STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155707	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/07/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SWISS VILLAGE	1350 W MAIN ST BERNE, IN 46711

(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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: September 29 & 30, 2015 October 1, 2, 5, 6 & 7, 2015 Facility number: 000280 Provider number: 155707 AIM number: 100274540 Census bed type: SNF: 30 SNF/NF: 85 Residential: 63 Total: 178 Census payor type: Medicare: 6 Medicaid: 52 Other: 120 Total: 178 These deficiencies also reflect state findings in accordance with 410 IAC 16.2-3.1. QR completed on October 13, 2015 by 17934.	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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

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F 0323 SS=D Bldg. 00	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure adequate supervision was provided for a resident to prevent 18 falls in less than an 8 month period of time for 1 of 3 residents reviewed for falls. (Resident #80) Findings include: On 10/1/15 at 3:00 p.m., the clinical record of Resident #80 was reviewed. Diagnoses included, but were not limited to, the following: CHF(congestive heart failure), history of falls, generalized muscle weakness, hypertension, senile dementia, generalized pain, chronic kidney disease, difficulty in walking and Rhabdomyolysis (breakdown of muscle tissue). The MDS (Minimum Data Set) assessment, dated 1/18/15, indicated the following: moderately impaired cognition, functional status for bed mobility, transfers, toileting, ambulation on the unit required extensive assistance; balance was a "2" (only steady, only able	F 0323	**F323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/ DEVICES (D)** **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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure adequate supervision was provided for a resident to prevent 18 falls in less than an 8 month period of time for 1 of 3 residents reviewed for falls. (Resident #80).**	10/30/2015

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	to stabilize with human assistance) for all; falls within the last month "yes." A Physical Therapy (PT) Evaluation and plan of treatment, dated 1/6/15, included, but was not limited to, the following: "... (patient) presents with significant decline in functional mobility, requiring extensive level of assist for safe functional transfers, bed mobility and gait training...Risk Factors: Due to the documented physical impairments and associated functional deficits, the patient is at risk for...falls...." On 10/5/15 at 11:12 a.m., the DON (Director of Nursing) provided copies of Resident #80's fall investigation reports since his admission on 1/5/15. The reports included the following: A copy of the fall risk assessment dated 1/6/15, was provided on 10/7/15 at 10:00 a.m., by the Administrator. The assessment included, but was not limited to, the following: forgetful/confused in new or unfamiliar surroundings, high risk of falling (more aggressive precautions and Interventions are needed); bed and chair alarms, has fallen in last 3 months, uses walker and wheelchair, has gait or balance problems, has experienced recent decline in function; frequent or urgent elimination needs, confused at all times,		**1. Describe what the facility did to correct the deficient practice for each resident cited in the deficiency.** a) An outlet was installed in the hallway and documentation cart with the computer mounted to the cart was place right across from the Resident #80 room. The cart was positioned in a way that staff member documenting on the computer can visualize Resident #80 while at the cart and provide adequate supervision. All Nursing staff working with Resident #80 were made aware of this intervention on 10/16/15. b) Mobility care plan for resident #80 was reviewed. Care plan indicated that on 1/20/15 Resident #80 was transferring with 2 assist and gait belt. Sara lift for all transfers with 1-2 assists was initiated on 4/17/15. This date was added to the current mobility care plan. CNA Flow sheet was	

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	uses diuretics and antihypertensives. Comment: Bed and chair alarms to alert staff when rising unsafely. Will try to get up at times without calling for assist. Fall risk: recent fall, recent MI (myocardial infarction), pneumonia and influenza, weakness, non-ambulatory at this time, abilities vary, confusion noted, able to propel self in wheelchair short distances. Working with therapy. Fall #1. 1/20/15 at 2:15 a.m.: "At 2:15 a.m. bed alarm sounded...When CNA (Certified Nursing Assistant) entered room, res (resident) sitting on the floor beside his bed...Res unaware of what he was trying to do...Corrective action taken:..Res placed on 30 mint (sic) minute checks t/o (throughout) the night. New intervention: floor mats and low bed initiated. Measures to prevent recurrence:...working with OT (occupational therapy) until 3/10/15. PT (physical therapy)...until 2/17/15...Bed and chair alarms...." On 10/6/15 at 11:00 a.m., the DON and Administrator were interviewed. The DON indicated the resident had been admitted on the Rehab unit but currently resided on the Lavendel unit. He indicated the resident had been fidgeting. He indicated 30 minute checks after the fall continued on the resident until the		checked to ensure Sara lift for all transfers indicated on this sheet. c) All Nursing staff were instructed on 10/16/15 to ensure accurate and timely documentation on the "Frequent Resident Monitoring Log" (30 minutes checks). Resident #80 was already assigned to group C. The staff member on each shift responsible for group C was instructed to ensure that the monitoring documentation is completed for Resident #80. On 10/16/15 nurses working with Resident #80 instructed to follow up and ensure that the Frequent Resident Monitoring Log/Hourly Monitoring documentation is completed by CNAs accurately and timely. The Frequent Resident Monitoring Log was revised for Hourly Monitoring (See Forms #1A, 1B, and 1C), 30-minute Monitoring (See Forms #2A, 2B, and 2C) and 15-minute Monitoring (See Forms #3A, 3B, 3C). These forms will be utilized	

