

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155241	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/18/2013
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NAME OF PROVIDER OR SUPPLIER  FOREST CREEK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 525 E THOMPSON RD INDIANAPOLIS, IN 46227
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F000000	<p>This visit was for the Investigation of Complaints IN00138980, IN00139559, and IN00139568.</p> <p>Complaint IN00138980 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00139559 - Substantiated. Federal/state deficiencies related to the allegations are cited at F323.</p> <p>Complaint IN00139568 - Unsubstantiated due to lack of evidence.</p> <p>Survey dates: November 12, 13, &amp; 18, 2013</p> <p>Facility number: 000145 Provider number: 155241 AIM number: 100275110</p> <p>Survey team: Diana Zgonc, RN-TC</p> <p>Census bed type: SNF: 15 SNF/NF: 98 Total: 113</p> <p>Census payor type: Medicare: 17 Medicaid: 78</p>	F000000	<p>This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Forest Creek Village desires this Plan of Correction to be considered the facility's allegation of compliance. Compliance is effective on December 4, 2013.</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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	<p>Other: 18 Total: 113</p> <p>Sample: 5</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on November 20, 2013; by Kimberly Perigo, RN.</p>			

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F000323 SS=G	<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 record review and interview, the facility failed to ensure staff followed the facility protocol while transferring a resident in a hooyer lift and failed to follow the plan of care to prevent falls and injuries for 2 of 4 resident's reviewed for falls in a sample of 5 (Resident #B, Resident #E, CNA #1, CNA #2).</p> <p>Findings include:</p> <p>1. The clinical record for Resident #B was reviewed on 11/12/13 at 10:55 A.M.</p> <p>Diagnoses for Resident #B included, but were not limited to, Alzheimer's disease, contractures, arthritis, anemia, anxiety, coronary artery disease, osteoporosis, gastroesophageal reflux disease, and cerebral vascular accident.</p> <p>A current quarterly MDS (Minimum Data Set) assessment dated 11/4/13, indicated an interview was not conducted with the resident due to</p>	F000323	F323 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #B no longer resides within the facility. Resident #E was assessed by occupational therapy and placed into a more appropriate wheelchair. Resident #E's careplan and resident profile (CNA sheet) were updated to reflect safe positioning in her new chair. Resident #E will also not be left alone in room. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents that are hooyer transfers or who are at risk for falls have the potential to be affected by the same alleged deficient practice. All nursing staff have been inserviced by the Clinical Education Coordinator/Designee on hooyer transfers to ensure the alleged deficient practice does not occur again. All nursing staff have provided return demonstrations and skills validations for hooyer transfers. All nursing staff have been inserviced by the Clinical Education Coordinator/Designee	12/04/2013	

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	<p>the severe cognitive impairment related to Alzheimer's disease. The resident's functional status for transfers was total dependence with the assistance of 2 staff members and the use of a Hoyer lift. Resident #B's range of motion (ROM) was upper and lower impairments on both sides due to contractures.</p> <p>A nurses note dated 11/6/13 at 5:41 P.M., indicated the nurse was called to Resident #B's room at approximately 4:30 P.M., by CNA #1 and CNA #2. The nurse found Resident #B on the floor.</p> <p>A nurses note dated 11/6/13 at 5:45 P.M., indicated the Director of Nursing (DON) entered the room and found the resident lying on the floor. The resident was observed with bleeding from the nose and mouth and the nose appeared to be displaced and slight swelling to the bilateral (both) cheek bones. EMT's (Emergency Medical Technician) transported Resident #B to the hospital by ambulance.</p> <p>An IDT (interdisciplinary team) note dated 11/7/13 at 1:47 P.M., indicated through investigation, the strap to the lift had not been secured appropriately and slipped off allowing</p>		<p>on following careplans and resident profiles according to protocol to ensure the alleged deficient practice does not occur again. A review of care plans and resident profiles was conducted by the DNS to ensure they were accurate and appropriate. What measures will be put into place or what systematic changes will be made to ensure the deficient practice does not recur? Nursing staff will continue no less than monthly inservicing on resident profiles and hoyer transfers to ensure the alleged deficient practice does not recur. The IDT team will review all residents that require a hoyer lift or have a current fall intervention weekly to ensure care plans and resident profiles are appropriate and to ensure the alleged deficient practice does not recur. DNS/Designee will conduct rounds every shift on observations for hoyer lift transfers and to ensure fall interventions are in place. How will the corrective action(s) be monitored to ensure the deficient practice does not recur? What quality assurance program will be put into place? Mandatory weekly inservicing X4 weeks and monthly X6 months will be provided to staff in regards to hoyer transfers and following resident profiles/careplans. A CQI tool on hoyer transfers will be utilized weekly X4 and monthly X6. If a threshold of 95% is not met an</p>		

