

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155674	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/09/2015
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NAME OF PROVIDER OR SUPPLIER ST CHARLES HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 3150 ST CHARLES ST JASPER, IN 47546
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey dates: November 30, December 1, 2, 3, 4, 8, and 9, 2015</p> <p>Facility number: 002628 Provider number: 155674 AIM number: 200299110</p> <p>Census bed type: SNF: 14 SNF/NF: 37 Residential: 33 Total: 84</p> <p>Census payor type: Medicare: 12 Medicaid: 25 Other: 14 Total: 51</p> <p>These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by #02748 on December 14, 2015.</p>	F 0000	<p>Preparation or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged, or conclusions set forth on the statement of deficiencies.</p> <p>This plan of correction is prepared and executed solely because it is required by Federal and State law.</p> <p>This plan of correction is submitted in order to respond to the allegations of noncompliance cited during annual survey review concluding on December 9,2015</p> <p>Please accept this plan of correction as the provider's credible aggregation of compliance effective on 1-8-2016</p> <p>We respectfully request paper compliance.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F 0250 SS=D Bldg. 00	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on observation, interview, and record review the facility failed to ensure effective behavior management services were provided for 1 of 1 resident who met the criteria for review of Social Services. (Resident #78)</p> <p>Findings include:</p> <p>The clinical record of Resident #78 was reviewed on 12/2/15 at 8:00 A.M. The record indicated Resident #78 was admitted on 7/21/15 with diagnoses including, but not limited to, dementia. The clinical record further indicated Resident #78 was discharged to a behavioral health unit on 9/22/15.</p> <p>A hospital Mini-Mental status exam dated 7/21/15 indicated Resident #78 experience moderate to severe cognitive impairment.</p> <p>The Admission MDS (Minimum Data</p>	F 0250	<p>F 250</p> <p>Resident #78 no longer resides in the health campus</p> <p>Completion Date 1-8-2016</p> <p>All residents have the potential to be affected by the alleged deficient practice and therefore through in services, re education of staff, and audits the campus will ensure it effective behavior management services are provided. An audit has been completed of all residents to assure any resident in need of a behavior management program has one implemented.</p> <p>Completion Date 1-8-2016</p>	01/08/2016

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	<p>Set) assessment dated 7/29/15 indicated Resident #78 experienced severe cognitive impairment, mood impairment, and no behaviors.</p> <p>The Admission Physician's Orders dated 7/21/15 lacked any documentation related to behaviors.</p> <p>The Admission Nursing Assessment dated 7/21/15 indicated Resident #78 experienced impaired cognition and had a history of behaviors.</p> <p>A Care Plan for "Behaviors...Sundowns [sic]" dated 7/21/15 included the following interventions, "...Approach in a calm manner, Assess for behavior triggers, Remove triggers when possible, Reduce stimuli, Redirect/reorient, Involve in activity of choice, Explain reason for care/treatment, Explain risks of noncompliance with care/treatment...</p> <p>A Resident First Conference Note dated 7/28/15 indicated Resident #78 experienced no behaviors.</p> <p>Behavior #1: A Nursing Progress note dated 8/22/15 at 4:00 P.M. indicated, "...Res. . [resident] aggitated [sic] et spit</p>		<p>Social services has been in serviced on the behavior management program. All campus staff have been in serviced on documentation of behaviors and where to find care plan interventions for behaviors. Campus nurses have been in serviced on using the assessment titled Mental Wellness Circumstance, Assessment and Intervention form when a new or an exacerbation of a behavior occurs. Nurses have also been in serviced on implementing new behavior interventions and capturing interventions applied to mitigate behaviors.</p> <p>Systemic change will include Social Services maintaining a tracking log of all residents on behavior management</p> <p>Completion Date 1-8-2016</p>	

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	<p>meds [medicines] out @ [at] nurse...attempted to clean res mouth...grabbed wash clothes et [and] threw on ground et began raising voice...reassured et attempted to difuse [sic] situation when res. grabbed nurse arm et began angerly [sic] twisting. ...had to pry res hands off of nurse..." The note lacked any documentation to indicate a new intervention was implemented to manage the behavior of Resident #78.</p> <p>The Social Service Progress notes from 7/29/15 through 8/23/15 lacked any documentation related to the behaviors of Resident #78.</p> <p>An untimed Social Service Progress note dated 8/24/15 indicated, "...See nurses notes for behavior details, dated 8/22/15...will continue to monitor." The note lacked any documentation related to the tracking of behavior episodes or to indicate an effective behavior management program was implemented.</p> <p>During an interview on 12/8/15 at 2:00 P.M., the SSD (Social Services Designee) indicated she was not aware it was necessary to develop a behavior plan after one episode was exhibited.</p> <p>Behavior #2: A Nursing Progress note dated 8/31/15 at 7:30 P.M. indicated,</p>		<p>SSD and /or designee will print group behavior detail report daily to assure the Mental Health Wellness Circumstance, Assessment, and Intervention form was completed when indicated to assure behaviors and psychosocial needs were documented, monitored, and addressed 5x a week for a month then 3x a week for a month then weekly with results forwarded to QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments</p> <p>Completion Date 1-8-2016</p>		

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	<p>"...res. hit at nurse et yelled...Res. redirected et left sitting in hallway to calm..." The note lacked any documentation to indicate a new intervention was implemented to manage the behavior of Resident #78.</p> <p>Behavior #3: A Nursing Progress note dated 8/31/15 at 8:00 P.M. indicated, "...during care resident combative with staff. Res grabbed...by wrist et squeezed hand had to be removed ...resting quietly abed..." The note lacked any documentation to indicate a new intervention was implemented to manage the behavior of Resident #78.</p> <p>Behavior #4: A Nursing Progress note dated 8/31/15 at 9:15 P.M. indicated, "...observed laying sideways abed with gown off...assisted res up in bed...aggitated [sic] but more cooperative than previously through day..." The note lacked any documentation to indicate an intervention was implemented to manage the behavior of Resident #78.</p> <p>An untimed Social Service Progress note dated 9/1/15 indicated, "...See nurses notes for behavior details dated for 8/31/15. Will continue to observe." The note lacked any documentation related to the tracking of behavior episodes or to indicate an effective behavior</p>			

