

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155703	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/21/2016
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NAME OF PROVIDER OR SUPPLIER BROOKSIDE VILLAGE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1111 CHURCH AVE 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: July 18, 19, 20, 21, 2016</p> <p>Facility number: 003240 Provider number: 155703 AIM number: N/A</p> <p>Census bed type: SNF/NF: 4 SNF: 23 Residential: 39 Total: 66</p> <p>Census payor type: Medicare: 10 Other: 17 Total: 27</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by #02748 on July 28, 2016.</p>	F 0000		

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 0314 SS=G Bldg. 00	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a 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 resident admitted to the facility without pressure, developed pressure for 1 of 3 residents who met the criteria for review of pressure. This deficient practice resulted in Resident #1 experiencing an unstageable pressure ulcer on the left heel and right hip. (Resident #1)</p> <p>Findings include:</p> <p>During an observation on 7/18/16 at 8:00 A.M., Resident #1 was observed lying on back in bed with heel protectors on the bilateral feet. The left heel was observed to be askew in the heel protector, not to be floated, and in direct contact with the surface of mattress.</p> <p>The clinical record of Resident #1 was</p>	F 0314	<p>This plan of correction is to serve as Brookside Village's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Brookside Village or their management companies that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.</p> <p>F 314 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>The facility respectfully wishes to present an IDR for this citation.</p> <p>Resident #1 continues to have appropriate interventions in place to prevent further skin breakdown and is end of life with family</p>	08/17/2016

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	<p>reviewed on 7/21/16 at 8:30 A.M. The clinical record indicated Resident #1 was admitted to the facility on 4/19/15 with no skin impairment to the left heel and diagnoses including, but not limited to, Parkinson's disease, postural kyphosis, weakness, abnormal posture, cognitive communication deficit, and dementia with behaviors.</p> <p>The Annual MDS (Minimum Data Set) assessment dated 3/7/16 indicated Resident #1 was at risk for developing a pressure ulcer, was cognitive intact, and needed the extensive assistance of 2 people for bed mobility and transfers.</p> <p>The Significant Change MDS assessment dated 5/12/16 indicated Resident #1 was at risk for developing a pressure ulcer, experienced severe cognitive impairment and needed the extensive assistance of 2 people for bed mobility and transfers.</p> <p>A Skin Assessment dated 5/21/16 at 6:10 A.M. indicated Resident #1 experienced no skin impairment to the left heel or the right hip.</p> <p>A Care Plan for, " ...at risk for skin breakdown r/t [related to] friction and shear ... "dated 5/16/16 included the following interventions: "Avoid shearing resident's skin during</p>		<p>consideringHospice involvement.</p> <p>All residents at risk for pressure ulcers have been identified andreviewed for appropriate interventions for prevention of pressure ulcers. A skin sweep was completed on all residentsin house and no other concerns were found.</p> <p>The systemic change includes: ·Nurses will complete a rounding tool to monitorresidents at risk for pressure ulcers regarding appropriate use of currentinterventions and positioning. ·Nursing staff will complete a skills validationfor use of heel protectors and positioning methods to prevent pressure ulcersupon hire, annually, and as needed.</p> <p>Education will be provided to nursing staff regarding prevention ofpressure ulcers, including the use of heel lift boots and wheelchairpositioning, as well as the systemic change.</p> <p>The Director of Nursing or designee will complete a quality assuranceaudit tool to monitor for residents at risk for pressure ulcers and appropriateuse of current interventions and positioning. This will be completed daily (including weekends) on random residents andrandom shifts, for four weeks, and then weekly for a duration of</p>	

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	<p>positioning, transferring, and turning, Conduct a systemic skin inspection weekly, Elevate /off load heels while in bed, Skin prep to bilateral heels and toes daily, Turn and reposition, Use cushion for pressure reduction when resident is in chair, Use pressure reduction mattress for pressure reduction when resident is in bed"</p> <p>A Care Plan for "SDTI to left heel" dated 5/26/2016 included the following interventions: "Heel lift boots at all times, No shoes on at any time at this time, Skin Prep TID [three times a day] to bilateral heel"</p> <p>A Care Plan for "bruise to right hip" dated 6/13/2016 included following intervention: "Monitor bruise/blister to right hip q shift til healed"</p> <p>A Skin Risk Assessment dated 5/12/16 indicated Resident #1 was at risk to develop pressure related skin impairment.</p> <p>The May 2016 Physician's Order Recap lacked any documentation related to pressure ulcer prevention.</p>		<p>twelve monthsof monitoring.</p> <p>The results of these reviews will be discussed at themonthly facility Quality Assurance Committee meeting monthly for 3 months andthen quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will beincreased as needed, if compliance is below 100%.</p> <p>Date of completion: August 17, 2016</p>				

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	<p>A Restorative Nursing Progress note dated 5/9/16 at 11:40 A.M. indicated, "...Resident will utilize transfer bars, to pull self over and push up with legs... "</p> <p>Development of Area to Left heel:</p> <p>An Event Report dated 5/26/16 at 1:59 P.M. indicated, "...SDTI [Suspected Deep Tissue Injury] [A Suspected Deep Tissue Injury: Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear...Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar] left heel...] 9.6 cm [centimeters] length X [by] 4.2 cm...area is light purple with small areas of deeper purple ...2 cm ring of erythema surrounds entire area ...area is fluid filled...interventions -Heels elevated in bed...heel lift boots at all times and no shoes at this time..."</p> <p>A "Resident Progress Notes" dated 5/27/16 at 12:26 P.M., read as follows, "...MD acknowledged SDTI to left heel..."</p> <p>A Skin Condition Assessment note dated 6/2/16 at 11:34 A.M. indicated, "...SDTI-left heel...8 x 4 cm, base dark</p>			

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	<p>red/grey with intact blister...Offload heels in bed...Heel lift boots at all times... "</p> <p>A Skin Condition Assessment note dated 6/9/16 indicated, "...SDTI-Left heel 8.2 cm x 4.3 cm...Stage...Unstageable...Eschar [black, brown, dry nonviable tissue] 100%..."</p> <p>A Resident Progress note dated 6/9/16 at 3:00 P.M., indicated, "A procedure was performed to determine the Ankle Brachial Index [ABI] [a test to determine blood profusion] of resident's lower legs...Right leg ABI...1.1...Left leg ABI...1.2...incate (sic) normal blood sufficiency...compressionable arteries..."</p> <p>A Skin Condition Assessment dated 6/23/16 at 4:57 P. M. indicated, "...SDTI - Left heel...8.3 cm x 4.0 cm...Eschar 100%...Resident has a decline in health and mobility in past several months, and has had to be laid down or transferred to recliner between meals for increase in abnormal posture and leaning..."</p> <p>A Skin Condition Assessment dated 7/7/16 at 12:07 P.M. indicated, "...SDTI - Left heel...5.0 cm x 3.0 cm...Eschar 100%...dark brown ...25% serous drainage..."</p> <p>A Skin Condition Assessment dated</p>			