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	resident got the floor mat and low bed, which the DON indicated was on 1/20/15 at 9:20 a.m. On 10/6/15 at 3:30 p.m., the DON provided copies of the resident's "FSI" (Fall scene Investigation Report" for each of the resident's falls. The FSI for 1/20/15 indicated "poor safety awareness, often attempts to transfer per self, poor balance, gait unsteady, unaware of need to call for assist." Resident was alone and unattended at time of fall. On 10//7/15 at 10:00 a.m., the Administrator was interviewed and indicated the bed and chair alarm had been placed on the resident on admission. She indicated all beds in the facility have the capability to "go low" (be positioned very low to the floor, rather than standard bed height)." Fall #2. 1/23/15 at 10:00 p.m.: "CNA...stated she found the res (resident) on knees and hands in front of wc (wheelchair) on floor in...commons area...chair alarm sounding...fall unwitnessed...Outcome...abrasion to right knee 1 (sic) x 1.6 cm (centimeters) and 1.8 (sic) x 1.6 cm and to left lateral knee 0.8 (sic) x 1 cm and 3.6 (sic) x 1.6 cm. Contributing factors: confusion, tired, restless, sitting up in bed continually,		to ensure that monitoring of 4Ps (positioning, potty, personal belongings, and pain) is being completed as fall intervention. d) To address a lack of activity documentation on weekends for Resident #80, the Activity Attendance and In Room Interest Participation Log was created (See Forms #4A and 4B). On 10/21/15 all nursing staff will be instructed on how to complete the weekend activity log appropriately for Resident #80. **2. Describe how the facility reviewed all of the residents in the facility who could be affected by the deficient practice, and state what actions the facility took to correct the deficient practice for any resident that the facility identified as being affected.** a) Administrator and Director of Nursing reviewed all residents currently in the facility who	

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	throwing legs over bed and setting off bed alarm so staff assisted res to WC (wheelchair) and brought him to common area...Corrective actions taken: bed and chair alarms. Floor mats (sic) and low bed...New intervention: CBC (complete blood count), Chem 6 (bloodwork, lab panel) and UA (urinalysis) with C and S (culture and sensitivity)...." On 10/6/15 at 11:00 a.m., the DON and Administrator were interviewed. They indicated the "chair alarm" was a pressure pad alarm and the resident had been in the common area close to the nurses station. He indicated they were rounding on the resident hourly for the "4 P's" (Positioning, Personal needs (potty), pain and personal items). The Administrator indicated the labwork would have been drawn the next morning after the fall. On 10/6/15 at 3:30 p.m., the DON provided a copy of the FSI for 1/23/15. This form included, but was not limited to, the following: "...type of assistance was resident receiving at time of fall? Alone and unattended...." On 10/7/15 at 9:00 a.m., a request was made to the Administrator to provide documentation of the labwork which was ordered in response to the above fall. On 10/7/15 at 10:00 a.m., she provided the		are frequent fallers (10 residents total) and ensured that proper fall prevention measures were in place for all 10 residents. All residents currently on monitoring as a fall intervention reviewed. b) Current fall prevention practices reviewed. Nursing staff will continue to utilize the Fall Scene Investigation Report (FSI) as an internal tool (worksheet) to provide guidance to nurses in assessing the cause of fall and environment immediately after the fall. Nursing staff was re-educated to ensure that immediate interventions are implemented immediately after the fall. c) Hourly Monitoring, 30-minute Monitoring, and 15-minute Monitoring logs were revised and implemented on all units. d) The Activity Attendance and In Room Interest Participation Log was created and implemented on all units. **3. Describe the steps or systemic changes the**	

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	following: CBC, urinalysis with culture and sensitivity and Chemistry Lab (included, but not limited to, the following components: electrolytes, BUN, creatinine). These reports indicated the specimen was collected on 1/27/15 at 6:30 a.m. The urine culture report indicated the results were available 1/29 /15 at 9:45 a.m. Fall #3. 1/27/15 at 11:30 p.m.: "Writer heard resident say "Help, someone help me."...found resident lying on his back on floor...beside bed...Contributing factors: bed alarm was not plugged in. Resident has been confused...Corrective actions taken:...bed alarm was plugged back in and working properly...New intervention: staff to ensure bed alarm is plugged in and functioning properly...." On 10/6/15 at 11:00 a.m., the DON and the Administrator were interviewed. They indicated the alarms were checked on a monthly basis and the bath aides performed this duty. The DON indicated at some point, the bed alarm "got unplugged." He also indicated the resident began Bactrim for a UTI on 1/27/15. The FSI, dated 1/27/15, included, but was not limited to, the following: Root cause of the fall was the alarm, medical		**facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you have made.** 1. The Fall Intervention Policy & Procedure was updated on 10/16/15 to indicate that appropriate interventions, including adequate supervision, monitoring , and assistive devices will be implemented (when necessary), consistent with the resident's needs, goals, plan of care, and current standards of practice in order to reduce the risk of an accident. Hourly Monitoring, 30-minute Monitoring, and 15-minute Monitoring forms will be utilized to ensure that monitoring of 4Ps (positioning, potty, personal belongings, and pain) is being completed as fall intervention. (See Form #5; lines 7&8).The nursing staff will be re-educated on adequate supervision and	