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	<p>management program was implemented.</p> <p>Behavior #5: A Nursing Progress note dated 9/1/15 at 9:30 P.M. indicated, "...irritable following supper...approached res et asked if ready to go to bed....verbally inappropriate et swinging arms...allowed res to calm down. Later assisted to bed. During transfer et bed bath res physically agitated...grabbing arms of staff et squeezing/twisting during all care..." The note lacked any documentation to indicate an intervention was implemented to manage the behavior of Resident #78.</p> <p>An untimed Social Service Progress note dated 9/2/15 indicated, "...See nurses note from 9/1/15 for behavior details. Will continue to observe..." The note lacked any documentation related to the tracking of behavior episodes or to indicate an effective behavior management program was implemented.</p> <p>Behavior #6: A Nursing Progress note dated 9/4/15 at 11:40 A.M. indicated, "...assisted...to transfer...hoyer [brand name of mechanical lift] lift to bed, to change brief et wet shots [sic] staff explained...what we were going to do...pushed...lift away. staff then explained...pants were wet et needed to be changed...was okay with us @ [at] that</p>			

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	<p>moment...secured rsd [resident]...in lift...grabbed...thumb et squeezed...pulled thumb/hand away...stated Im [sic] going to beat the s--- out of you..." talked to rsd about that being inapporprate [sic] to talk to someone like that...rsd stated 'I don't give a d---'. Staff con't [continue] to turn et change rsd. Rsd holding onto staff members wrist while T & R [turn and reposition] et changing. rsd then threatened to slap...staff explained that is not apporiate [sic] behavior. Staff got rsd up with hoyer [mechanical lift] out of bed to w/c [wheelchair], rsd pushed... lift while staff trying to unhook lift pad. Rsd positioned in chair properly et taken to lunch..." The note lacked any documentation to indicate interventions were attempted to manage the behavior of Resident #78.</p> <p>An untimed Social Service Progress note dated 9/4/15 indicated, "...See nurses note from 9/1/15 for behavior details. Will continue to observe. New order to d/c [discontinue] Celexa [an anti-depressant medication] and to start Zyprexa [an anti-psychotic medication]. Will continue to observe..." The note lacked any documentation related to the tracking of behavior episodes or to indicate an effective behavior management program was implemented.</p>			

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	<p>Behavior #7: A Mental Health Wellness Circumstance Report dated 9/4/15 at 1:30 P.M. indicated Resident #78 experienced an incident of, "Physical, Verbal...Resistant to Care...Mood Swings with interventions of, "remove resident from situation, engage in activities, anticipate needs, provide exercise opportunities, reassurance, encourage family visitation, engage SS [Social Service] staff, toilet, provide fluid/food, check glasses/hearing aid/dentures, provide rest period, pain medication, explain procedures, break task in to simple step, validate feelings, offer helping tasks, engage in activities, evaluate medication and change as indicated, determine patterns to behaviors"</p> <p>Behavior #8: A Nursing Progress note dated 9/6/15 at 5:00 P.M. indicated, "...started swinging...grabbed nurses arm and squeezed as hard as possible ...started using expletives...decided to leave res in bed..." The note lacked any documentation to indicate interventions were attempted to manage the behavior of Resident #78.</p> <p>Behavior #9: A Nursing Progress note dated 9/6/15 at 6:00 P.M. indicated, "...was being loud et inappropriate...trying to feed him...this</p>			

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	<p>nurse attempted to feed res...spit food out...attempts to feed res stopped et staff left room to help res attempt to settle down..." The note lacked any documentation to indicate interventions were attempted to manage the behavior of Resident #78.</p> <p>Behavior #10: A Nursing Progress note dated 9/6/15 at 9:00 P.M. indicated, "...pills offered et res yelled...wasn't taking any (expletive) pills. 45 mins [minutes] later this nurse re-entered room et res took meds [medications] et no additional behaviors noted as of this time..." The note lacked any documentation to indicate interventions were attempted to manage the behavior of Resident #78.</p> <p>Behavior #11: A Nursing Progress note dated 9/7/15 at 2:10 P.M. indicated, "...very aggitated [sic]...yelled at staff...assisted rsd with [brand name of mechanical lift] into bed...told rsd step by step the process et told rsd that...needed to be changed so...wasn't wet...stated get the h--- away...had BM [bowel movement] in brief et staff educated rsd the reason to change him as staff rolled rsd he started to hit...easily reach from res hands et asked him not to hit staff. rsd then stated well don't put your hands on my a--. this nurse stated I was only</p>			

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	<p>cleaning up. As this nurse was cleaning his scrotum rsd grabbed this nurses hand and squeezed hand really hard...reached for rsd hand to let go of his grip et told rsd he could squeeze...hand but you can't be mean to a lady...rsd seemed calmed down." The note lacked any documentation to indicate interventions were attempted to manage the behavior of Resident #78.</p> <p>Behavior #12: A Nursing Progress note dated 9/8/15 at 12:10 A.M. indicated, "...while putting BP [blood pressure] cuff on resident, resident was rubbing hand up et down nurses R [right] hip et buttock. This nurse moved out of reach of resident..." The note lacked any documentation to indicate interventions were attempted to manage the behavior of Resident #78.</p> <p>Behavior #13: A Nursing Progress note dated 9/8/15 at 9:40 A.M. indicated, "...being very aggressive with staff...yelling...swinging arms...cussing at staff. this nurse went in room with a male...softly explained what we was [sic] doing as we did it et why we did it. seemed to calm down a bit after we started putting him in bed..."</p> <p>Behavior #14: A Nursing Progress note dated 9/8/15 at 10:40 A.M. indicated,</p>			

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	<p>"...rsd needed to be cleaned up by staff d/t incontinence [sic] et staff uses hoyer to transfer this nurse...brought hoyer into room...started yelling stating what are you gonna do with that. this nurse explained to rsd that staff must use it to transfer him saftly [sic] so staff can change him. as this nurse et CRCA [Certified Resident Care Assistant] was lifting rsd started cussing at CRCA et attempting to bite CRCA this nurse stopped lowered him back into his chair to calm him down...rsd still continues to be aggressive with staff this nurse asked another CRCA to get ... the adminstrator [sic] to assist...[Administrator] came in assisted with calming rsd down et was able to get rsd transferred his bed. this nurse crca started to help roll rsd rsd stated he could do it et keep our hands off him. staff allowed rsd to role [sic] himself et staff slightly helped rsd then started yelling at staff again The administrator [sic] calmed him down again. this nurse was the [sic] able to clean rsd up. rsd now resting in bed..."</p> <p>A Nursing Progress note dated 9/8/15 at 5:40 P.M. indicated, "... transferred to [name of hospital for psych [psychiatric] eval [evaluation d/t [due to] mental status change et verbal physical abuse to staff..."</p>			