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	<p>7/14/16 at 4:59 P.M., "...SDTI - Left heel...2.0 cm x 1.2 cm...Eschar 100%..."</p> <p>A "Resident Progress Notes" dated 7/17/2016 at 3:46 P.M., "Open area found to L [left] heel when getting resident out of bed. CNA's noticed blood on heel lift boot that was coming from a small opened area to heel measuring 0.3 x 0.3 cm. Resident unaware of the area or how it was obtained..."</p> <p>Development of Area to right hip.</p> <p>A Skin Condition Assessment dated 6/11/16 at 2:15 A.M., indicated Resident #1 experienced no skin impairment to the right hip.</p> <p>An "Event Report" dated 6/12/16 at 10:06 P.M., read as follows, "...Bruise to right hip measuring 6.0 x 2.0 cm...This started on: 6/12/16 at 6:30 P.M...A bruise was noted to resident's right hip measuring 6.0 cm x 2.0 cm. Bruise red in color. Resident favors/leans to right side. Resident repositioned et [and] is off right hip. No c/o [complaint of] pain voiced..."</p> <p>An Event Report dated 6/21/16 at 5:43 P.M., indicated, "Blister inferior right hip- Stage 2...3.7 [cm] x 2 cm...has a custom wheelchair- decrease in alertness...less active...has outline of</p>			

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	<p>interior guard of wheelchair arm. Guard immediately removed from chair...Continue comfort foam dressing for protection- MD noted that even minor rubbing with the Xarelto [blood thinning medication that can cause bruises] can develop into a lesion as this..."</p> <p>A Skin Condition Assessment dated 6/30/16 at 2:25 P.M., indicated, "...Stage 2-right hip...4.0 cm X 2.0 cm...Eschar- 50 %...Epithelial (Deep pink to pearly pink) - 50 %...Dark Red /brown base...Lift sheet when repositioning to avoid shearing... "</p> <p>A Skin Condition Assessment dated 7/07/2016 at 12:07 P.M. indicated, "...Stage 2-right hip...3.0 cm X 2.0 cm...Slough [non-viable tissue] - 50 %...Eschar- 50 %...Grey/brown base...Lift sheet when repositioning to avoid shearing..."</p> <p>A Skin Condition Assessment dated 7/14/2016 at 4:56 P.M., read as follows, "...Stage 2-right hip...4.0 cm X 2.0 cm...Slough-50 %...Eschar-50 %...Grey/brown base...Current nursing measures in place; Turn and reposition every 2 hours, Lift sheet when repositioning to avoid shearing..."</p> <p>During an interview on 7/20/16 at 8:11</p>			

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	<p>A.M., OT (Occupational Therapist) #1 indicated the root cause of the right hip wound was related to improper wheelchair positioning and the use of an arm guard in the wheelchair.</p> <p>During an observation on 7/20/16 at 3:15 P.M., Resident #1 was observed sitting in a recliner leaning towards the right with heel protectors on the bilateral feet. The left heel was observed to be askew in the heel protector, not be floated, and in direct contact with the surface of the recliner's footrest. During an interview, at that time, the WCN (Wound Care Nurse) indicated she was preparing to assess and provide wound care to Resident #1. The left heel wound bed was observed to be 100% black eschar and measure 2.0 cm X 1.2 cm. The right hip wound bed was observed to have 25% gray slough with 25% dark brown eschar. The WCN then indicated the left heel wound was facility acquired after a change in condition and the right hip wound was facility acquired and related to positioning equipment that caused Resident #1 to lean to the right side.</p> <p>A Policy and Procedure for, "Pressure Ulcer Staging System" provided by the HFA (Health Facilities Administrator) on 7/21/16 at 3:15 P.M. indicated, "... A Pressure ulcer is [sic] localized injury to</p>			

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	<p>the skin...underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear ...friction...</p> <p>...Suspected Deep Tissue Injury: Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear...Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar</p> <p>...Stage II: Partial thickness loss of dermis presenting as a shallow open ulcer with a red [sic] pink wound bed, without slough... May also present as an intact or open/ruptured serum-filled blister...present as a shiny or dry shallow ulcer without slough or bruising...Bruising indicates suspected deep tissue injury</p> <p>...Stage III: Full thickness tissue loss...Slough may be present but does not obscure the depth of tissue loss</p> <p>...Unstageable: Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed..."</p> <p>During an interview on 7/21/16 at 3:50 P.M., the Director of Nursing (DON) indicated the area on Resident #1's heel could have been caused by Resident #1</p>			

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F 0323 SS=D Bldg. 00	<p>using heels to assist staff during repositioning in bed.</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. Based on observation, interview, and record review, the facility failed to ensure effective interventions were implemented or adequate supervision was provided for 2 of 3 residents who met the criteria for review of accidents. (Resident #23, Resident #51)</p> <p>Findings include:</p> <p>1. During an observation on 7/18/16 at 9:29 A.M., Resident #23 was observed near the nursing station in an upright wheelchair. Resident #23 was observed to be sitting on the front half of the wheelchair seat, leaning forward with the</p>	F 0323	<p>This plan of correction is to serve as Brookside Village's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Brookside Village or their management companies that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. F323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility respectfully</p>	08/17/2016

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	<p>lower legs outside of the leg rests. At that time, no staff were observed near the nursing station.</p> <p>During an interview on 7/18/16 at 2:23 P.M., LPN #6 indicated Resident #23 experienced frequent falls and sometimes required one on one supervision.</p> <p>The clinical record of Resident #23 was reviewed on 7/20/16 at 3:30 P.M. The record indicated the diagnoses of Resident #23 included, but were not limited to, dementia, abnormal posture, age-related physical debility, muscle weakness, unsteadiness on feet, muscle wasting and atrophy, difficulty in walking, lack of coordination, and history of falls.</p> <p>The most recent Significant Change MDS (Minimum Data Set) assessment dated 12/2/15 lacked any documentation to indicate the cognitive status of Resident #23. The assessment further indicated Resident #23 experienced no behaviors, required the extensive assistance of two staff for bed mobility and transfers, experienced unsteadiness transfers, was only able to stabilize balance with staff assistance, and had a history of falls.</p> <p>The most recent Quarterly MDS</p>		<p>wishes to present and IDR for this citation. Resident #23 has effective interventions implemented and adequate supervision, and will be reviewed for an activity basket available to staff to provide activities of the resident's interests when the resident is restless. A new therapy evaluation order has been placed for resident #23 for wheelchair positioning. Resident #51 no longer resides at the facility. All residents at risk for falls have been reviewed and are receiving effective interventions and adequate supervision to prevent falls. The systemic change includes:</p> <ul style="list-style-type: none"> ·Nursing will complete a communication form to therapy after a fall to review the resident for any positioning or other therapeutic issues and the plan of care will be adjusted to reflect any changes. The therapy coordinator will participate in the morning clinical meeting to discuss any falls that occurred and provide input into any interventions. ·The Activity Director or designee will be involved with the interdisciplinary review of all falls for a need for activities to occupy the resident as appropriate and the plan of care will be adjusted to reflect this intervention. ·Any resident with a fall will be reviewed weekly by the interdisciplinary team, for duration 				