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	status/physical condition/diagnoses, mood or mental status. Resident was alone and unattended at time of fall. On 10/7/15 at 9:20 a.m., the Administrator provided an "Administration Documentation History Detail Report" dated 1/27/15. She indicated this report indicated the resident's pressure alarm had been checked on 1/27/15 at 8:29 a.m. and 5:18 p.m. Fall #4. 1/28/15 at 5:00 a.m.: "Resident...found sitting on floor..New intervention: Perimeter mattress. Maintenance slip sent for perimeter mattress...." On 10/6/15 at 11:00 a.m., the DON and Administrator were interviewed. They indicated the resident received the perimeter mattress on the morning of 1/28/15 at approximately 8 a.m. The FSI, dated 1/28/15, included, but was not limited to, the following: "...what did resident say he was doing prior to fall, "itching my butt"...new meds/changed dose within last 30 days, Bactrim for UTI...charge nurse...sent request to maintenance for a concave mattress...." This form also indicated the alarm being used at the time of the fall was working		use of assistive devices to prevent accidents, proper monitoring with fall prevention, and completion of the activity log on 10/21/15. New employees will be oriented on fall interventions, bed and chair alarms, Maxi and Sara lifts, and monitoring documentation. This has been added to the new nursing employee orientation (See Form #6; lines #26, #28, #31, & #38 for nurses and Form #7; lines #23, #42, #43, #44 for CNAs). Nursing staff was in-serviced on 10/21/15 on adequate supervision and assistive devices to prevent accidents. Activity staff will be inserviced on activity log documentation this week. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place.** Director of Nursing and/or Administrator will review each Accident and Incident	

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	correctly. Resident was alone and unattended at time of fall. Fall #5. 2/3/15 at 11:00 a.m.: "...Chair alarm sounding. Staff immediately into resident's room. Found resident sitting on floor by w/c (wheelchair)...Contributing factors: on Bactrim for UTI...New Intervention: notified activity staff to try to encourage resident to attend am (morning) activity to keep active...." The FSI, dated 2/3/15, included but was not limited to, the following: Alone and unattended at time of fall; confused, does not attempt to call staff for assistance. On 10/6/15 at 11:00 a.m., the DON and Administrator were interviewed. They indicated they pulled a report which indicated the response time of when an alarm goes off to when the alarm is reactivated by staff was a range of 2 - 8 minutes. The DON indicated the resident wanted to be very independent and also had a cognitive deficit. On 10/7/15 at 10:00 a.m., the Activity Participation Log was reviewed for February 2015. This log included, but was not limited to, the following: Morning warm ups was attended twice, with two refusals documented; Men		Report to ensure adequate supervision and assistive devices are utilized to prevent accidents. Unit managers or their designee on each unit will make 3 random monitoring observations weekly for four weeks, then biweekly for two months, and monthly thereafter. Findings will be documented on the QA Checklist (see Forms #8 and #9). Director of Activities will review the activity log documentation on a weekly basis and enter documentation into the activity documentation system (ProActivity).	

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	Shoot the Breeze was documented as having been refused twice for the month and once was unable. Review of the overall activity calendar for February 2015 included but was not limited to, the following: of the 28 days in the month, 11 days lacked any documentation and were blank. Of the remaining days, 7 days had documented 1 activity attempt or interaction. Fall #6. 2/7/15 at 7:25 p.m.: "CNAs...attempting to transfer resident to toilet when his (resident's) knees gave out...res lowered to floor...New intervention: will initiate toilet riser in BR (bathroom) - maintenance request form sent..." On 10/6/15 at 11:00 a.m., the Administrator and DON were interviewed. They indicated the resident probably received the toilet riser the next day after the fall. The FSI, dated 2/7/15, included but was not limited to, the following: "Recreation of Last 3 hours before fall" included, but were not limited to, the following: "...Res had been weak today, CNA's were using Maxi lift (resident lift in which the resident is placed in a sling attached to the lift. The resident does not need to bear any weight on extremities). Res			

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	tried to stand x (times) 3 w/o assist, alarm sounded. Res insisted he needed to have a BM. Stood w/o (without) difficulty to get into WC from recliner - stood to trans to toilet, while turning knees gave out; type of assistance receiving at time of fall: assist per care plan." A copy of the current care plan, provided by the Administrator on 10/7/15 addressed the problem of falls. Interventions included, but were not limited to, the following: "All transfers via Sara (a lift which assists the resident from a sitting to a standing position and the reverse) lift, prn (as needed) Maxi lift." This intervention had an effective date of 1/20/15. Fall #7. 3/25/15 at 9:00 p.m.: "Res noted on floor. Res was sitting in recliner with kick stand up before fall. Resident's call light was on writer...heard res yelling...Res stated didn't know how he fell or what he was trying to do...New intervention: staff to ensure call light is within reach when resident is in room. Routine Norco (pain medication) bid started 3/23/15." The FSI, dated 3/25/15, included, but was not limited to, the following: type of assistance was resident receiving at time of fall was alone and unattended; noted			