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	<p>An untimed Social Service Progress note dated 9/8/15 indicated, "Behaviors continued over the holiday weekend. No behaviors on 9/5/15. See nurses notes from 9/6/15 to 9/7/15 for behavior details. SS [Social Services] talked to staff and family about behaviors. Family and staff feel like resident would benefit from a Caring Hands consult. See nurses notes for today (9/8/15) for behavior details. Will continue to observe." The note lacked any documentation related to the tracking of behavior episodes or to indicate an effective behavior management program was implemented.</p> <p>An untimed Patient Transfer Form dated 9/8/15 indicated Resident #78 was transferred to hospital for "Mental Status change. verbal et physically abusive to staff..."</p> <p>An Physician's History and Physical dated 9/11/15 indicated Resident #78 experienced, "...Acute...behavioral problems..."</p> <p>A Nursing Progress note dated 9/14/15 at 2:30 P.M. indicated Resident #78 was re-admitted to the facility from the hospital. The note lacked any documentation to indicate behavior management interventions were implemented.</p>			

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	<p>A Nursing Admission Assessment dated 9/14/15 indicated Resident #78 had a history of behaviors managed by care plan interventions.</p> <p>A Behavior Care Plan dated 9/14/15 included the following interventions: "Approach in a calm manner, Remove trigger when possible, Reduce stimuli, Involve in activity of choice, Provide medication per physician order, Explain consequences of behaviors"</p> <p>Behavior #15: A Nursing Progress note dated 9/15/15 at 5:00 P.M. indicated, "...Approached...to admin [administer] meds [medicines] per MD [physician] order. Res took spoon from nurse et gave self meds, drink offered et taken. Res then spit meds et water out. Shirt soiled. Staff attempted to change shirt, working with res. calmly et quietly. Res became agitated et cont yelling @ staff et refusing care. Wife arrived...agitated mood cont...remains angry but agreeing to care..." The note lacked any documentation to indicate interventions were attempted to manage the behavior of Resident #78.</p> <p>Behavior #16: A Nursing Progress note dated 9/15/15 at 6:45 P.M. indicated,</p>			

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	<p>"...agitation began again. Staff attempts to redirect unsuccessful. Res. left in room with call light in reach to difuse [sic] situation. Will attempt with care later."</p> <p>Behavior #17: A Nursing Progress note dated 9/15/15 at 7:30 P.M. indicated, "...responded to res alarm...observed attempting to transfer self...began yelling @ staff, grabbed CRCA by wrist then hit aid across face. CRCA left room immediately..." The note lacked any documentation to indicate interventions were attempted to manage the behavior of Resident #78.</p> <p>Behavior #18: A Nursing Progress note dated 9/15/15 at 7:45 P.M. indicated, "...Staff responded to res alarm. Redirection attempted. Snack, toileting et bed offered but refused. Staff attempted to discuss children, wife et pet bird but unable to calm res..." The note lacked any documentation to indicate new interventions were attempted to manage the behavior of Resident #78.</p> <p>Behavior #19: A Nursing Progress note dated 9/15/15 at 8:15 P.M. indicated, "...Nurse responded to res alarm. Res [up] in room transferring [sic] self. When res saw nurse res attempted to push nurse, close door et began yelling to go away help wasn't needed...While calling</p>			

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	<p>for help res grabbed nurses arms then legs et squeezed. Male aid responded to call...Res began yelling louder et told nurse the man would kill her. Nurse had male leave et get female nurse. Nurses assisted res back in chair. Res cont to yell @ nurse she was going to die. Res holding on to [sic] wrists refusing to let go. Male aid saw walking in hall by res et res screaming @ aid. Res refused to let nurse leave. Res remain 1 on 1 with nurse. Attempts to contact spouse cont."</p> <p>Behavior #20: A Nursing Progress note dated 9/15/15 at 8:35 P.M. indicated, "Res cont 1 on 1 with nurse. Res yelling occasionally that nurse is stupid et should know better than to mess with man d/t [due to] him killing nurse...Bed [sic] toileting an [sic] snack offered. Res. talking briefly about bird then began yelling again"</p> <p>Behavior #21: A Nursing Progress noted dated 9/15/15 at 8:50 P.M. indicated, "...began kicking et yelling @ nurse. Nurse ignored outburst et res stopped..." The note lacked any documentation to indicate interventions were attempted to manage the behavior of Resident #78.</p> <p>Behavior #22: A Nursing Progress note dated 9/15/15 at 9:05 P.M. indicated, "Res paranoid et watching aids in</p>			

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	<p>hallway telling nurse every thing [sic] each aid is doing. Res states nurse is still in danger but nurse does not care. Res reassured nurse cares et cont to sit with res. Res voices...prefers nurse remains with res for safety 1 on 1 cont."</p> <p>Behavior #23: A Nursing Progress note dated 9/15/15 at 9:15 P.M. indicated, "Res states there are three 'rotten eyes' behind curtains et in doorway. Res states the women is just as bad then [sic] man. No people present in doorway or curtains." The note lacked any documentation to indicate interventions were attempted to manage the behavior of Resident #78.</p> <p>The Behavioral Detail Report from 7/23/15 through 9/15/15 lacked any documentation to indicate Resident #78 experienced any behaviors.</p> <p>Behavior #24: A Nursing Progress note dated 9/16/15 at 4:20 A.M. indicated, "...trying to get out of bed...staff tried to assist...began yelling loudly et calling staff names. no amount of redirecting will work....Received order to send resident to [name of behavioral health unit] for evaluation et tx [treatment] "</p> <p>An untimed Social Service Progress note dated 9/16/15 indicated, "Behaviors</p>			

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	<p>occurred [sic] on 9/15/15. See nurses notes. Behaviors continued. Resident sent to ER for evaluation. Resident returned from hospital with an order for Seroquel [an anti-psychotic medication]" The note lacked any documentation related to the tracking of behavior episodes or to indicate an effective behavior management program was implemented.</p> <p>The Behavioral Detail Report dated 9/16/15 indicated Resident #78 experienced a behavior of verbal abuse, socially inappropriate behavior/other" at 4:00 P.M. The plan indicated 1 to 1 care was provided et not effective, and unspecified diversion activities of redirection were provided and not effective.</p> <p>A Mental Health Wellness Circumstance report dated 9/16/15 indicated Resident #78 experienced an incident of "Physical, verbal, sundowning, resistant to care, mood swings, yelling out" with interventions of "engage in activities, anticipate needs reassurance encourage family visitation, toilet, explain procedures, simple choices, engage in activities, discuss old memories evaluate medications and change as indicated" The note lacked any documentation to indicate new interventions were attempted to manage the behavior of</p>						