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	<p>assessment dated 6/1/16 lacked any documentation to indicate the cognitive status of Resident #23. The assessment further indicated Resident #23 experienced no behaviors, required the extensive assistance of two staff for bed mobility and transfers, experienced unsteadiness during transfers, was only able to stabilize balance with staff assistance, and had a history of falls with injury.</p> <p>A Fall Risk Assessment dated 3/2/16 indicated Resident #23 experienced cognitive impairment and was at high risk to experience a fall.</p> <p>A Care Plan for "history of falls" dated 3/13/16 included the following intervention: "...Resident have [sic] floor alarms beside bed and w/c [wheelchair] alarm..."</p> <p>A Care Plan for "Safety Alarm Device Use: Resident utilizes a personal safety alarm r/t [related to]: recent fall history, cognitive impairment altering resident ability to make safe decisions" dated 3/13/16 included the following interventions: "...Alarming floor mat placed at beside when resident in bed. Check function and placement every shift, Batteries will be changed monthly and as</p>		<p>of four weeks, for adequate interventions and supervision and adjustments to the plan will be made and added to the plan of care as needed.</p> <p>Education will be provided to nursing, the therapy coordinator and activity personnel regarding the systemic change. The Director of Nursing or designee will complete a quality assurance audit tool for all residents with falls regarding completion of a communication form to therapy after a fall, completion of a weekly review for four weeks after the fall, and updating of the plan of care for any new interventions. In addition, a review for involvement with the Activity Director or designee with the interdisciplinary review of falls and any needed activity intervention in place and the plan of care adjusted. This audit will be completed daily (Monday through Friday) for 30 days, and then weekly thereafter for a duration of twelve months of monitoring. The Director of Nursing or designee will audit for implementation of new interventions by rounding on random residents and random shifts. These rounds will occur daily (including weekends) for 30 days, then weekly for 30 days, then monthly for a duration of 12 months of monitoring. The results of these reviews will be discussed at the monthly facility Quality</p>				

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	<p>needed, Bed alarm. Check function and placement every shift. Bed alarm at all times to alert staff of attempts to self transfer. May remove with direct supervision of staff or family, Chair alarm when up in (recliner/dining room chair). Check function and placement every shift. Chair alarm at all times to alert staff of attempts to self transfer. May remove with direct supervision of staff or family, IDT [Interdisciplinary Team] Personal safety alarm evaluation will be completed upon initiation of the alarm, quarterly and with significant changes, IDT to interview family/resident regarding alarm use request/decline in regards to visual and auditory privacy when toileting as applicable, IDT to review for appropriateness and treatment related to their medical symptoms and the resident's preference (with consideration of the resident's cognitive ability) The IDT team to review upon initiation, quarterly and with significant change, Wheel chair [sic] alarm. Check function and placement every shift. Wheel chair [sic] alarm at all times to alert staff of attempts to self transfer. May remove with direct supervision of staff or family.</p> <p>A Care Plan for "...at risk for falls r/t HX</p>		<p>Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Date of completion: August 17, 2016</p>	

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	<p>[history of] falls...dementia DX [diagnosis], HX of attempts to transfer self without assist..." dated 3/14/16 included the following interventions: "...Bed in lowest position when in bed, Moved to room closer to nurses station, Chair alarm, Easy grip liner placed on w/c alarm, Floor pad alarm changed at bedside, Assure the floor is free of glare, liquids, foreign objects, Check and change q [every] 2 hours and prn [as needed], Keep call light in reach at all times, Provide resident an environment free of clutter, Update MD [Medical Doctor] prn..."</p> <p>The May 2016 Physician's Order Recap included, but was not limited to, an order for, "...Chair alarm when up in (recliner/dining room chair). Check function and placement every shift. Special Instructions: Chair alarm at all times to alert staff of attempts to self transfer. May remove with direct supervision of staff or family..."</p> <p>Fall #1</p> <p>A Fall Event note dated 5/7/16 at 5:45 P.M. indicated Resident #23 experienced an unwitnessed fall from a wheelchair in front of the nursing station. The note</p>			

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	<p>further indicated Resident #23 was at high risk to experience falls and an immediate intervention of, "changed wheelchair alarm" was implemented.</p> <p>A Nursing Progress note dated 5/7/16 at 6:25 P.M. indicated, "Resident had unwitnessed fall at 5:45 pm [sic] in front of nurses [sic] station from wheel chair [sic]. CNAs [sic] were assisting other residents in dining room when they heard someone yelling in the hallway. Resident was observed sitting on the floor in front of the nurses [sic] station...Wheelchair alarm was not sounding at the time. Alarm was replaced and functioning..."</p> <p>A Nursing Progress note recorded as a late entry on 5/9/16 at 3:03 P.M. for 5/7/16 at 7:00 P.M. indicated, "Immediate intervention for fall 5/7/16: chair alarm replaced [sic] as well as [sic] dycem [an anti-slip device] replaced."</p> <p>An IDT Post Fall Assessment dated 5/9/16 at 3:03 P.M. indicated, "...cause of the fall was...fell from w/c in hallway...root cause/potential factors that could have contributed to the fall...Does have continuous confusion. Is alert at times...does [unreadable] move around 'wiggle' in w/c at time [sic]. Sits at nurses; [sic] station throughout most of day for as [sic] resident does enjoy the</p>			