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	some confusion at times; "...what appears to be the root cause of the fall? Res thinks he can walk; Describe initial interventions to prevent future falls: has bed alarm, just d/c (discontinued) chair alarm...". Fall #8. 3/29/15 at 8:00 p.m.: "CNA heard resident yell "help me." CNA observed resident sitting on floor in front of toilet...Resident stated "I have to pee." Resident has a Foley catheter...reminded resident of catheter and resident stated "oh, I forgot."...Contributing factors: resident confused and does not call for assistance...New intervention: resident was placed on 30 minute checks from 7 p.m.. - 10 p.m...." On 10/6/15 at 11:00 a.m., the DON and Administrator were interviewed. They indicted the resident had been in a wc and propelled himself to the toilet. They indicated the chair alarm had been discontinued on 3/17/15. The FSI, dated 3/29/15, included, but was not limited to, the following: assistance resident receiving at time of fall was alone and unattended; resident forgetful and confused at times; resident is weak. Fall # 9. 4/4/15 at 7:35 a.m.:..."Transferring resident from			

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	recliner to wheelchair...not bearing weight during transfer and was lowered to floor by CNAs...New intervention:... PT (physical therapy) evaluation and x 1 tx (treatment) on this date. Pt to use Sara lift for ...transfers...". On 10/6/15 at 11:00 a.m., the Administrator and DON were interviewed. They were made aware of the "Corrective Actions Taken" of "PT eval and treat transfers. 4/9/15 - PT evaluation and x 1 tx on this date. Pt to use Sara lift for safe functional transfers with x 2 person assist...and to continue Maxi lift prn." At this time, the Administrator and DON were made aware the current plan of care which addressed the problem of "falls" indicated the intervention of "All transfers via Sara lift. PRN Maxi lift" had an effective date of 1/20/15. The Administrator and DON indicated the immediate intervention after this fall was for 15 minute checks until the IDT (interdisciplinary team) team met on the daily rounds to review the fall. The Administrator and DON indicated 4/4/15 was on a Saturday and the resident got the PT order and evaluation on Monday 4/6/15. The FSI dated 4/4/15 included, but was not limited to, the following: type of assistance was resident receiving at time			

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	of fall? Assisted per care plan. Documentation was lacking on the form as to the "re-creation of last 3 hours before fall." The form indicated the root cause of this fall was "amount of assistance in effect and assistive protective device." Fall #10. 4/5/15 at 7:20 p.m.: ..."Resident was unsupervised sitting in his recliner in his bedroom prior to fall...observed sitting on the floor by CNA from another unit...New intervention: - 15 minute checks from 7 p.m. to 10 p.m...." On 10/6/15 at 11:00 a.m., the Administrator and DON were interviewed. They indicated they were increasing the frequency of checks to the resident due to the increase in frequency of falls during the time of 7:00 p.m. to 10:00 p.m. The FSI, dated 4/5/15, included, but was not limited to, the following: "...alone and unattended; confused and forgetful; "What appears to be the root cause of the fall? Resident unable to bear weight, Resident believes he can transfer himself without assistance...". A PT evaluation and plan of treatment was dated 4/9/15, and included, but was			

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	not limited to, the following: pleasantly confused, demonstrates impaired safe functional transfers, bed mobility, and is non-ambulatory. Note PT educated pt and caregivers on safe transfers with use of Sara/stand up lift. PT recommends use of Sara lift, gait belt and 2 person assist. PT recommends use of hoyer lift prn on days that pt is unable to stand up. No skilled PT services recommended at this time and no change in current level of function. Fall # 11. 4/11/15 at 6:00 a.m.: "...Res observed sitting on floor by housekeeper...who notified nursing staff. Bed in low position, floor mat in place...bed alarm working and sounded when res ended up on floor...Contributing factors: Res lays on bed most of the night with feet off bed and on floor. Returns to this position even after being repositioned with feet in bed. Res also frequently sits up and lays back down, this sometimes results in his bottom moving closer and closer to the edge of bed...Corrective action taken:...New intervention:...address pain management by moving Norco administration from 8 a (a.m.), 8 p (p.m.) to with breakfast, supper...". The FSI, dated 4/11/15, included but was not limited to, the following: type of			