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	<p>Resident #78.</p> <p>A Care Plan for "Activities of Interest" dated 9/16/15 included interventions of, "...enjoy crossword puzzles that my wife supplies...you might ask me some of the questions on the puzzle to assist me in completing it...love Western movies, Turner Classics and game shows..."</p> <p>Behavior #25: A Nursing Progress note dated 9/16/15 at 4:20 P.M. indicated, "refusing...Coumadin [a blood thinning medication]...refused staff to assist with toileting, refused snack/fluids, et refused to go to evening meal...res repeatedly tries to pull pants down et open brief. Staff approaches Res calmly from front to offer assist/request Res not remove clothing in public areas-Res yells "Leave me alone, d--- it!" Staff attempts to reassure et redirect without effect." The note lacked any documentation to indicate new interventions were attempted to manage the behavior of Resident #78.</p> <p>Behavior #26: A Nursing Progress note dated 9/16/15 at 6:00 P.M. indicated, "Res 1:1 with wife...cont to yell @ wife et nurse periodically..." The note lacked any documentation to indicate new interventions were attempted to manage the behavior of Resident #78.</p>			

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	<p>An untimed Social Services Progress note dated 9/17/15 indicated, "Resident had behaviors yesterday evening. See nurses notes dated 9/16/15 . Will continue to observe." The note lacked any documentation related to the effective tracking of behavior episodes or to indicate an effective behavior management program was implemented.</p> <p>An untimed monitoring sheet dated 9/16/15 indicated, "...Res found on floor 9/15/15...cont with agitated behavior towards staff. Seroquel started 9/16/15 per psych NP [Nurse Practitioner]. Staff cont to approach calmly et attempt to redirect during episodes. call wife to assist [sic] when unable to diffuse [sic] situation..." The note lacked any documentation to indicate new interventions were attempted to manage the behavior of Resident #78.</p> <p>A Mental Health Wellness Circumstance report dated 9/16/15 indicated Resident #78 experienced an incident of, "Physical, Verbal...Sundowning...resistant to care...Mood swings...Yelling out" with interventions of "Engage in activities , anticipate needs, reassurance, encourage family visitation, toilet, explain procedures, simple choices, engage in</p>			

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	<p>activities, discuss old memories, evaluate medications and change as indicated." The report lacked any documentation to indicate new interventions had been implemented.</p> <p>Behavior #27: A Nursing Progress note dated 9/18/15 at 12:00 A.M. indicated, "Res was very concerned about a 'male' that his dtr [daughter] is with. Res was stating he wanted to kill this male. Res stated if he had a shotgun he would kill this male. This nurse suggested that res get [up] in WC [wheelchair] et come to TV area to take his mind off of his concerns. Res agreed.</p> <p>The Behavioral Detail Report dated 9/18/15 indicated Resident #78 experienced no behaviors on 9/18/15.</p> <p>Behavior #28: A Nursing Progress note dated 9/19/15 at 12:15 A.M. indicated, "While res was in TV area res became agitated yelling @ staff, et combative with staff...was upsetting et awakening other Res. Res was transferred to the TV area at front of building. At this time DHS [Director of Health Services] was notified. DHS stated to call his wife et see if she could come in to see res."</p> <p>A Nursing Progress note dated 9/19/15 at 12:30 A.M. indicated, "...remained</p>			

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	<p>agitated while wife at his side became aggressive with wife..." The note lacked any documentation to indicate new interventions were attempted to manage the behavior of Resident #78.</p> <p>Behavior #29: A Nursing Progress note dated 9/19/15 at 9:00 A.M. indicated, "Res attempting to stand from w/c. Staff assist res with gaitbelt to standing position. Res becomes hateful et combative, yelling at staff to get their [sic] d--- hands off him. Attempted to explain to res that staff was assisting res because his legs are weak et he could fall. Res states How in the hell do you know. That's s--- et your [sic] all stupid...slapping @ staff. Yelling...cursing loudly...cont to stumble et attempt to walk alone. when staff attempt to assist res, he becomes compative [sic] squeezing staff's arms et trying to bite staff. Asked res if he needed to use bathroom Res stated I don't need to use bathroom. Res denied pain. no s/s/ of pain. Res refused any type drink or snack. Stating 'I just want to get away from these people stealing the cart'. Asked resident about sitting outside with staff in w/c res agreeable but then refused to sit in w/c or let staff assist him saying. "Im not going any where with any of you." Alternate staff used multiple times without success [soc] Social Services notified..."</p>			

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	<p>A Nursing progress note dated 9/19/15 at 10:00 A.M. indicated, "...upset with wife yelling et cursing...wife 1:1 with res..." The note lacked any documentation to indicate interventions were attempted to manage the behavior of Resident #78.</p> <p>The Behavioral Detail report dated 9/19/15 indicated Resident #78 experienced "verbal abusive behavior" at 9:30 A.M. "redirection provided not effective" "physical abuse" at 9:45 A.M., "redirection provided not effective" and "verbal abuse" at 3:00 P.M., "diversion activities provided not effective" The report lacked any documentation Resident #78 experienced any behaviors at 0015.</p> <p>Behavior #30: A Nursing Progress note dated 9/21/15 at 8:15 P.M. indicated, "...restless...offered toileting or ambulation...refused all redirection...became verbally inappropriate with staff et physically by grabbing a hold of staff et hitting @...This nurse was bent down calmly et quietly asking res if he would like a snack et res pushed nurse over et into floor. staff [sic] able to get res into bed while res behaviors cont. once abed res ref [refused] all help except for this nurse...yelling @ all other staff to leave.</p>			

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	<p>..this nurse finished change [sic] res clothes et cont with HS [hour of sleep] care. Res told nurse several times nurse must be careful or would die. Reassurance provided..." The note lacked any documentation to indicate new interventions were attempted to manage the behavior of Resident #78.</p> <p>An untimed Social Services Progress note dated 9/20/15 indicated, "Several behaviors noted on 9/19/15. See nurses notes. SS talked to family about transferring [sic] resident to a facility who specialized in behaviors. Will follow up on Monday. Will continue to observe." The note lacked any documentation related to the tracking of behavior episodes or to indicate an effective behavior management program was implemented.</p> <p>The Behavioral Detail Report dated 9/21/15 indicated Resident #78 experienced behaviors of "verbally abusive" at 8:15 A.M., "1 to 1 provided and not effective, diversion not effective redirection not effective toileting not effective" "physical abuse" at 8:15 A.M. "1 to 1 not effective diversion not effective redirection provided not effective validation provided not effective toileted not effective"</p>			

