirations 20. The resident's level of consciousness was charted as awake and alert. The assessment area for pupil size/response had been left blank.</p> <p>Review of the Nursing Home to Hospital Transfer Form, dated 5/21/16 at 10:30 p.m. indicated the resident had last received pain medication, Norco (hydrocodone-acetaminophen, a narcotic pain medication) 7.5-325 milligrams on 5/21/16 at 10:30 p.m.</p> <p>Review of the hospital ED (emergency department) Physician Progress Note, dated 5/21/16 at 11:53 p.m. indicated the resident had come in with altered mental status after a fall out of bed. The note indicated the resident had been put back in bed, had blood in her left ear, and pin point pupils. The note indicated the resident had emesis twice and had a blood pressure of 242/120. It indicated the resident had a chest x-ray completed at 12:09 a.m. that indicated early RLL (right lower lobe) infiltrate which was "...likely aspiration..." The impression and plan indicated, " 1. Acute right parietal &amp; (and) temporal subdural hematomas... 2. Acute hypertensive emergency... 3. Acute AMS (altered mental status)...4. Acute cervical strain...5. Acute fall."</p>			

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	<p>A hospital imaging CT (computerized tomography (a scan of the body that produces images of internal organs) result of the head/brain was completed on 5/21/16 at 11:59 p.m. The findings included "...There are 2 new subdural hemorrhages. One right temporal which measures 17 mm (millimeters) diameter and one right parietal which measures 15 mm..." The impression indicated "1. Acute appearing right subdural hematomas... "</p> <p>Review of the hospital Neurosurgery Staff Initial Consult, dated 5/22/16 at 12:57 a.m. indicated the resident had "...multiple episodes of emesis and hypertension on arrival. Patient altered and moaning and unable to provide any history..."</p> <p>Interview with Nurse Consultant #1 and Regional Director #2 on 5/27/16 at 1:41 p.m. indicated they were unaware of the extent of the resident's injury following the fall until the morning of 5/23/16 when the resident's daughter had come in to the facility and notified them the resident had passed away. They indicated once they had been made aware of the extent of the resident's injury, the incident was reported to the Indiana State Department of Health.</p>			

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	<p>Interview with CNA #1 on 5/31/16 at 12:37 p.m. indicated she had worked the evening shift on 5/21/16. She indicated she was charting at the Nurse's Station just after change of shift, around 10:00 p.m. She indicated the midnight shift CNA, CNA #2, had just started her rounds and found Resident #B on the floor in her room. CNA #2 came to the Nurse's Station and indicated to LPN #1 that she had found Resident #B lying on the floor in her room. CNA #1 indicated LPN #1 did not get up at first and CNA #2 had to tell LPN #1 a second time before LPN #1 followed CNA #1 and CNA #2 to Resident #B's room. CNA #1 indicated LPN #1 entered the room and immediately told CNA #1 and CNA #2 to get Resident #B up off the floor and put her in bed. CNA #1 indicated she and CNA #2 did not want to move the resident but did so because LPN #1 had told them to. CNA #1 indicated there was blood on the floor and in the resident's hair but she could not tell where the blood was coming from. CNA #1 indicated LPN #1 did not assess the resident prior to telling the CNA's to assist the resident off the floor and back into bed. CNA #1 indicated Resident #B was yelling "help me" the whole time. She further indicated the resident was usually alert and able to communicate</p>			
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	<p>with staff. CNA #1 indicated she then left the facility as her shift was over.</p> <p>Interview with CNA #2 on 5/31/16 at 2:12 p.m. indicated she had worked the midnight shift on 5/21/16. She indicated she had just come on shift and was starting her rounds when she noted Resident #B lying on the floor beside her bed with blood on the floor around her. She indicated she immediately went to notify LPN #1 and had to "coax" LPN #1 to come the resident's room with her and CNA #1. She indicated she observed blood coming out of the resident's ear and blood all over her gown and in her hair. CNA #2 indicated LPN #1 entered the room and told her and CNA #1 to put Resident #B back in bed. She indicated LPN #1 then left the room to get Resident #B a pain pill. She indicated she and CNA #1 were cleaning the blood out of the resident's hair trying to find out where the bleeding was coming from when the resident started vomiting. CNA #2 indicated the resident's face was swelling up, her eyes were bulging out, she wasn't swallowing properly, and she wasn't acting like her normal self. She indicated LPN #1 then came back to the resident's</p>			