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	assistance was resident receiving at time of fall: alone and unattended; confused. On 10/7/15 at 10:00 a.m. the Administrator provided a copy of the fall risk assessment dated 4/12/15, which included, but was not limited to, the following: "...makes personal choices that may increase risk (i.e. refuses assistance, doesn't use call light); forgetful/confused; high risk of falling (more aggressive precautions and interventions are needed); bed and/or chair alarms; scheduled toileting...lowering bed; relocate resident's belongings within reach; history of falls in the last 6 months,...fallen within the last 3 months, uses assistive device for locomotion, has gait or balance problems, has chronic pain or discomfort, impaired vision, confused occasionally, diagnosis of dementia...medications: diuretics, antihypertensives, narcotics...". A progress note dated 5/19/15 at 8:04 a.m., indicated the following: "On 5/17/15, (no time documented), it was reported that (name of Resident #80) was found wheeling himself in the...parking lot looking for his car..." Documentation indicated the resident had a code alert (device applied to applied the resident's wc to alert the facility when the resident			

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	nears an exit door) applied after his return to the facility. On 10/5/15 at 11:00 a.m. the Administrator was interviewed regarding the elopement incident on 5/17/15. She indicated the resident was found in the parking lot at 6:25 p.m. after having been seen in the facility "a little after 6 p.m." The Administrator indicated in addition to the code alert, additional preventative measure was the activity department to increase the resident's involvement in activities. She also indicated the resident had a UTI (urinary tract infection) at this time and was on an antibiotic. Fall #12. 5/30/15 at 2:35 p.m.: "...Res found sitting on floor...3 feet from recliner...Res stated he was trying to get his walker which was on the other side of bed under window...CNA stated she look (sic) in on resident a few minutes before and he was resting in recliner...Outcome: faint purple bruise noted to left buttock...New intervention: Res wheelchair will be kept with in reach when res in recliner in room...". On 10/6/15 at 8:40 a.m. the DON provided a copy of "Preventing a Fall: Frequent Checks/Rounding of the Resident Using the 4 P's." They included, but were not limited to, the			

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	following: "Are the resident's personal items within easy reach? Is the ...walker, all within easy reach? Place all these items within easy reach." On 10/6/15 at 11:00 a.m. the DON and Administrator were interviewed. The DON indicted they wanted to keep things in reach the resident wanted as they didn't want a fall. He indicated they also didn't want him to ambulate himself. He indicated this was part of the 4 P's. The FSI, dated 5/30/15, included, but was not limited to, the following: tried to stand up per self, weak; alone and unassisted; confused. Indicated resident had been sitting in recliner, call light within reach. Fall #13. 6/9/15 at 9:50 p.m.: "...Alarm went off, CNA went to room immediately and observed resident sitting on floor...Stated he was "itching his butt" and slid out of bed...New Intervention: Calmoseptine...topical ointment to itchy areas..." The FSI, dated 6/9/15, included, but was not limited to, the following: "alone and unattended; Continues to have itching issues that does not improve with treatment. May need to see dermatologist. Root cause of fall:			

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	medication, not effective with itching; may have encountered an allergen while walking with son; root cause of fall: itching - chronic." On 10/7/15 at 9:00 a.m. the Administrator was asked to provide a copy of the physician order for Calmoseptine ointment (used to prevent and treat minor skin irritations). On 10/7/15 at 10:00 a.m., the Administrator provided a copy of the following physician order, dated 7/1/15 for "first became standing" and "start date" was 7/2/15. The Administrator also provided a copy of the physician order for "Hydrocortisone Cream (used to treat skin irritations, allergic reactions and other types of skin problems)...apply to itchy areas twice a day." This order had a start date of 4/20/15 and a "first became standing "on 4/20/15." On 10/7/15 at 10:00 a.m. the Administrator provided a copy of the Fall Risk Assessment, dated 7/13/15, which included, but was not limited to, the following: "makes personal choices that may increase risk (i.e. refuses assistance, doesn't use call light); forgetful/confused; high risk of falling (more aggressive precautions and interventions are needed); bed and/or chair alarms; scheduled toileting...lowering bed;			

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	relocate resident's belongings within reach; history of falls in the last 6 months (was left blank)...fallen within the last 3 months, uses assistive device for locomotion, has gait or balance problems, impaired vision, confused occasionally, diagnosis of dementia...medications: diuretics, antihypertensives, narcotics...special interventions:...floor mat when in bed for safety and injury prevention...30 min (minute) checks." Fall #14. 8/14/15 at 3:35 a.m. "Res bed alarm sounded. CNA nearby in hallway...res sitting on floor...by bed. Top drawer of bedside table was pulled part way out. Res acknowledged getting into drawer "...Is there any sucking candy in there? ...New intervention: oxygen orders added - O2 (oxygen) for SOB (shortness of breath) and monitor O2 sats (saturation) prn (as needed)." Nurses notes for 8/13/15 and 8/14/15 were reviewed and lacked documentation of the resident having complained of or observations of shortness of breath. The FSI, dated 8/14/15, included but was not limited to, the following: alone and unattended, Re-creation of last 3 hours before fall, was left blank; root cause of fall was medical status/physical condition/diagnoses and confusion and			