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	<p>An untimed Mental Health Wellness Circumstance report dated 9/21/15 indicated Resident #78 experienced an incident of, "physical, verbal...sundowning... resident to care...mood swings...yelling out..." with interventions of, "remove resident from situation, anticipate needs reassurance, encourage family visitation, provided outlet to vent, toilet, provide fluid/food, check glasses/hearing aid/dentures, provide rest period, pain medication, explain procedures, simple choices, model tasks, break task into simple steps, validate feeling, offer helping tasks, discuss old memories, evaluate medication and change as indicated. The report lacked any documentation to indicate new interventions were implemented.</p> <p>A Care Plan for Behaviors dated 9/21/15 included new interventions of, "please be patient with me. At times [sic] different interventions work. You can leave me along [sic], making sure I am in a safe environment, and then try again later. You can take me outside because I enjoy being out doors [sic] I have two birds at home who I enjoy spending time with so please talk to me about my birds. I also enjoy sitting alone and watching the television. If these interventions are unsuccessful, please contact my wife and</p>			

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	<p>have her sit with me...I enjoy watching Walker Texas Ranger, so please assist me with watching this show as I enjoy..."</p> <p>Behavior #31: A Nursing Progress note dated 9/22/15 at 4:30 A.M. indicated, "Res stated, 'I want to get up'...tried to help resident get up...became combative et was swinging et cursing at staff...LPN went into room to try to help get res up...calmed down a little until LPN tried to change brief...then resident became combative again...came et got this nurse to try to calm resident down...nurse tried to talk to resident about his family to distract him this was unsuccessful...had legs out of bed trying to get up, offered to help res get up...refused et called this nurse stupid et kicked this nurse in leg. This nurse one on one with res d/t resident refusing to get up or put legs back in bed. Res remains combative et cursing at this nurse..." The note lacked any documentation to indicate interventions were attempted to manage the behavior of Resident #78.</p> <p>A Nursing Progress note dated 9/22/15 at 5:10 A.M. indicated "RN on floor spoke with [name of attending physician] et DON order received to give Haloperidol [an anti-psychotic medication] 10 mg [milligrams] IM [intramuscular] STAT [immediately]."</p>			

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	<p>An untimed Social Service progress note dated 9/21/15 indicated, "5 day assessment complete. See SS assessment."</p> <p>An Initial Psychosocial Assessment dated 9/21/15 indicated Resident #78 experienced hallucinations, was physically and verbally abusive towards others, experienced behaviors that significantly interfered with care and participation in activities and social interactions, put others at significant risk for physical injury, intruded on privacy or activity of others, disrupted care or living environment and rejected evaluation or care that is necessary to achieve goals for health and well-being with a handwritten notation of, "Resident was transferred [sic] to ER [emergency room] on 9/16/15 for increase behaviors. Resident returned a few hours later with an order for Seroquel...Resident is alert with severe cognitive impairment..."</p> <p>A Nursing Progress note dated 9/22/15 at 3:45 P.M. indicated, "N.[new] O.[order] to admit to [name of behavioral health hospital]..."</p> <p>The Behavioral Detail report for 9/22/15 lacked any documentation to indicate Resident #78 experienced any behaviors.</p>			

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	<p>The Plan of Care lacked any documentation to indicate an effective behavior management program was initiated between 8/22/15 and 9/22/15.</p> <p>A Mental Health Wellness Circumstance report dated 9/22/15 indicated Resident #78 experienced, "physical verbal, repetitive verbalization, resistant to care, moods swings, paranoia, delusions, yelling out" with an intervention of "Depakote 125 mg @ noon and HS"</p> <p>During an interview on 12/2/15 at 10:00 A.M., the SSD [Social Service Designee] provided a Behavior Management binder for 2015 and indicated the binder was kept in her office and she used the binder to monitor resident behaviors. The binder lacked any documentation to indicate Resident #78 experienced behaviors during 2015. The SSD further indicated behaviors were tracked through the Behavior Detail report and provided a Behavior Detail Log for Resident #78 dated 7/22/15 through 9/22/15. The SSD then indicated Resident #78 experienced no episodes of behaviors before 9/16/15 and behavior interventions were the same for all residents. The SSD then indicated no documentation could be provided to indicate the behaviors of Resident #78 were effectively monitored from 8/22/15</p>			

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F 0314 SS=D Bldg. 00	<p>through 9/22/15.</p> <p>During an interview on 12/2/15 at 2:00 P.M. the SSD indicated she was not aware of who was responsible to develop behavior management plans.</p> <p>During an interview on 12/8/15 at 9:00 A.M., the DON indicated no documentation could be provided to indicate the behaviors of Resident #78 were effectively managed from 8/22/15 through 9/22/15. The DON further indicated, the current behavior management system was ineffective and would need to be changed.</p> <p>A Policy and Procedure for Behavior Observations provided by the HFA (Health Facilities Administrator] on 12/3/15 at 12:22 P.M. indicated, "...To provide guidelines for the observation, monitor ing and tracking of behavior episodes"</p> <p>3.1-34(a)(1)</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</p>			

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	<p>resident who enters the facility without 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 a dependent resident admitted without pressure ulcers was provided effective interventions to prevent the development of an unstageable pressure area on the right buttock for 1 of 3 residents who met the criteria for review of pressure ulcers. This deficient practice resulted in Resident # 53 experiencing an unstageable pressure ulcer on right buttock. (Resident #53)</p> <p>Findings include:</p> <p>During an observation on 12/1/15 at 9:05 A.M., Resident #53 was observed in the hall, outside her room door, sitting in a high back wheelchair, head tilted to the left and eyes closed.</p> <p>The clinical record of Resident #53 was reviewed on 12/1/15 at 9:30 A.M. The clinical record indicated Resident #53 was admitted to the facility on 8/20/15 with no skin impairments noted to the</p>	F 0314	<p>F 314</p> <p>Resident # 53's wound healed on 12-7-2015.</p> <p>Completion Date 1-8-2016</p> <p>All residents have the potential to be affected by the alleged deficient practice and through alterations in processes and in servicing the campus will ensure measures to prevent the development of new pressure sores and provide care for current pressure ulcers in accordance with physician's orders</p> <p>Completion Date 1-8-2016</p> <p>All nursing staff have been in serviced concerning implementing effective interventions to prevent</p>	01/14/2016