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	<p>interaction and provides staff with supervision [sic] resident at most times. Resident is reminded on importance of safety...forgets and continues to attempt to get out of w/c..."</p> <p>During an interview on 7/21/16 at 3:15 P.M., the ADON [Assistant Director of Nursing] indicated the wheelchair alarm was not working properly on 5/7/16 and was replaced. The ADON further indicated, at that time, adequate supervision was not provided to Resident #23 because staff was in the dining room.</p> <p>Fall #2</p> <p>A Fall Event note dated 5/21/16 at 9:00 P.M. indicated Resident #23 experienced an unwitnessed fall from a wheelchair in front of the nursing station. The note further indicated Resident #23 was at high risk to experience falls and an immediate intervention of, "15 minute checks" were implemented.</p> <p>A Nursing Progress note recorded as a late entry on 5/22/16 at 3:04 A.M. for 5/21/16 at 9:00 P.M. indicated, "Alarm sounding. Resident found sitting on floor in front of W/C at nurses [sic] station...DON [Director of Nursing] notified et [and] immediate intervention is for resident to be started on 15 minute</p>			

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	<p>checks..."</p> <p>An IDT Post Fall Assessment dated 5/23/16 at 11:27 A.M. indicated, "...cause of the fall was...Resident found sitting on floor in front of W/C at nurses [sic] station...new immediate intervention...placed on 15 min [minute] checks and therapy to screen resident for appropriate seating...root cause/potential factors that could have contributed to the fall...has chronic confusion...HX of attempts to self transfer without assist..."</p> <p>An Occupational Therapy (OT) Plan of Care dated 5/26/16 indicated, "...referred to skilled OT due to decline in wheelchair positioning and upright sitting posture impacting safety...Precautions:...Fall Risk...Bed/Chair/Floor Alarm...15 minute Checks...Underlying Impairments...patient repositioned by staff ever 2 hours...patient demonstrates increased neck extension and thoracic kyphosis [a spine deformity] [sic] as well as [sic] mild right lateral lean. Due to decrease in posture and safety..."</p> <p>An untimed OT Daily Treatment note dated 5/26/16 indicated, "...Due to recent decline, patient present with increased risk for falls..."</p>			

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	<p>An untimed OT Daily Treatment note dated 5/31/16 indicated, "...CNAs [sic] educated on reclining wheelchair for optimal posture..."</p> <p>A Fall Risk Assessment dated 5/31/16 at 3:58 P.M. indicated Resident #23 was at high risk to experience a fall.</p> <p>The 24 Hour Resident Flow Record dated 5/22/16 through 5/31/16 was reviewed and indicated Resident #25 did not receive 15 minute checks as follows: from 5/23/16 at 5:15 A.M. through 6:45 A.M., from 5/25/16 at 3:15 P.M. through 10:45 P.M., from 5/26/16 at 2:15 P.M. through 2:45 P.M., from 5/30/16 at 5:00 A.M. through 6:45 A.M.</p> <p>Fall #3</p> <p>A Fall Event note dated 6/1/16 at 2:57 A.M., indicated Resident #23 experienced a witnessed fall from a wheelchair by the nursing station and received a hematoma [a solid swelling of clotted blood within the tissue]. The note further indicated Resident #23 was a high risk to experience falls and an immediate interventions of, "...rest...offer repositioning during 15 min checks" were</p>			

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	<p>implemented. The note lacked any documentation to indicate the wheelchair was in a reclined position, new effective interventions were implemented, or effective supervision was provided to ensure the safety of Resident #23.</p> <p>A Nursing Progress note dated 6/1/16 at 3:03 A.M., indicated, "Resident was sitting at nurse station et had been toileted an hour prior to fall. This nurse et another nurse was [sic] in room helping resident up. Heard alarms sounding outside of room. Upon hearing alarm both nurses [sic] exited room and saw this resident [located at the nurses station] sliding out of wheelchair. Both nurses [sic] attempted to prevent fall but [sic] were unsuccessful. Resident landed on left side of body. Resident was wearing glasses et upon landing on left side of body resident hit head [sic] side of face et glasses hit left eye area. Resident noted to have hematoma to left eye measuring 2cm [sic] [centimeters] by 1.5 cm [sic] et a bruise to left elbow measuring 3cm [sic] by 2 cm [sic]...Part of intervention to prevent future falls is to offer repositioning during 15 min checks..." The note lacked any documentation to indicate the wheelchair was in a reclined position, new effective interventions were implemented, or effective supervision was provided to</p>			

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	<p>ensure the safety of Resident #23.</p> <p>An IDT Post Fall Assessment dated 6/1/16 at 3:40 P.M., indicated, "...Witness [sic] at last second during fall by 2 nurses [sic] exiting another resident's room...Resident fell out of w/c while sitting at nurses [sic] station in hallway...cause of the fall was...Resident restless and fell from W/C...Is there a pattern to resident's falls?...Yes--This is 3rd [third] fall where resident was found as [sic] nurses [sic] station fallen from W/C...has chronic continuous confusion which alters resident's ability to make safe decisions. Multiple attempts to self transfer [sic]. Resident requires extensive assist of 2 for transfers...new immediate intervention...offer repositioning during 15 minute checks...15 min check already in in [sic] progress d/t [due to] previous fall..." The note lacked any documentation to indicate the wheelchair was in a reclined position, new effective interventions were implemented, or effective supervision was provided to ensure the safety of Resident #23.</p> <p>The June 2016 Physician's Order Recap indicated a new order had been obtained on 5/6/16 for, "...Activity Level: up with assist..."</p> <p>An untimed OT Daily Treatment note</p>			

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	<p>dated 6/2/16 indicated, "...Patient noted to have a fall from wheelchair on 6/2/16...patient placed on 15 minute check with repositioning as needed...Nursing staff educated on importance of providing repositioning as needed [sic] as well as [sic] frequent interactions to reduce fidgeting and decreased posture..."</p> <p>During an interview on 7/21/16 at 3:30 P.M., the ADON indicated staff could not turn their backs or Resident #23 might experience a fall.</p> <p>Fall #4</p> <p>A Fall Event note dated 7/9/16 at 6:45 A.M., indicated Resident #23 experienced an unwitnessed fall from a wheelchair in the hallway. The note further indicated Resident #23 was at high risk to experience falls and an immediate intervention of, "Resident offered food and/or drink, toileting" was implemented. The note lacked any documentation to indicate the wheelchair was in a reclined position, new effective interventions were implemented, or adequate supervision was provided to ensure the safety of Resident #23.</p> <p>A Nursing Progress note dated 7/9/16 at 4:46 A.M. indicated, "Resident has been</p>			