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	dementia. The "Describe initial interventions to prevent future falls" was left blank. On 10/7/15 at 10:00 a.m. the Administrator provided a copy of the physician order, dated 8/15/15 at 8:58 a.m. for "Oxygen at 2 liters per nasal cannula as needed for shortness of breath." A note, written by the Administrator on the copy of this order, indicated the following: "Oxygen applied as nursing measure immediately post fall on 8/14/15. Order received 8/15/15." Fall #15. 8/18/15 at 12:55 a.m. "Res observed sitting on floor in his room...Outcome:...SPO2 94% on room air...prn O2 applied for SOB...New intervention: Fax prepared for physician for orders for PT/OT eval and tx. PT evaluation only..." On 10/6/15 at 11:00 a.m. the Administrator and DON were interviewed and indicated the immediate intervention implemented to prevent the resident from falling was prn benadryl (for itching) given as well as prn oxygen. They indicated the staff continued to sit close to the resident's door. The FSI, dated 8/18/15, included but was			

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	not limited to, the following: alone and unattended; alarm being used and working, had been given antibiotic Keflex and a duoneb treatment (respiratory treatment). Re-creation of Last 3 hours before fall: "Res appeared to be resting quietly prior to fall. Bed alarm had not sounded due to Res restless and c/o itching prior to his getting out of bed." The physical therapy evaluation, dated 8/19/15, included, but was not limited to, the following: "...Evaluating therapist discussed with nursing staff about any changes with his consistency with Sara Lift transfers, which they said there is no change. Nursing implementing floor mat and silent bed alarms (when alarm is activated by the resident, it does not sound but vibrates on the CNA device) to prevent future falls. PT recommended and educated patient for preventing future falls. But due to his STML (short term memory loss) he needs constant staff supervision and periodical checks for which PT made recommendations and possibly a bariatric bed so as to prevent him rolling out of bed..." On 10/7/15 at 10:00 a.m., the Administrator provided a copy of a physician order dated 8/20/15 as a late entry for 8/19/15 for "PT evaluation			

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	only." Fall #16. 8/20/15 at 9:45 p.m.: "...Resident bed alarm sounding as CNAs were approaching his room for bed check. He was found on the floor mat beside low bed...Resident stated "itching/pain" to bilateral legs...Contributing factors:...continues to be confused and itching at HS (bedtime) persists. Occasionally short of breath...New Intervention: continue to monitor for itching and treat with Calmoseptine, Tylenol and Benadryl as needed..." The FSI, dated 8/20/15, included but was not limited to, the following: confused and restless, more so than usual. Re-creation of last 3 hours before fall: Resident had been highly confused...recent atb (antibiotic) for URI (Upper respiratory infection). Fall #17. 8/23/15 at 1:15 a.m.: "Resident found on floor beside bed...alarm sounded and answered promptly by writer and CNA, writer had just peeked in on resident 10 minutes previous. He was resting quietly, w/c close to bed...New Intervention: PT to address fall, 9/1/15 - PT evaluation and tx completed. Pt to be seen ...for NMR (neuromuscular reeducation)...and E stim			

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	(Electrical stimulation to muscles, which increase muscle strength and also promotes blood supply to the area to assist in healing)..." On 10/6/15 at 11:00 a.m., the Administrator and DON were interviewed. They indicated an physician order was date 9/1/15 for Physical therapy to address the fall, evaluate and treat. They indicated the resident began therapy on 9/3/15. They also indicated the E stim began on 9/3/15. On 10/7/15 at 10:00 a.m., the Administrator provided a copy of the physician order, dated 9/1/15, for "Physical Therapy Evaluate and Treat for E-stim (treatment) to wounds on right foot." The Administrator indicated they thought the E stim would possibly help the resident's pain and itching in his lower extremity. The FSI, dated 8/23/15, included but was not limited to, the following: alone and unattended; alarm being used and sounding; resident confused; What appeared to be the root cause of the fall? "Res itchy but kept talking about tell me the story of my parents again." Initial Intervention to prevent future falls: continue 30 minute checks.			

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	A PT evaluation, dated 9/3/15, included but was not limited to, the following: "Patient referred due to new onset of reduced ADL participation, increased fall risk, decrease in functional mobility. Impressions included, but were not limited to, the following: "...pt requires extensive level of assist for transfers now requiring stand up lift...PT plans a trial of e-stim for wound care/facilitate healing...and improve overall strength for transfers..." Fall #18. 9/4/15 at 10:30 p.m.: "Alarm sounded and CNA observed resident on floor...contributing factors: needed to...toilet and confused...New intervention: Wide bed...". On 10/7/15 at 10 a.m., the Administrator provided a physician order, dated 9/8/15, which indicated the resident's bed alarm had been discontinued. On 10/615 at 11 a.m., the Administrator and DON were interviewed. They indicated at the time of this fall, the resident remained on 30 minute checks. They indicted the process of the resident getting a wide bed was initiated on the morning of 9/5/15. They indicated the resident had the wide bed by 8 a.m. on 9/5/15.			