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	<p>right buttock and diagnoses including, but not limited to, Parkinson's disease, paralysis agitans, depression.</p> <p>The Quarterly MDS (Minimum Data Set) assessment dated 10/14/15 indicated Resident #53 experienced severe cognitive impairment and needed the extensive assistance of 2 people for bed mobility, transfers, and was at risk for developing a pressure ulcer.</p> <p>The Nursing Admission Assessment dated 8/20/15 and 11/16/15 indicated Resident #53 experienced cognitive impairment, no skin impairments upon admission, was unable to change positions and was dependent for care.</p> <p>The Individual Plan Report (care plan) dated 9/2/15 read as follows: "I have potential for alteration in my skin integrity related to dementia and parkinsons and decreased mobility... Provide me with assistance as I need it for bed mobility..."</p> <p>The Individual Plan Report (care plan) dated 12/1/15 read as follows: "I have developed a purple unstageable area to my right buttock related to my overlay and seating/positioning in my high back wheelchair causing material to bunch...Please place nonskid pad to</p>		<p>the development of pressure ulcers.</p> <p>Systemic changes as follows OT to screen residents on seating and positioning quarterly and prn to assure effective interventions in place to prevent pressure in seating.</p> <p>Completion Date 1-8-2016</p> <p>DHS/designee will complete a random audit on 3 different residents to assure effective interventions are being implemented to provide pressure relief per the care plan 5x a week x one month 3x a week x one month then weekly with results forwarded to the QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments.</p> <p>Completion Date 1-8-2016</p>				

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	<p>wheelchair seat, full length padded insert, then place multi air cell cushion on top of padded insert...Please lay me down after meals..."</p> <p>The Progress note from Dr. (Name of doctor) MD dated 11/10/15 read as follows: "1. Severe advanced idiopathic Parkinson's disease...She needs to sit in her electric wheelchair that has appropriate padding and reclining features to ensure she does not get pressure ulcers..."</p> <p>The "PRESSURE/STASIS/ARTERIAL/DIABETIC ULCER ASSESSMENT" form for Resident #53 dated 11/26/15 read as follows: "...R.[right] buttock...Pressure...Stage E...[E: unstageable-Non-removable dressing, slough/escar: suspected deep tissue injury in evolution]...Length 3.0 width 1.0 Depth 0...Color Purple...TX: [treatment] Optifoam...Wound margins intact"</p> <p>The "PRESSURE/STASIS/ARTERIAL/DIABETIC ULCER ASSESSMENT" form for Resident #53 dated 12/2/15 read as follows: "...R.[right] buttock...L [Length] 1 cm [centimeter] W [width] 0.7 Depth 0...Color Purple...Current treatment: Cont [continue] foam dressing change Q</p>			

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	<p>[every] 3 days et [and] PRN [as needed]"</p> <p>The "PRESSURE/STASIS/ARTERIAL/DIABETIC ULCER ASSESSMENT" form for Resident #53 dated 12/7/15 read as follows: "...R.[right] buttock area healed."</p> <p>The Skin Impairment Circumstance Assessment and Intervention form dated 11/26/15 indicated a Stage E pressure ulcer was found on Resident #53's right buttock. The form also indicated Resident #53 was unable to change positions and was unable to respond to pain/discomfort.</p> <p>A Physician's Order dated 11/26/15 indicated an order for "...Optifoam to buttocks (R [right] side) change everyday et PRN..."</p> <p>A Physician's Order dated 11/30/15 indicated an order for "Pt. [patient] to use high back w/c [wheelchair] with head extension. Nonskid pad to w/c seat. Full w/c length pad insert, place coccyx cut out pressure reducing cushion with nonskid bottom..."</p> <p>The Nurse's Notes dated 11/26/15 at 7:00 A.M., read as follows: "...area noted to buttock. Intervention in place..."</p>			

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	<p>During a dressing change to Resident #53's right buttock on 12/2/15 at 10:25 A.M., the pressure area was observed to be clean and dry. 2 small brown areas were observed: 1. Approximately 1/2 inch in diameter. 2. Approximately 1/4 inch in diameter. Area appears to be healing. At that time, LPN #16 indicated Resident #53 had a seat cushion and that the material on top of the cushion had become wrinkled, which explain why the pressure area developed. LPN #16 further indicated the cushion had been replaced and the wound had improved.</p> <p>During an interview on 12/8/15 at 11:27 A.M., the Occupational Therapy Director (OTD) indicated Resident #53 was unable to reposition herself in a wheelchair or bed. The OTD indicated Resident #53 had a non-skid material placed on top of the padded wheelchair liner and nursing felt this material bunched up while the resident was sitting on it and that may have caused the pressure ulcer development. OTD indicated the non-skid material is now under the full padded liner, not on top of the liner as it was previously.</p> <p>During an interview on 12/8/15 at 12:04 A.M., the Director of Nursing was made aware of the concerns with Resident</p>			

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F 0323 SS=D Bldg. 00	<p>#53's development of a pressure ulcer. The DON indicated she had been aware upon Resident #53 admission to the facility that Resident #53 was at a high risk to develop pressure ulcers. The DON further indicated the staff had initiated and revised interventions to prevent any occurrence of a pressure ulcer.</p> <p>A Policy and Procedure titled "WEEKLY SKIN ASSESSMENT GUIDELINES" was provided by the Director of Nursing on 12/9/15 at 9:35 A.M., and it read as follows: "...To monitor the effectiveness of intervention for pressure reduction..."</p> <p>3.1-40(a)(1) 3.1-40(a)(2)</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>Based on interview and record review the facility failed to ensure interventions were implemented, new interventions were initiated, or adequate supervision was provided to prevent falls for 1 of 4</p>	F 0323	F 323 Resident #78 no longer resides in the health campus	01/08/2016			

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	<p>residents who met the criteria for review of accidents. (Resident #78)</p> <p>Findings include:</p> <p>The clinical record of Resident #78 was reviewed on 12/2/15 at 8:00 A.M. The record indicated Resident #78 was admitted on 7/21/15 with diagnoses including, but not limited to, dementia, weakness, syncope, and falling. The clinical record further indicated Resident #78 was discharged from the facility on 9/22/15.</p> <p>The Admission MDS (Minimum Data Set) assessment dated 7/29/15 indicated Resident #78 experienced severe cognitive impairment, required the extensive assistance of two staff for bed mobility and transfers, experienced unsteady balance, and had a history of falls.</p> <p>The Admission Physician's Orders dated 7/21/15 lacked any documentation related to activity or locomotion.</p> <p>The Admission Nursing Assessment dated 7/21/15 indicated Resident #78 experienced impaired cognition, required the extensive assistance of one staff for transfers, and was at risk to experience a fall.</p>		<p>Completion Date 1-8-2016</p> <p>All other residents are at risk to be affected by the alleged deficiency and through alterations in processes and in servicing the campus will 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>All resident's plan of care for safety have been reviewed to ensure safety interventions implemented and updated if necessary.</p> <p>Completion Date 1-8-2016</p> <p>Nursing staff have been in serviced by DHS/ADHS on safety care plans and implementation of new interventions when appropriate. Systemic change is nurses will consult with a nurse leader after every fall to assure a new intervention has been implemented.</p> <p>Completion Date 1-8-2016</p>	