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	<p>restless all night. Resident has been offered fluids et snacks but [sic] refused both. Resident was changed et put to bed but [sic] continued to be restless et tore apart brief et attempt [sic] to try et get out of bed. Resident was gotten back out of bed et brought to the nurse station. Resident was sitting at nurse station. When this nurse walked out of a room this nurse found resident on floor in from [sic] of wheelchair. Immediate intervention due to fall include one on one with resident through breakfast et obtain in house dipstick [a urine sample]..."</p> <p>The Nursing notes from 7/9/16 from 4:47 A.M., through 7/9/16 at 11:59 A.M., lacked any documentation to indicate Resident #23 received one on one supervision.</p> <p>A Nursing note dated 7/9/16 at 12:00 P.M., indicated, "Resident continues on 15 minute checks..."</p> <p>An IDT Post Fall Assessment dated 7/11/16 at 11:38 A.M., indicated, "...Resident found on floor in front of w/c at the the [sic] nurses [sic] station...cause of the fall was...scouted out of w/c...Is there a pattern to resident's falls?...Yes, resident has HX of falls r/t attempts to self transfer...new immediate</p>			

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	<p>intervention...Resident was placed on 1:1 [one on one] supervision from time of fall through breakfast on 7/9/16...When up in w/c from the hours of 11pm [sic] -6am [sic] place alarming floor mat in front of w/c...root cause/potential factors that could have contributed to the fall...Resident was restless and scooted self out of w/c...does have poor safety awareness and cognitive deficit...does require staff assist to safely transfer...does have HX of falls r/t attempts to self transfer..." The note lacked any documentation to indicate the wheelchair was in a reclined position, new effective interventions were implemented, or adequate supervision was provided to ensure the safety of Resident #23.</p> <p>The July 2016 Physician's Order Recap indicated no new orders had been obtained related to safety interventions.</p> <p>During an interview on 7/21/16 at 3:35 P.M. the ADON indicated Resident #23 experienced a fall from a wheelchair on 7/9/16 at 4:46 A.M. The ADON further indicated Resident #23 received one to one supervision from the time of the fall until "after breakfast". The ADON then indicated no documentation could be provided to indicate new, effective interventions were implemented or</p>			

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	<p>effective supervision was provided to ensure the safety of Resident #23.</p> <p>Fall #5</p> <p>A Fall Event note dated 7/12/16 at 2:06 P.M., indicated Resident #23 had been sleeping in bed and experienced a witnessed fall. The note further indicated Resident #23 was a high risk to experience falls and an immediate intervention of, "toileting, rest, and low air loss mattress traded with pressure reduction mattress" was implemented. The note lacked any documentation to indicate adequate supervision was provided to prevent further falls for Resident #23.</p> <p>A Nursing note dated 7/12/16 at 2:07 P.M. indicated, "Resident's alarms sounded. Upon entering room, resident observed to slide from...bed to the floor, landing on ...bottom. Bed was in lowest position at time of fall...Low air loss mattress traded out for pressure reduction mattress...15 minute checks continue..."</p> <p>An IDT Post Fall Assessment dated 7/13/16 at 11:43 A.M., indicated, "...witnessed. Upon entering room, resident observed to slide from her bed to the floor, landing on...bottom...cause of the fall was...slipped from bed...Is there a</p>			

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	<p>pattern to resident's falls?...No...slipped from bed during this fall event...new immediate intervention...Low loss air mattress removed from bed and replaced with foam pressure reduction mattress...root cause/potential factors that could have contributed to the fall...Resident slid from low air loss bed to floor. Low loss air mattress removed from bed and replaced with foam pressure reduction mattress..."</p> <p>The 24 Hour Resident Flow Records for 15 minute checks from June and July 2016 were requested from the Regional Nurse Consultant on 7/21/16 at 3:45 P.M. and not provided.</p> <p>During an interview on 7/21/16 at 5:00 P.M., the DON indicated it was unreasonable to expect staff to provide one on one supervision 24 hours a day, 7 days a week to Resident #23.</p> <p>2. On 7/18/16 at 7:40 A.M., Resident #51 was in bed with his lower extremities resting on the floor next to the bed and covers askew. No alarm was observed to be sounding.</p> <p>During a staff interview on 7/18/16 at 2:40 P.M., with RN #10 she indicated Resident #51 had experienced 2 falls in the last 30 days.</p>			

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	<p>The clinical record for Resident #51 was reviewed on 7/20/16 at 9:10 A.M. The diagnoses included, but were not limited to urinary tract infection and anxiety.</p> <p>A Minimum Data Set (MDS) assessment dated 6/5/16 indicated Resident #51 had a BIMS (Brief Interview for Mental Status) score of 6 indicating he experienced sever cognitive impairment.</p> <p>Fall #1 A "Fall Event" report dated 6/19/16 at 6:12 A. M, included, but was not limited to, "DESCRIPTION...Upon entering room resident was found sitting on floor beside bed...Was the fall witnessed 'No'...INTERVENTIONS... Indicate what interventions were in use at the time of the fall: Low bed, Non-skid footwear, Resident in close proximity to nurse's station...Indicate the new immediate intervention was initiated...Toileting...Therapy referral...Notes 6/19/2016 06:13 A.M. Heard resident holler out. Upon entering resident room resident was found sitting on floor beside bed. Resident had kicked floor alarm under bed. No injuries noted at this time...Resident was toileted et [and] dressed after being assessed. Resident then brought out to nurses station...6/20/16 2:15 A.M., Resident continues on 15 minute checks..."</p>			

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	<p>An IDT (Interdisciplinary Team) form dated 6/20/2016 at 11:22 A.M., included, but was not limited to"...Summarize root cause...Resident attempted to self transfer from bed without assist. Resident does require staff assist to steady with transfers and to safely transfer to and from bed, toilet and chair. He does have confusion and poor safety awareness..."</p> <p>Fall #2 A "Fall Event" report dated 6/21/16 at 9:27 A.M., included, but was not limited to, "DESCRIPTION...Un-witnessed Fall...INTERVENTIONS...Indicate what interventions were in use at the time of the fall...low bed...Non-skid mat at bedside...Non-skid footwear...Resident in close proximity to nurse's station...Bed alarm...Indicate what new immediate intervention was initiated and communicate to staff...Resident offered food and/or drink...Toileting...Other-monitored at nurses station...NOTES 6/21/16 at 09:27 AM Resident was found sitting on buttock on floor beside bed, resident denies hitting head, and states no pain or discomfort...resident offered toileting, food, and drink. Resident then taken to nurses station for observation, continue with 15 minute checks, bed and chair alarms, and mat to floor beside bed..."</p>			