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	The FSI, dated 9/4/15, included but was not limited to, the following: resident was alone and unattended; was scratching his legs, they were itching; alert and oriented, as usual; CNA to stay in hall and chart next to his room. On 10/2/15, the resident was not observed in his room at 9 a.m. At 9:30 a.m., the resident was observed in the Lavendel dining room in a group of residents waiting for an activity to begin. The "Frequent Resident Monitoring Log" for 10/2/15 was reviewed and indicated the resident was documented as being in his room at 9 a.m. and 9:30 a.m. On 10/7/15 at 11 a.m., the resident's Activity participation log was reviewed. This form indicated on 10/2/15, the resident had been assisted to the activity which was "Morning Warm Ups" at 9:30 a.m. in the Lavendel dining room. On 10/5/15 at 10:10 a.m., CNA #5 was interviewed regarding which staff did the 30 minute checks on the resident. She indicated "...whoever, anyone can do them..." She indicated if a staff member walks by and sees the resident they can document it in the log book. At this time, she looked in the book and documented from 6 a.m. to the current time on this date.			

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	On 10/6/15 at 8:45 a.m., the DON provided a copy of the facility policy and procedure for "Fall Intervention Policy and Procedure." The policy was dated 6/2012. The purpose included, but was not limited to, the following: "To assess residents at risk for falls and to implement fall prevention plan of care...Utilizing a multidisciplinary team evaluation of resident falls will enhance the prevention or reduction of continuing resident falls..." The policy included, but was not limited to, the following: "...A proactive plan of care will then be implemented. If an incident occurs...causative factors and actions taken by the facility personnel will be completed in the Accident and Incident (A and I) and/or the medical record...". The procedure included, but was not limited to, the following: "A multi-disciplinary review will be conducted to minimize repeated occurrences...An A (sic) and I will be completed by (name of facility) staff and reviewed by Administration, the Director of Nursing...Human Resources and the Social Service Director...Within 24 hours of a fall, the nursing staff will try to identify possible or likely causes of the incident and implement appropriate interventions to prevent future falls...Staff will follow- up with any new interventions prescribed...or			

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	recommended by the interdisciplinary team...". On 10/6/15 at 8:50 a.m., CNA #6 was interviewed. She indicated it takes her about 45 minutes to an hour to complete her charting for her shift. She indicated on her shift, she does bed checks every 2 hours but not everyone gets bed checks, only those resident's who are a "check and change" (utilize a brief for incontinent needs). She indicated the CNA's observed all the resident's for the 4 P's (Positioning, potty, pain and personal items). On 10/6/15 at 3:20 p.m., the Administrator was interviewed. She indicated she reviewed the (name of call light response report) report and the facility call light response times ranged from 2-8 minutes. She indicated the response time included the time the pressure alarm sounded until it was reset. She indicated when the resident was on the Rehab unit, the fall alarm on the resident was set so it sounded audibly. She indicated when the resident moved to the Lavendel unit, where he is currently located, the alarm was programmed to vibrate on the CNA's pagers to alert them the resident's pressure alarm had been activated.			

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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
	On 10/7/15 at 9:20 a.m., the Administrator provided a copy of the resident's current care plan for Falls. The goal was "...no serious injuries from falls..." Interventions included, but were not limited to, the following: Interventions with an effective date of 1/20/15: floor mat when in bed for safety and injury prevention, low bed for safety; call light kept in reach, all transfers via Sara lift, prn Maxi lift; Bed alarm for safety; Staff will encourage resident to call for assistance before attempting transfer or ambulation, Very forgetful and confused. Hourly rounding (4 P's) as fall prevention and alarm reduction, effective date of 4/16/15. On 10/7/15 at 9:20 a.m. the Administrator was interviewed. She indicated the "bed alarm for safety" was not for fall prevention but for safety. She also indicated in regards to the Kiosk (computer mounted to the wall in the hallway) located on the wall in the hall near the resident's room, they felt this was a benefit as staff could stay close to the resident and document on the KIOSK, since they know the resident was a fall risk and can respond to him. On 10/7/15 at 10:00 a.m., the resident's room was observed. The room was located at least 49 feet from the unit			

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	nursing station, and at least 38 feet from the opposite hall. At the opposite end of the hall from the nurses station was a lounge. The entrance door to the resident rooms in the hall, was at least 4 feet from the walls in the hall. While standing in the resident's doorway, and looking to the right, the KIOSK (facility computer device mounted to the wall) was not visible but was located to the right of the resident's door, at a 45 degree angle. On 10/7/15 at 10:20 a.m., Activity Staff #7 was interviewed. Resident #80's Daily Activity Flow Sheet for October 2015 was reviewed. On 10/5/15, Resident #80 was documented as having attended the " (name of person supplying activity) activity. At this time, Activity Staff #7 indicated the two sets of initials on the activity log for Resident #80 indicated the staff who brought the resident to the activity and the other staff who assisted the resident from the activity at its completion. The Activity Flow sheet for 10/5/15, was reviewed and was observed to have two sets of initials for the 2:00 p.m. activity. The current activity calendar was reviewed and indicated the "(name of person supplying activity)" activity began at 2:00 p.m. The resident's Frequent Resident Monitoring Log was reviewed for 10/5/15. This form indicated for the entries at 1:00 p.m., 1:30			