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	<p>A Care Plan dated 7/21/15 for; "Safety" included the following interventions:</p> <p>Assess fall risk at admission, quarterly, and PRN (as needed), Provide assistive device and ensure it is accessible, Provide assistance for transfers and ambulation as needed, Provide clear directions and ensure resident understanding, Ensure glasses are clean and in place, Observe medication for side effects that may effect [sic] balance, cognition and/or gait, Refer to therapy, Toilet resident per toileting schedule, Ensure call light is within reach, Implement enabler to assist with fall prevention. Type: pressure alarms, Obtain physician order for enabler, Observe elopement attempts and wandering redirect resident, Observe for compliance with safety interventions, Provide side rail for bed mobility 1/2 [half]... X [times] 2, Instruct resident on use of call light..."</p> <p>Fall #1 A Nursing Progress note dated 7/22/15 at 6:45 P.M. indicated, "staff responded to alarm sounding. Res [resident] leaning</p>		<p>DHS /designee will monitor 3 random resident at risk for accidents/incidents to assure safety interventions in place and interventions effective 5x a week for a month then 3x a week for a month then weekly with results forwarded to QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments</p> <p>Completion Date 1-8-2016</p>	

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	<p>back in w/c [wheelchair] et pressure reducing cushion sliding forward-cushion came to rest on w/c pedals et [and] Res partially sitting on cushion et edge of w/c seat sliding down...N.O. [new order] for dicem [sic] [an anti slip device] to w/c at all times-in place.</p> <p>During an interview on 12/8/15 at 2:00 P.M., the DON (Director of Nursing) indicated the immediate intervention after Fall #1 was to add dycem between the surface of the wheelchair and the cushion. The DON further indicated bed and chair pad alarms, at all times, were added to the safety plan. The DON then indicated a Fall Circumstance Report for Fall #1 could not be provided.</p> <p>A Resident First Conference Note dated 7/28/15 indicated Resident #78 was at risk to experience falls, had not experienced any falls since admission, and utilized bed/chair alarms.</p> <p>A Care Plan for Falls dated 8/4/15 included a new intervention of, "I am in a tilted w/c with dycem"</p> <p>A Physician's Telephone Order dated 8/14/15 indicated a new order was received for, "D/C previous order for w/c w [with]/tilt. Patient to use high back w/c, dycem under cushion and on top of</p>			

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	<p>cushion..."</p> <p>Fall #2 A Nursing Progress note dated 8/18/15 at 11:00 A.M. indicated, "Res was found on floor with alarm going off...had slid out of wheelchair to floor high back chair was up in highest position...Dycem placed between...bottom et lift pad..." The note lacked any documentation a new, immediate intervention was implemented or supervision was provided.</p> <p>A Fall Circumstance Report dated 8/18/15 at 11:00 A.M. indicated Resident #78 was found on the floor of his/her room and "slid out of chair" The report indicated the new intervention was, "...Dycem placed between his bottom et lift pad..." The report lacked any documentation a new, immediate intervention was implemented or supervision was provided.</p> <p>A Physician's Progress note dated 8/19/15 indicated, "...having multiple falls...exhibiting decerebrate posturing, meaning that...kicks the legs outward, throws the arms upwards, and pushes the pelvis forward; therefore putting him at high risk of falling out of...wheelchair...patient is at high risk for falls...is unaware...is unable to walk...The</p>			

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	<p>patient is at high risk for falls...does have significant dementia and does periodically exhibit decerebrate posturing. For this reason, I think a Pommel cushion would be of benefit to prevent him from falling out of his wheelchair..."</p> <p>A Physician's Telephone Order dated 8/21/15 indicated a new order was received for, "Pommel wedge cushion in W/C [wheelchair] to keep hips safely positioned in w/c. Continue dycem under cushion, on top of cushion, and between him and lift pad..."</p> <p>During an interview on 12/8/15 at 2:05 P.M., the DON indicated the dycem was not in place on top of the cushion as ordered at the time of Fall #2. The DON further indicated the immediate intervention after Fall #2 was to place dycem between the resident's bottom and the lift pad.</p> <p>Fall #3</p> <p>A Nursing Progress note dated 8/28/15 at 9:30 P.M. indicated, "...observed laying in floor...between bed et wall...alarms not in place. Education provided to staff as intervention..."</p>			

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	<p>A Fall Circumstance Report dated 8/28/15 at 9:30 P.M. indicated Resident #78 was found on the floor of his/her room with alarms not in place. The report indicated Resident #78 rolled out of bed.</p> <p>During an interview on 12/8/15 at 2:10 P.M., the DON indicated the alarms were not applied by a new staff member as ordered and Resident #78 experienced Fall #3.</p> <p>A Nursing Progress note dated 9/8/15 at 6:00 P.M. indicated Resident #78 was admitted to the hospital for behavior changes.</p> <p>A Nursing Progress note dated 9/14/15 at 2:30 P.M. indicated Resident #78 was re-admitted to the facility.</p> <p>A Nursing Admission Assessment dated 9/14/15 indicated Resident #78 required the extensive assistance of two staff for transfers and bed mobility, had a history of falls, and was at risk to experience a fall.</p> <p>A Care Plan dated 9/14/15 for; "Safety" included the following interventions:</p> <p>Assess fall risk at admission, quarterly, and PRN (as needed),</p>			

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	<p>Provide assistive device and ensure it is accessible, Provide assistance for transfers and ambulation as needed, Provide clear directions and ensure resident understanding, Ensure glasses are clean and in place, Observe medication for side effects that may effect [sic] balance, cognition and/or gait, Refer to therapy, Toilet resident per toileting schedule, Ensure call light is within reach, Provide side rail for bed mobility 1/2... X2, Instruct resident on use of call light..."</p> <p>During an interview on 12/8/15 at 2:15 P.M., the DON indicated Resident #78 was at risk to experience a fall after returning from the hospital, but new interventions were not implemented because the alarms were suspected to be the cause of the behaviors that required hospitalization.</p> <p>Fall #4 A Nursing Progress note dated 9/15/15 at 9:30 A.M. indicated, "...found on floor...stated, 'I got up to shut the door because it was open'...pad alarms to bed et w/c at all times...."</p>			

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	<p>A Fall Circumstance report dated 9/15/15 at 9:30 A.M. indicated Resident #78 was found on floor of his/her room. The report further indicated the immediate intervention was, "bed and/or chair alarm"</p> <p>A Nursing Progress note dated 9/15/15 at 5:00 P.M. indicated, "...Res attempting to self transfer. Easily redirected..."</p> <p>A Nursing Progress note dated 9/15/15 at 7:30 P.M. indicated, "...responded to res alarm...observed attempting to transfer self..."</p> <p>A Nursing Progress note dated 9/15/15 at 7:45 P.M. indicated, "...Staff responded to res alarm.</p> <p>Fall #5 A Nursing Progress note dated 9/15/15 at 8:15 P.M. indicated, "...Nurse responded to res alarm. Res [up] in room transferring [sic] self. When res saw nurse res attempted to push nurse, close door et began yelling to go away help wasn't needed. Res began to fall backwards. Nurse caught just in time to prevent fall. Nurse unable to get res in chair completely et called for help to prevent res from going to floor. The note lacked any documentation a new, immediate intervention was implemented or</p>			