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	<p>An IDT form dated 6/22/16 at 3:40 P.M., included, but was not limited to,"...Summarize root cause...Resident has confusion and has HX [history] of attempts to transfer. Resident does require staff assist to safely steady with transfers and ambulation...."</p> <p>Fall #3 A "Fall Event" report dated 7/9/16 at 7:55 P.M.,included, but was not limited to, "...DESCRIPTION...Resident fell in Skilled Dining room. 7/9/16 at 1945 [7:45 P.M.]...What was resident doing just prior to fall? propelling self in w/c [wheel chair] around facility... Was the fall witnessed...'No'...Does resident exhibit or complain of pain related to the fall?... 'Yes' RFA [Right forearm] skin tear...INTERVENTIONS...Low bed...Non-skid mat at bedside...Non-kid footwear...Resident in close proximity to the nurse's station...Chair alarm...Bed alarm...Therapy treating resident...Indicate what new immediate intervention was initiated and communicated to staff...Resident offered food and/or drink...Toileting...Analgesic...Other-give n noc [narcotic] medications...NOTES 7/9/16 at 10:49 PM Resident found sitting on floor in skilled dinning room. Fall unwitnessed...Neuro-checks initiated</p>			

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	<p>d/t [due to] unwitnessed fall NOted [sic] skin tear to RFA [Right forearm]...Immediate interventions to initiate 15 min checks..."</p> <p>An IDT form dated 7/11/16 at 12:19 P.M., included, but was not limited to,"...OBSERVATIONS DETAILS...unwitnessed, found on floor in skilled dining room...Location Of Fall...Dining Room...Was the fall a: Found on the floor (unwitnessed)...The cause of the fall was...Other-attempted to self transfer...Fall History...This is the third fall noted in last 30 days...Is there a pattern to resident's falls...Yes, the resident has a HX of falls r/t [related to] attempts to self transfer. Resident does require staff assist to steady and safely transfer...Summarize root cause...Resident does have cognitive deficit and poor safety awareness...He does have weakness and balance deficit. He does require staff to steady and assist with transfers. He requires staff assist to safely transfer..."</p> <p>The care plans included, but were not limited to, the following:</p> <p>A care plan for falls initiated 5/10/16. The interactions included, but was not limited to, Assure the floor is free of glare, liquid, foreign objects, Bed in</p>			

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	<p>lowest position when in bed, Keep call light in reach at all times, provide resident an environment free of flutter, Update MD (Medical Doctor) PRN (as needed) initiated on 5/10/16. Bed/Char Alarms in place initiated 5/13/16, Non skid textured floor alarm initiated 6/19/16, Resident offer toilet, food and drink, Resident placed at nurses station for monitoring initiated 6/21/16 and Resident on 15 minute checks initiated 7/9/16.</p> <p>A care plan behaviors including wandering initiated 7/6/16.</p> <p>Resident #51 chart included "24 Hour Resident Flow Record" for 15 minute checks starting on 6/15/16 and ending on 6/23/16.</p> <p>During an interview with the DON (Director of Nursing) on 7/21/16 at 1:10 P.M., she indicated Resident #51 was assessed to be at high risk to experience a fall on entrance to the facility. She indicated Resident #51 was started on 15 minute checks on 6/14/16 for behaviors not related to falls. The DON indicated Resident #51 had experienced the following falls.</p> <p>Fall #1 Occurred when Resident #51 experienced an unwitnessed fall on</p>			

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	<p>6/19/16 at 6:20 A.M., in his room. She indicated Resident #51 had attempted to get up by himself. The DON indicated Resident #51 had experienced no injuries and the new immediate interventions for was to replace the regular floor alarm with a non skid floor alarm.</p> <p>Fall #2 occurred on 6/21/16 at 9:27 A.M. when Resident #51 experienced an unwitnessed fall in his room. She indicated at that time Resident #51 had been attempting to get up by himself and lost his balance. The DON further indicated Resident #51 experienced no injuries and the new immediate intervention was to bring Resident #51 to the nurses desk for supervision.</p> <p>Fall #3 occurred on 7/9/16 at 7:55 P.M., when Resident #51 experienced an unwitnessed fall in the skilled unit dining room. The DON indicated Resident #51 experienced a skin tear on his right forearm from this fall and the new immediate intervention was to place Resident back on 15 minute checks.</p> <p>An undated policy titled "Fall Prevention Program" was provided by the facility on 7/21/16 at 11:08 A.M. The policy included, but was not limited to "...Falling, by definition is a problem characterized by the failure to maintain</p>			

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F 0329 SS=D Bldg. 00	<p>an appropriate lying, sitting, or standing position, resulting in an individual's abrupt undesired location to the ground. Falling is a significant cause of injury and death in the elderly population...A structured fall prevention program can substantially reduce the rate of falls and related injuries. Identifying risk factors and applying timely interventions are the keys to a successful program...Identify residents at risk for falls...Completion of care planning and implementation of interventions...Ongoing evaluation of fall prevention plans...Training and education of staff...Document immediate interventions implemented to prevent another fall..."</p> <p>3.1-45(a)(2)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that</p>						

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	<p>residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident did not receive unnecessary insulin on 4 occasions and failed to ensure the correct dose of insulin was administered on 2 occasions for 1 of 5 residents who met the criteria for review of unnecessary medication. (Resident #62)</p> <p>Findings include:</p> <p>On 7/18/16 at 10:51 A.M., Resident #62 was observed sitting in a wheelchair in no apparent distress.</p> <p>The clinical record of Resident #62 was reviewed on 7/18/16 at 11:08 A.M. The record indicated Resident #62 was admitted to the facility on 7/8/16 with diagnoses including, but not limited to, type 2 diabetes mellitus.</p> <p>The Admission MDS (Minimum Data Set) assessment dated 7/15/16 indicated</p>	F 0329	<p>F329 483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Resident #62's physician was notified of the insulin administration during the survey process and is receiving the correct dose of insulin as ordered. In addition, the sliding scale insulin orders were reviewed and adjusted by the physician.</p> <p>All residents receiving insulin were reviewed for the correct dose of insulin administered over the last 30 days and any concerns addressed.</p> <p>The systemic change includes that all sliding scale insulin administered will be verified by two licensed nurses.</p> <p>Education will be provided to licensed nurses regarding the systemic change</p> <p>The Director of Nursing or designee will complete a quality assurance audit daily to review for the correct dose of sliding scale</p>	08/17/2016			