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	p.m., 2:00 p.m., 2:30 p.m., 3:00 p.m., 3:30 p.m., the resident was observed in his room. On 10/7/15 at 11:55 a.m., the Administrator and DON were interviewed. In review of the "Frequent Resident Monitoring Log," they indicated staff have a group of residents they care for. They indicated this resident had been a challenge to track because he self propelled himself in his wheelchair. The Administrator indicated if Resident #80 was included in a staff members assignment, that person would be responsible for accounting for the resident on his 30 minute checks, but anyone could document they had seen a resident for the 30 minute checks. The Administrator indicated if another staff member sees the resident on a 30 minute check, they could also document the resident was observed and where. On 10/7/15 at 12:30 p.m., Activity Staff #7 was interviewed. He provided a copy of Resident #80's current activity log for October 2015. The log indicated the resident attended the "Shoot the Breeze" activity on 10/2/15. The activity calendar, which was also provided, indicated the activity began at 10:30 a.m. Activity Staff #7 indicated Resident #80 attended this activity and remained in			

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	attendance for the entire activity. Activity Staff #7 indicated this activity would have lasted until 10:52 a.m. or 10:55 a.m. The activity log had documented the resident left the activity himself. The "Frequent Resident Monitoring Log" for 10/2/15 indicated the resident was in his room at the following documented times: 9:00 a.m., 9:30 a.m., 10:00 a.m., 10:30 a.m., 11:00 a.m. 3.1-45(a)(2)			

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F 9999 Bldg. 00	3.1-14 PERSONNEL (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. The facility must assure the following:	F 9999	**Based on interview and record review, the facility failed to ensure TB (tuberculin) skin testing was completed for 4 of 10 staff at hire (RN - Registered Nurse) #1, CNA (Certified Nursing Aide) #2, CNA #3 and LPN (Licensed Practical Nurse) #4). This deficient practice had the potential to affect all new staff hired by the facility.** **1. Describe what the facility did to correct the deficient practice for each resident cited in the deficiency.** The records of 4 staff members indicated above was reviewed and the facility ensured that TB (tuberculin) skin testing was	10/30/2015

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	(1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. Based on interview and record review, the facility failed to ensure TB (tuberculin) skin testing was completed for 4 of 10 staff at hire (RN (Registered Nurse) #1, CNA (Certified Nursing Aide) #2, CNA #3 and LPN (Licensed Practical Nurse) #4). This deficient practice had the potential to affect all new staff hired by the facility. Findings include: On 10-5-2015 at 10:30 a.m., ten personnel records were reviewed. The following 4 new staff did not have the TB test documentation to indicate a		completed for all 4 staff members. RN #1, LPN #4, and CNA#3 all had TB tests completed on 10/13/15 and read on 10/15/15. CNA#2 already had 2-step TB test completed. **2. Describe how the facility reviewed all of the employees in the facility who could be affected by the deficient practice, and state what actions the facility took to correct the deficient practice for any employee that the facility identified as being affected.** All records for new hires from 2015 were reviewed and TB was administered to three (3) new hires who did not have TB administered/documented prior to their employment. **3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also**	

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	TB test was administered and read prior to starting work at the facility: RN #1, with a hire date of 3-25-2015, had only documentation of a TB test administered on 12-9-2014 and 1-27-2014 from another facility in her record. CNA #2, with a hire date of 5-20-2015, had a first step TB test administered on 7-25-2015 and a second step TB test on 8-13-2015 by the facility. CNA #3, with a hire date of 6-3-2015, had a first step TB test administered on 11-12-2014 and the second step on 12-2-2014 at another facility. LPN #4, with a hire date of 3-25-2015, had a TB test administered by the facility on 9-3-2015. The documentation in the record indicated TB tests were administered on 7-23-2014 and 10-14-2013 at another facility. During an interview with the Vice President of Human Resource Management on 10-6-2015 at 2:17 p.m., she indicated if the newly hired staff provided proof of an active TB test or 2-step TB tests within the past 2 years, she did not require the new hires to have a TB test administered prior to their start		**should include any system changes you have made.** The Policy & Procedure for Tuberculin Screening for Employees was updated to reflect the current state requirements (See Form #10). The updated policy reviewed with Vice President (VP) of Human Resources. The Human Resources (HR) department hired the assistant HR to help ensure proper documentation and TB requirements are met on ongoing basis. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place.** VP of Human Resource will keep the list of all new hires with their hire dates and TB dates. She will turn this list monthly to the Administrator for review (See Form #11).	

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	of work at the facility. The Vice President of Human Resource Management indicated that was how she understood the state regulation. A current and undated, blank Employment Application provided on 10-6-2015 at 2:18 p.m. by the Vice President of Human Resource Management, indicated "...I understand that if offered a position...I will be required to undergo a Mantoux TB test...as a condition of employment...." A current and undated Pre-Employment Drug Screen and Physical policy was provided by the Vice President of Human Resource Management on 10-6-2015 at 2:20 p.m., and indicated "...also included in the medical file and required prior to employment is a two-step TB Mantoux test...."			
R 0000 Bldg. 00	Swiss Village was found to be in compliance with 410 IAC 16.2-5 in regards to the State Licensure Survey.	R 0000		