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	<p>supervision was provided.</p> <p>A Nursing Progress note dated 9/16/15 at 4:20 A.M. indicated, "...alarm was going off. Staff responded et resident was trying to get out of bed.Received order to send resident to Caring Hands unit for evaluation et tx [treatment] "</p> <p>Fall #6 A Nursing Progress note dated 9/21/15 at 1:30 P.M. indicated, "...was walking down back hallway with therapy...tripped over his own feet et fell to floor on hands et knees...intervention to walk with assist 2..." The note lacked any documentation a new, immediate intervention was implemented or supervision was provided.</p> <p>During an interview on 12/8/15 at 2:20 P.M., the DON indicated no documentation could be provided to indicate new, effective interventions were implemented or supervision was provided after each fall.</p> <p>A Policy and Procedure for Falls Management provided by the HFA (Health Facilities Administrator) on 12/3/15 at 12:22 P.M. indicated, "...To mitigate fall risk factors and implement preventative measures...a fall is considered to be: an unintentionally</p>			

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NAME OF PROVIDER OR SUPPLIER ST CHARLES HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 3150 ST CHARLES ST JASPER, IN 47546
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R 0000 Bldg. 00	<p>coming to rest on the ground, floor, or other lower level...An episode where a resident lost his/her balance and would have fallen, if not for staff intervention, is considered a fall..."</p> <p>3.1-45(a)(2)</p> <p>This visit was for a State Residential Survey.</p> <p>Residential Census: 33</p> <p>Residential Sample: 7</p> <p>The following residential finding was cited in accordance with 410 IAC 16.2-5.</p>	R 0000	<p>Preparation or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged, or conclusions set forth on the statement of deficiencies.</p> <p>This plan of correction is prepared and executed solely because it is required by Federal and State law.</p> <p>This plan of correction is submitted in order to respond to the allegations of noncompliance cited during annual survey review concluding on</p> <p>December 9,2015</p>	

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R 0243 Bldg. 00	<p>410 IAC 16.2-5-4(e)(3) Health Services - Deficiency (3) The individual administering the medication shall document the administration in the individual ' s medication and treatment records that indicate the: (A) time; (B) name of medication or treatment; (C) dosage (if applicable); and (D) name or initials of the person administering the drug or treatment.</p> <p>Based on observation, interview, and record review, the facility failed to ensure medications were administered as ordered for 1 of 5 residents observed for medication administration by 1 of 1 nurse reviewed for administration of medications. (R #16)</p> <p>Findings include: On 12/9/15 at 8:09 A.M., LPN # 1 began preparing R #16's morning medications. One of cards of R #16's medications</p>	R 0243	<p>Please accept this plan of correction as the provider's credible aggregation of compliance effective on 1-8-2016</p> <p>We respectfully request paper compliance.</p> <p>R 243 Resident # 16 medication orders were reviewed for accuracy with MD and against all medication cards in the medication cart</p> <p>Completion Date 1-8-2016</p> <p>All residents have the potential to be affected by the deficient practice and through alterations in processes and in servicing the campus will ensure medications are administered as ordered. All medications in the AL</p>	01/08/2016

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	<p>contained Potassium CHL (chloride) capsules -10 meq (milliequivalents). The label of the potassium medication card indicated: "...GIVE 4 CAPSULES (40 MEQ) ORALLY THREE TIMES DAILY..." LPN #1 removed 4 capsules of the 10 meq potassium chloride capsules and placed the capsules in the medication cup with R #16's other morning medications and administered the medications to R #16.</p> <p>On 12/9/15 at 10:55 A.M., R #16's clinical record was reviewed. R #16 had been admitted to the facility on 5/15/15. Her diagnoses included, but were not limited to, hypertension, hyperlipedemia, chronic obstructive pulmonary disease, anxiety, and dementia.</p> <p>R #16's current December 2015 routine physician's orders included but were not limited to, "... POTASSIUM CL [chloride] ER [extended release] CAP [capsule] GIVE 4 CAPSULES (40 MEQ) ORALLY THREE TIMES DAILY, AM, MIDDAY, EVENING..." The order date listed for the potassium chloride was 11/17/15. Documentation indicated the order had been changed on 11/30/15.</p> <p>A physician's order dated 11/30/15 had been handwritten on the December 2015</p>		<p>medication cart have been cross referenced with current MD orders to assure accurate.</p> <p>Completion Date 1-8-2016</p> <p>An in service was provided to nurses/QMA concerning following MD orders when passing medications. Systemic change is all assisted living nurses/QMA will complete a medication pass competency now and annually thereafter.</p> <p>Completion Date 1-8-2016</p> <p>DHS/designee will observe one nurse pass 2 resident's medication to assure accuracy of following MD orders 3x a week x one month then weekly with results forwarded to QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments</p> <p>Completion Date 1-8-2016</p>		

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	<p>physician order sheet and instructed, "...Potassium Cl [chloride] 60 meq po [orally] TID [three times a day] for Hypokalemia [low potassium]..."</p> <p>A physician's telephone order dated 11/30/15, included, but was not limited to, "...increase KCL [potassium chloride] to 60 meq po [orally] TID [three times a day] ..."</p> <p>On 12/9/15 at 10:58 A.M., R #16's current physician's orders were reviewed with LPN #1. LPN #1 indicated the current order for potassium was the order of 60 meq tid not the order 40 meq tid that she had administered. Review of R #16's December 2015 medication administration record (MAR) indicated LPN #1 had documented she had administered potassium 60 meq instead of the 40 meq LPN #1 had administered. LPN #1 indicated, at that time, that she would contact the nurse practitioner regarding the medication error.</p> <p>On 12/9/15 at 11:15 A.M., the Director of Nursing (DON) was made aware of the medication error. The DON inquired, at that time, if the physician had been notified of the error.</p> <p>On 12/9/15 at 12:52 P.M., the DON provided a facility policy entitled,</p>				

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	"Assisted Living Guidelines Medication Administration dated December 2010. The policy included but was not limited to, "...a. The administration of medications and the provision of residential nursing care shall be ordered by the resident's physician and shall be supervised by a licensed nurse on the premises or on call..."				