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	<p>Resident #62 experience moderate cognitive impairment, had a diagnosis of diabetes mellitus, and received daily insulin injections.</p> <p>A Care Plan for, "Resident is at risk for further complications related to diabetes mellitus" included, but was not limited to, an intervention of, "...Administer medications per Md [sic] [Medical Doctor] order..."</p> <p>The July 2016 Physician's Order Recap included, but was not limited to, orders for, "Humalog [a fast-acting insulin]...100 unit/mL [milliliter]; amt [amount]: Per Sliding Scale; If Blood Sugar is 70 to 150, give 0 units. If Blood Sugar is 151 to 200, give 2 units. If Blood Sugar is 201 to 250, give 4 units. If Blood Sugar is 251 to 300, give 6 units. If Blood Sugar is 301 to 350, give 8 units. If Blood Sugar is 351 to 400, give 10 units. If Blood Sugar is greater than 400, give 12. units. If Blood Sugar is greater than 400, call MD...at 8:00 PM [sic]..."</p>		<p>insulin and signature of two nurses to confirm the correct dose was given. This audit will be completed daily for 30 days and then weekly thereafter for a duration of twelve months of monitoring.</p> <p>The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Date of completion: August 17, 2016</p>	

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	<p>"Humalog...100 unit/mL; amt: Per Sliding Scale; If Blood Sugar is 70 to 150, give 0 units. If Blood Sugar is 151 to 200, give 4 units. If Blood Sugar is 201 to 250, give 8 units. If Blood Sugar is 251 to 300, give 10 units. If Blood Sugar is 301 to 350, give 12 units. If Blood Sugar is 351 to 400, give 16 units. If Blood Sugar is greater than 400, call MD...at 6:00 AM [sic], 11:00 AM, 4:00 PM..."</p> <p>The July 2016 MAR [Medication Administration Flowsheet] indicated Humalog was administered as follows:</p> <p>7/8/16 at 8:00 P.M. for glucometer result of 309: 12 units (8 units of Humalog should have been administered)</p> <p>7/9/16 at 6:00 A.M. for glucometer result of 201: 4 units (8 units of Humalog should have been administered)</p> <p>7/10/16 at 11:00 A.M. for glucometer result of 272: 8 units (10 units of Humalog should have been administered)</p> <p>7/14/16 at 4:00 P.M. for glucometer</p>			

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	<p>result of 418: 10 units (No insulin should have been administered before physician notification)</p> <p>7/16/16 at 6:00 A.M. for glucometer result of 181: 16 units (4 units of Humalog should have been administered)</p> <p>7/16/16 at 11:00 A.M. for glucometer result of 468: 16 units (No insulin should have been administered before physician notification)</p> <p>The Nursing notes from 7/8/16 at 2:30 P.M. through 7/9/16 at 12:12 P.M. lacked any documentation related to insulin administration.</p> <p>The Nursing notes from 7/10/16 at 10:57 A.M. through 7/10/16 at 5:21 P.M. lacked any documentation related to insulin administration.</p> <p>A Nursing note dated 7/14/16 at 10:34 P.M. indicated, "Took resident's bs [blood sugar] at this time et it was 418. Paged MD numerous times with no response until 8:00 pm [sic] this evening. While waiting, this nurse went ahead et gave 13 units of novolog [sic]. Rechecked resident's bs at 6:00 pm [sic] et it was 323...MD called at 8 [8:00 P.M.] et said this was fine..."</p>			

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	<p>The Nursing notes from 7/16/16 at 4:12 A.M. through 7/16/16 at 5:01 P.M. lacked any documentation related to insulin administration.</p> <p>During an interview on 7/21/16 at 10:45 A.M., the DON (Director of Nursing) indicated insulin should be administered according to the physician's order. The DON further indicated Resident #62 was administered more Humalog than ordered on 7/8/16 at 8:00 P.M., 7/14/16 at 4:00 P.M., 7/16/16 at 6:00 A.M., and 7/16/16 at 6:00 A.M.</p> <p>10 units of Humalog was administered to Resident #23 on 7/14/16 at 4:00 P.M. without a physician's order. The DON then indicated no response related to the incorrect dose administered 7/16/16 at 6:00 A.M. or the administration of insulin without a physician's order on 7/16/16 at 11:00 A.M.</p> <p>A Policy and Procedure for Insulin Administration provided by the Regional Nurse Consultant on 7/21/16 at 11:00 A.M. indicated, "...Preparation...Dosage requirements...must be verified before administration...double check the order for the amount of insulin..."</p> <p>3.1-35(g)(2)</p>			

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F 0353 SS=E Bldg. 00	<p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS</p> <p>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>Based on observation, interview, and record review, the facility failed to ensure sufficient staff was available to prevent falls for 2 of 3 residents on 1 of 1 units who met the criteria for review of falls, and provide care and assistance for 1 of 2 residents reviewed for pressure, and 1 of 3 families interviewed who indicated staff was frequently insufficient to provide supervision needed. (Resident #23, Resident #51, Resident #1, Resident #600)</p>	F 0353	<p>This plan of correction is to serve as Brookside Village's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Brookside Village or their management companies that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey</p>	08/17/2016

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	<p>Findings include:</p> <p>1. During a confidential family interview Resident #600's family indicated they feel the facility needed more staff. The family member indicated they are often called and made to come in and set in with Resident #600 as the facility said they were "not staffed to provide one on one supervision" for Resident #600.</p> <p>2. On 7/20/16 at 3:30 P.M., Resident #23's clinical record was reviewed. Resident #23's diagnoses included, but were not limited to, dementia, muscle wasting and atrophy.</p> <p>Resident #23 experienced the following falls:</p> <p>Fall #1 On 5/7/16 at 5:45 P.M. indicated Resident #23 experienced an unwitnessed fall from a wheelchair in front of the nursing station.</p> <p>Fall #2 On 5/21/16 at 9:00 P.M., Resident #23 experienced an unwitnessed fall from a wheelchair in front of the nursing station. An intervention of, "15 minute checks" was implemented.</p> <p>The 24 Hour Resident Flow Record dated 5/22/16 through 5/31/16 was reviewed</p>		<p>allegations.</p> <p>F353 483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS</p> <p>The facility respectfully wishes to present an IDR for this citation.</p> <p>Residents #23, #51, #1 and #600 have sufficient staff available to prevent falls and to provide care, assistance, and supervision.</p> <p>All residents at risk for falls and pressure ulcers were identified and reviewed for sufficient staff available to prevent falls, provide care, assistance and supervision and no concerns were identified.</p> <p>The systemic change includes: ·The facility will implement the "Caring Hearts" program, which assigns each resident and family member with a member of the facility's administrative team. The Caring Heats representative interviews the resident and/or family member on a routine basis concerning satisfaction with various areas, including sufficient staffing. Any concerns are brought to the Administrator for resolution. ·Any resident with a fall will be reviewed weekly by the interdisciplinary team, for duration of four weeks, for adequate interventions and supervision, and adjustments to the plan will be made and added to the plan of care as needed.</p>		