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	<p>room with the pain pill and administered the pill to the resident. CNA #2 indicated she and CNA #1 had then rolled the resident over at which time CNA #2 scooped the pill out of the resident's mouth because she was fearful the resident would choke on it as the resident had not swallowed the pill yet. CNA #2 indicated the nurse then "assessed the resident, called the resident's daughter, waited around for a little while, and then called 911." CNA #2 estimated the time from when she found Resident #B on the floor until LPN #1 called the ambulance was about 40 minutes.</p> <p>Interview with Nurse Consultant #1 on 5/31/16 at 2:49 p.m. indicated she had completed the fall investigation for Resident #B's fall on 5/21/16. She indicated she had spoken to LPN #1 about the fall but had not spoken to CNA #1 and CNA #2. She indicated she probably should have interviewed CNA #1 and CNA #2 about the fall as they had found the resident lying on the floor and assisted her back to bed. She further indicated the resident should not have been moved off the floor and 911 should have been called immediately.</p>			

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	<p>A facility policy titled "Fall Emergency, First Aid", dated 10/2014, and received as current from Nurse Consultant #1 as current on 5/31/16 at 2:53 p.m. indicated, "...Any resident who sustains a fall will be assessed for injury at the time of the fall and will receive first aid treatments promptly...Procedure: Certified Nursing Assistant: 1. If a resident falls, call for nurse and stay with resident...3. Do not move resident. Leave in same position until the nurse examines resident...Licensed Nurse: 1. Respond immediately to call. 2. Do not move resident prior to completion of a thorough assessment...4. Assess resident from head to toe for any injuries...8. Assess for injury to head. If noted, begin neurologic checks immediately...11. After resident is thoroughly assessed and deemed to be free from injury, assist resident up. 12. Interview resident and any witnesses to the fall..."</p> <p>An immediate jeopardy was identified on 5/31/16 at 5:35 p.m. The immediate jeopardy began on 5/21/16 at 10:05 p.m. when a licensed facility staff member failed to thoroughly assess Resident #B before moving the resident after the resident had fallen, hit her head, and was</p>			

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	bleeding from her left ear canal. The facility Administrator, Director of Nursing, Regional Consultant #1, Regional Consultant #2, and Nurse Consultant #1 were informed of the immediate jeopardy on 5/31/16 at 5:35 p.m. The immediate jeopardy was removed on 6/2/16 at 1:30 p.m. when through interviews and record reviews it was determined that the facility had implemented a plan of action to remove the immediate jeopardy and the steps taken removed the immediacy of the problem. Inservices had been completed with 19 of the 25 Nurses and CNAs on the following policies/procedures: Fall Emergency, Change in Resident Condition/Emergency Transfer to Acute Care Hospital, Neurological Assessment, Medication Administration, and Abuse. Interviews with the Nurses and CNAs indicated they were inserviced and knowledgeable of the above policies and procedures. Residents who had falls were reviewed by the Administrator and DON the day following the fall to confirm appropriate steps were taken in response to the fall/incident. The DON was notified of all falls immediately and reviewed immediate actions taken were appropriate. Even though the facility's corrective action removed the immediate jeopardy, noncompliance remained at a lower scope and severity level of no			

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	<p>actual harm with potential for more than minimal harm that is not immediate jeopardy.</p> <p>This Federal Tag relates to Complaint IN00201429.</p> <p>3.1-37(a)</p>			