

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155423	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/26/2015
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NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH ST WHITING, IN 46394
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F000000	<p>This visit was for the Investigation of Complaint IN00162393.</p> <p>Complaint IN00162393- Substantiated. Federal/State Deficiency related to the allegation is cited at F 323.</p> <p>Survey dates: January 23 & 26, 2015</p> <p>Facility number: 000365 Provider number: 155423 AIM number: 100287460</p> <p>Survey team: Janet Adams, RN-TC</p> <p>Census bed type: SNF/NF: 71 Total: 71</p> <p>Census payer type: Medicare: 21 Medicaid: 39 Other: 11 Total: 71</p> <p>Sample: 5</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F000000	<p>Please reference the enclosed 2567 as "Plan of Correction" for the January 26, 2015 Complaint Survey that was conducted at Hammond Whiting Care Center. I am respectfully requesting paper compliance and will fax supportive documentation to Indiana State Department of Public Health at fax number (317) 233-7322 prior to our completion date of February 23, 2015.</p> <p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provision of the Federal and State Laws. This facility appreciated the time and dedication of the Survey Team; the facility will accept the survey as a tool for our facility to use in continuing to better the quality of care provided to our Elders in our community.</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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F000323 SS=D	<p>Quality review completed on January 27, 2015, by Janelyn Kulik, RN.</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, record review, and interview, the facility failed to provide adequate supervision to prevent accidents related to not following Physical Therapy recommendations to utilize two staff members for transfers for 1 of 3 residents reviewed for accidents in the sample of 5.</p>	F000323	<p>The Plan of Correction submitted on February 6, 2015 serves as our allegation of compliance. Should you have any question or concerns regarding the Plan of Correction, please contact me.</p> <p>Respectfully,</p> <p>Kimberly M. Ready, HFA Executive Director</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Resident #E's transfer status has been evaluated by therapy and</p>	02/23/2015

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	<p>(Resident #E)(CNA #1)</p> <p>Findings include:</p> <p>On 1/23/15 at 8:55 a.m., Resident #E was observed in bed. The resident was awake and alert.</p> <p>The record for Resident #E was reviewed on 1/26/15 at 7:55 a.m. The resident's diagnoses included, but were not limited to, kidney failure, renal dialysis, arthritis, diabetes mellitus, and high blood pressure.</p> <p>Review of the 11/24/14 admission Fall Risk Evaluation assessment indicated the resident's score was (20). A score of (20) indicated the resident was at high risk for falls.</p> <p>The 11/24/14 Physician admitting orders were reviewed. An order was written on 11/24/14 for the resident to receive Physical Therapy seven times a week for 14 weeks. An order was written on 11/25/14 for the resident to receive OT (Occupational Therapy) seven times a week for 15 weeks for gait training and therapeutic exercises.</p> <p>The 12/2014 Physician orders were reviewed. An order was written on 12/1/14 for an X-ray of the left ankle to</p>		<p>updated on resident's care directive.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:</p> <p>A full facility audit of care directives and care plans will be conducted to ensure transfer status is accurate. Any questions regarding method of transfer will be directed to the rehab department for review.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>Nursing and therapy staff will be educated by DON and/or designee by February 20, 2015 on conveying therapy recommendations via the 24-hour report along with updating the care directive and plan of care, so proper transfer technique is communicated for staff to utilize when transferring residents.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <p>The process change for conveying therapy recommendation via the 24-hour</p>				