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NAME OF PROVIDER OR SUPPLIER BROOKSIDE VILLAGE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1111 CHURCH AVE JASPER, IN 47546			
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	<p>and indicated Resident #25 did not receive 15 minute checks as follows: from 5/23/16 at 5:15 A.M. through 6:45 A.M., from 5/25/16 at 3:15 P.M. through 10:45 P.M., from 5/26/16 at 2:15 P.M. through 2:45 P.M., from 5/30/16 at 5:00 A.M. through 6:45 A.M.</p> <p>Fall #3 On 6/1/16 at 2:57 A.M. Resident #23 experienced a witnessed fall from a wheelchair by the nursing station and received a hematoma [a solid swelling of clotted blood within the tissue]. The immediate interventions of, "...rest...offer repositioning during 15 min checks" was implemented</p> <p>Fall #4 On 7/9/16 at 6:45 A.M., Resident #23 experienced an unwitnessed fall from a wheelchair in the hallway. The immediate intervention of, "Resident offered food and/or drink, toileting" was implemented.</p> <p>Fall #5 On 7/12/16 at 2:06 P.M., Resident #23 experienced a witnessed fall. The immediate intervention of, "toileting, rest, and low air loss mattress traded with pressure reduction mattress" was implemented. Documentation to indicate adequate supervision was</p>		<p>Charge nurses will complete a rounding tool to monitor residents at risk for pressure ulcers regarding appropriate use of current interventions and positioning, as well as completion of a skills validation for use of heel protectors and positioning methods to prevent pressure ulcers upon hire, annually, and as needed.</p> <p>Education will be provided to administrative team members involved with the Caring Hearts program, the interdisciplinary team members, and nursing regarding the systemic change.</p> <p>The Administrator or designee will complete a quality assurance audit tool to review for timely completion of the Caring Heart interviews and resolutions with any concerns, completion of the interdisciplinary team review for falls and updating of the plan of care for four weeks post-fall, and a review of the rounding tool for charge nurses. This audit will be completed weekly for four weeks, and then monthly for a duration of twelve months of monitoring. This audit will be completed weekly for four weeks, and then monthly for a duration of twelve months of monitoring.</p> <p>The results of these reviews will be discussed at the monthly facility</p>				

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	<p>provided to prevent further falls for Resident #23</p> <p>3. The clinical record of Resident #51 was reviewed on 7/20/15 at 9:10 A.M. The record indicated Resident #51 was admitted with diagnoses of urinary tract infection and anxiety. Resident #51's MDS (Minimum Data Set) assessment dated 6/5/16 indicated he had a BIMS (Brief Interview for Mental Status) score of 6 indicating he was significantly cognitively impaired.</p> <p>Resident #51 experienced the following falls:</p> <p>Fall #1. An unwitnessed fall from bed on 6/19/16 at 6:12 A.M. The intervention added was to toilet and have therapy screen resident and replace the floor mat with a non-skid one as the resident had been able to remove the other one. Resident #51 was receiving 15 minute checks at the time of fall #1.</p> <p>Fall #2. An unwitnessed fall from bed on 6/21/16 at 9:37 A.M. The new immediate intervention was to toilet, give food or drink and place Resident #51 by the nurse's station. Resident #51 was receiving 15 minute checks at the time of fall #2.</p>		<p>Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.</p> <p>Date of completion: August 17, 2016</p>				

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	<p>Fall #3. An unwitnessed fall in the skilled unit dining room on 7/9/16 at 7:55 P.M. The new immediate intervention was to place Resident #51 back on 15 minute checks.</p> <p>A "Behavior Event" form dated 7/15/16 at 11:00 A.M., indicated Resident #51 had entered Room #118 on the Assisted Living while the resident of that room was sleeping in her recliner. She reports that she has heard a noise and opened her eyes and this resident was trying to 'get out through her closet'."</p> <p>4. The clinical record for Resident #1 was reviewed on 7/20/16 at 8:10 A.M. Her diagnoses included, but are not limited to, Parkinson's, abnormal posture, dementia with behaviors.</p> <p>The Annual MDS (Minimum Data Set) assessment dated 3/7/16 indicated Resident #1 was at risk for developing a pressure ulcer, was cognitive intact, and needed the extensive assistance of 2 people for bed mobility and transfers.</p> <p>The Significant Change MDS assessment dated 5/12/16 indicated Resident #1 was at risk for developing a pressure ulcer, experienced severe cognitive impairment and needed the extensive assistance of 2 people for bed mobility and transfers.</p>			

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	<p>A Skin Assessment dated 5/21/16 at 6:10 A.M. indicated Resident #1 experienced no skin impairment to the left heel or the right hip.</p> <p>Resident #1 developed the following pressure areas:</p> <p>An Unstagable pressure ulcer was found on 5/26/16 on Resident #1's left heel.</p> <p>An Unstagable pressure ulcer was found on 6/21/16 on Resident #1's right hip.</p> <p>5. The CNA assignment sheets dated 7/18/16 was provided by the DON on 7/18/16 at 7:45 A.M., indicated the following:</p> <p>200 unit- 8 residents with 1 nurse and 1 and 1/2 CNA's Need assist of two staff for transfers: 3 Need assist to turn and reposition: 8 Need regular incontinence care: 2 Resident receiving 15 minute checks: 1 Residents requiring catheter care: 2 Residents at risk to fall: 3</p> <p>300 unit -18 residents 1 nurse and 1 and 1/2 CNA's Need assist of two staff for transfers: 10 Need assist to turn and reposition: 18 Need regular incontinence care: 13 Resident receiving 15 minute checks: 5</p>			

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R 0000 Bldg. 00	<p>Residents requiring catheter care: 2 Residents at risk to fall: 14</p> <p>6. During an interview on 7/21/16 at 1:50 P.M., with the DON (Director of Nursing) she provided the "as-worked" nursing schedule from July 3-July 30, 2016. She indicated the facility routinely staffed 1 nurse on the 200 unit and 1 nurse on the 300 unit. She indicated there are 3 CNA's scheduled and they all work together on both halls. She indicated the facility did not have a staffing policy but it was the policy of the facility to provide adequate staff to meet the needs of all of the residents in the facility.</p> <p>3.1-17(b)</p> <p>This visit was for the State Residential Licensure Survey.</p> <p>Residential Census: 39</p> <p>Sample: 7</p> <p>Brookside Village was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure</p>	R 0000		

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

PRINTED: 08/09/2016

FORM APPROVED

OMB NO. 0938-0391

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