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	<p>the resident to fall to the floor.</p> <p>A statement signed by CNA #2 on 11/6/13, after the incident indicated the hoyer sling came unhooked from the hoyer when they turned it.</p> <p>A hospital note dated 11/6/13 at 17:28:00 (5:28 P.M.), indicated the resident was assessed in the emergency department (ED) after sustaining a fall from a Hoyer lift. The resident sustained a 3 cm (centimeter) laceration to the right eye brow. The radiology report also indicated the resident had a small amount of subarachnoid hemorrhage along the right temporal lobe and multiple facial fractures involving the bilateral nasal bones, nasal septum, bilateral maxillary sinuses, hard palate, inferior right orbit and nasal spine of the maxilla involving the roots of multiple teeth.</p> <p>During an interview with the Administrator on 11/12/13 at 9:25 A.M., he indicated CNA #1 and CNA #2 are currently suspended pending the completion of the investigation and will be terminated related to the resident being dropped from the Hoyer lift.</p> <p>During an interview with the DON on</p>		<p>action plan will be initiated to ensure compliance. A CQI tool on fall management/interventions will be utilized weekly X4 and monthly X6 to ensure compliance. If a threshold of 95% is not met and action plan will be initiated to ensure compliance. DNS or her designee will monitor to ensure compliance. Systematic changes have been completed as of December 4, 2013</p>		

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	<p>11/12/13 at 12:15 P.M., she indicated maintenance checked all Hoyers and they were all working properly and the slings were checked and none were damaged. When I walked into the resident's room, one side of the sling was not attached to the lift. I believe it was not attached to the Hoyer correctly.</p> <p>During an interview with the LPN #3 on 11/12/13 at 3:10 P.M., she indicated one side of the sling was not attached to the hoyer, it wasn't broken so you have to assume the CNA's didn't attach it correctly.</p> <p>A current CNA-Skills Validation titled "Mechanical Lift" indicated " ... 11. Attach lift to sling using straps per manufacturer's guidelines. ... 14. Ensure that sling is securely attached to lift device ..."</p> <p>2. The clinical record for Resident #E was reviewed on 11/12/13 at 3:25 P.M.</p> <p>Diagnoses for Resident #E included, but were not limited to, Alzheimer's disease, hypertension, osteoarthritis, adult failure to thrive, depressive disorder, glaucoma, osteoporosis and is a hospice patient.</p>			

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	<p>A current Quarterly Assessment dated 9/8/13, indicated the resident is severely cognitively impaired and is at risk for falls.</p> <p>A Fall Event Report dated 10/23/13 at 7:46 P.M., indicated the resident had an unwitnessed fall from the wheelchair.</p> <p>A nurses note dated 10/24/13 at 8:34 A.M., indicated the resident was found lying on the floor next to the bed. Resident #E had fallen from the wheelchair but could not explain how or why she fell due to cognitive deficits. Interventions put into place at that time, do not leave the resident in the room unattended in the wheelchair.</p> <p>The fall risk care plan for 8/25/10 and updated on 10/24/13, indicated the resident should not be left unattended in the wheelchair in the resident's room.</p> <p>A Fall Event Report dated 10/29/13 at 8:00 P.M., indicated the resident had an unwitnessed fall in the room from the wheelchair. CNA #1 had taken Resident #E back to the room and left the resident unattended in the wheelchair. The intervention at that time, CNA #1 was educated on the</p>			

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	<p>plan of care and given a written warning.</p> <p>Review of the CNA assignment sheets indicated the special needs of Resident #E included, do not leave the resident in the room alone in the wheelchair.</p> <p>A nurses note dated 10/29/13 at 9:20 A.M., indicated the resident was found lying on the floor from the wheelchair. The resident stated she fell out of bed but notes indicated she had not been in bed. An assessment was completed and could not complete passive range of motion to the upper right extremity. The resident also received an abrasion to the right shoulder (10.0 centimeters x 6.5 centimeters) and an abrasion to the right side of the face (4.5 cm x 1.0 cm). An order was received to send the resident to the hospital ER (no other injuries noted).</p> <p>During an interview with the Administrator and DON on 11/12/13 at 4:00 P.M., they indicated that CNA #1 had been given a written warning for the fall of Resident #E.</p> <p>This Federal tag relates to Complaint IN00139559.</p>			

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	3.1-45(a)(2)			