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	<p>be completed related to possible trauma. A second order was written on 12/1/14 to send the resident to the Emergency Room to evaluate the left leg after her dialysis treatment was completed. An order was written on 12/2/14 for the resident to have a soft cast in place to the left lower extremity.</p> <p>Review of the 11/24/14 PT (Physical Therapy) Daily Treatment Note indicated an evaluation was completed and noted a bed to wheelchair transfer was performed with a maximum of of + 1 assist. The note also indicated the CNA was present and it was suggested to the CNA for 2+ staff members to be present during transfers for safety precautions.</p> <p>Review of the 11/25/14 OT (Occupational Therapy) Treatment Note indicated the resident required moderate assist of 2 staff members for sit to stand activity. The 11/28/14 Treatment Note indicated the resident required maximum assist of two with transfers from the bed to the wheel chair for safety.</p> <p>The 11/2014 Nursing Progress Notes were reviewed. An entry was entered on 11/30/14 at 1:39 a.m. The entry was made as late entry for 11/24/14 at 3:00 p.m. The entry indicated the resident was bedridden with assist of two with</p>		<p>report along with updating the care directive and plan of care will be ongoing with revisions made as required. In addition, nursing administration will perform a weekly audit for the next 6 months on a minimum of 5 residents to ensure therapy recommendations are updated on the residents' care directive and plan of care. Any issues identified will be immediately addressed and all results will be discussed and system components will be reviewed monthly by the QA Committee with subsequent plans of correction developed and implemented as deemed necessary.</p>				

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	<p>transfers.</p> <p>The 12/2014 Nursing Progress Notes were reviewed. An entry made on 12/1/14 at 11:08 a.m. indicated the resident reported to the Nurse that yesterday in the morning her CNA got her to a standing position, her Foley catheter tubing was wrapped around her left leg which made her lose her footing, and she was then assisted to bed by the CNA. The resident also stated she had twisted her ankle in the process and her left ankle had been sore since then. The entry also indicated the resident's left ankle appeared swollen on the lateral side of the ankle and the area was sore to touch. The entry also indicated the Nurse called the CNA who had transferred the resident the night before and the CNA told the Nurse the resident did complain of pain to the left ankle.</p> <p>The results of the left ankle X-ray completed on 12/1/14 indicated the findings were suspicious for a non-displaced incomplete fracture of the left distal tibia.</p> <p>The Physician Progress Notes were reviewed. A Progress Note completed on 12/3/14 indicated the resident had a pathological left tibial (a bone in the leg) fracture secondary to osteopenia and End</p>				

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	<p>Stage Renal Disease.</p> <p>An Incident Follow-Up & Recommendation Form was completed for the investigation of an incident 12/2/14 at 9:00 a.m. The Summary of Investigative Facts indicated a CNA assisted the resident to the chair, the Foley catheter tubing got wrapped around the resident's foot, the resident lost her footing, and fell into the chair. X-rays were taken and the resident stated she felt like her ankle had been sprained.</p> <p>The investigation included a Witness Statement Form completed by RN #1. The form indicated Resident #E informed the RN that she had hurt her left ankle yesterday when the CNA had gotten her ready, stood her up, and she lost her footing or turned her ankle wrong way. The form also indicated the resident's left ankle was turned inward, swelling was noted to the malleolus (ankle) area, and a small bruise was noted under the malleolus bone. The form also indicated the CNA stated she sat the resident in a chair and the resident did complain of pain. There was no statement from the above CNA who had transferred the resident on 11/30/14.</p> <p>When interviewed on 1/26/15 at 9:00 a.m., Physical Therapist #1 indicated the</p>						

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	<p>resident was non ambulatory upon admit. PT #1 indicated they evaluated the resident on 11/24/14. PT indicated on 11/24/14 they communicated to the CNA that the resident was to be transferred with two staff members. PT #1 also indicated the Nursing staff were to follow the recommended instructions until Therapy recommended a change and Resident #E should have been transferred with two assists.</p> <p>When interviewed on 1/26/14 at 12:20 p.m. the Director of Nursing indicated the resident's Care Directive card was located and the card listed the resident as a one person transfer. The Director of Nursing indicated the information from the Therapy evaluation for the resident to be transferred with two persons should have been transferred to the Care Directive card for staff to follow when transferring the resident for her safety.</p> <p>This Federal tag relates to Complaint IN00162393.</p> <p>3.1-45(a)(2)</p>				

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

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