

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155523	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/21/2011
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NAME OF PROVIDER OR SUPPLIER  RICHLAND BEAN BLOSSOM HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5911 W SR 46 ELLETTSVILLE, IN47429
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F0000	<p>This visit was for Recertification and State Licensure Survey.</p> <p>Survey dates: December 19, 20 and 21, 2011</p> <p>Facility number: 000558 Provider number: 155523 AIM number: 100267550</p> <p>Survey team: Marla Potts RN, TC Melinda Lewis RN Sharon Whiteman, RN Susan Worsham, RN</p> <p>Census bed type: SNF/NF: 73 Total: 73</p> <p>Census payor type: Medicare: 6 Medicaid: 46 Other: 21 Total: 73</p> <p>Sample: 15</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p>	F0000	<p>Preparation and/or execution of this plan of correction in general, or this corrective action does not constitute an admission or agreement by Richland Bean Blossom Health Care Center of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in the compliance with the state and federal laws. Please accept this plan of correction as it constitutes our credible allegation of compliance with all regulatory requirements. This plan of correction also comes to you as a request for a desk review due to the scope and severity of the alleged deficiencies in this survey and supportive documentation is being attached exemplifying compliance and on going monitoring to assure compliance is maintained.</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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F0282 SS=D	<p>Quality review completed on December 27, 2011 by Bev Faulkner, RN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to ensure a physician order was followed for two staff members to transfer a resident with a Hoyer lift, resulting in the resident falling, for 1 of 15 residents reviewed for following the plan of care, in the sample of 15. Resident #54</p> <p>Findings include:</p> <p>Resident #54 was identified by the Assistant Director of Nursing, on 12/19/11 at 10:00 A.M., as being dependant for care and not interviewable, and transferred with a Hoyer lift. (mechanical lift) Resident #54's record was reviewed on</p>	F0282	<p>F 282 Services by qualified persons/per Care Plan</p> <p><b>Corrective action for affected resident:</b></p> <p>The facility continues to strive to ensure that services provided to the residents are adhered to as identified by the residents' plan of care per qualified persons and in accordance to facility protocol. Resident # 54 had no adverse effects from the mechanical lift transfer. On 9/11/11 nursing staff were immediately re-in-serviced on facility policy as to mechanical lift safety and the presence of 2 qualified staff member facility protocol during these types of transfers. Returned demonstration for qualified staff on proper use of the Hoyer lift was also completed on 9/12 thru 9/15 /11. Nurse aide involved was disciplined</p>	12/23/2011	

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	<p>12/20/11 at 11:00 A.M.</p> <p>A physician's order, which started, 12/29/10 indicated "up with assistance times 2 of Hoyer lift."</p> <p>Nurses notes indicated: "9/11/11 7:10 P.M. CNA reported to Nurse who reported to this writer that res [resident]was on floor in room. Upon entering room writer noted res lying on floor on left side, also noted res was under Hoyer sling that was still in air, CNA stated fell out of Hoyer during transfer...complaints headache...CNA stated resident hit head first hard...." The resident was sent to the hospital with the results of no acute abnormality found.</p> <p>During interview with the Director of Nursing on 12/20/11 at 1:00 P.M., indicated only 1 CNA was transferring the resident and indicated the facility policy as well as the physician order was to have two staff members for Hoyer transfers.</p> <p>3.1-35(g)(2)</p>		<p>for not adhering to facility policy and is no longer employed at the facility. No further noncompliance of this policy has occurred since this incident. Staff was again re-in-serviced on facility protocol and manufacturers guidelines as to safety with mechanical lift techniques on 12/21 thru 12/23/11 per return demonstration observance.</p> <p><b>Identification of others at risk:</b> Immediate action was taken thus removing residents from the potential of being at risk.</p> <p><b>Measures to ensure this deficient practice does not recur:</b> No further noncompliance of this policy has occurred since this incident. Staff was again re-in-serviced on facility protocol and manufacturers guidelines as to safety with mechanical lift techniques on 12/21 thru 12/23/11 per return demonstration observance.</p> <p><b>Monitoring of corrective action:</b> The Director of Nursing and/or her designee has been and continues in monitoring and assisting with mechanical lift transfers to ensure facility protocol of 2 qualified staff member assistance during these type of transfers are being adhered to. Monitoring of facility protocol of 2 qualified staff member presence will continue , per return demonstration observance, 5 times weekly for 2 weeks, then 3 times</p>		

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F0323 SS=D	<p>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 record review, observation and interview, the facility failed to ensure a resident was safe while being transferred with a mechanical lift and failed to ensure a resident with a history of falls in the bathroom was supervised while in the bathroom to prevent falls for 2 of 10 residents reviewed with falls in the sample of 15. Resident #54 and #62.</p> <p>Findings include:</p> <p>1. Resident #54 was identified by the Assistant Director of Nursing, on 12/19/11 at 10:00 A.M., as being dependent for care, not interviewable, and transferred with a Hoyer lift (mechanical lift). Resident #54 was observed sitting in a wheelchair with a lift pad under him at 11:00 A.m. on 12/20/11.</p>	F0323	<p>weekly times for one monthly, then monthly times 3 months. The result of this monitoring will be reviewed by the Health Facility Administrator, reported and reviewed by the interdisciplinary team. Compliance will be followed by the Quality Assurance Committee quarterly.</p> <p><b>Plan of Correction date:</b> <b>12/23/2011</b></p> <p>F 323 Free of Accidents/Hazards/Supervision/Devices</p> <p><b>Corrective action for affected residents:</b> The facility strives to ensure the resident environment remains as free from accidents/hazards as possible and with proper supervision provided. Residents # 54 and # 62 had no adverse effects from the incidents that occurred. The facility took immediate precautionary measures by re-educating, in-servicing of staff to include return demonstration, and patient/family education measures as to implemented interventions and facility protocol on safe environment standards for each resident. Resident #54 has qualified staff members of 2 during mechanical lift transfers and no further incidents have occurred since incident on 9/11/11. Resident # 62 has had</p>	12/23/2011

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	<p>Resident #54's record was reviewed on 12/20/11 at 11:00 A.M. Diagnoses included but were not limited to anxiety. The most recent MDS assessment (Minimum Data Set), dated 11/8/11, indicated the resident was cognitively impaired and required extensive assistance of two for transfers, and had fallen in the past 30 days. The current care plan included a problem, dated 11/16/11, for "at risk for falls...use of assistive devices: wheelchair and Hoyer lift...."</p> <p>A physician's order, which started, 12/29/10 indicated "up with assistance times 2 of Hoyer lift."</p> <p>Nurses notes indicated:</p> <p>"9/11/11 7:10 P.M. CNA reported to Nurse who reported to this writer that res [resident] was on floor in room. Upon entering room writer noted res lying on floor on left side, also noted res was under Hoyer sling that was still in air, CNA stated fell out of Hoyer during transfer...complaints headache...CNA stated resident hit head first hard..." The resident was sent to the hospital and returned after having been assessed the same day, with the results of no acute abnormality found.</p>		<p>adequate supervision during toileting since incident on 12/6/11, and no further noncompliance of supervision interventions have occurred since.</p> <p><b>Identification of other residents at risk:</b> Immediate action was taken thus removing residents from the potential of being at risk.</p> <p><b>Measures to ensure this deficient practice does not recur:</b> Immediate staff education and in-servicing of qualified staff was performed on 9/11/11 as to facility protocol and manufacturers' guidelines as to safety with mechanical lift techniques along with return demonstrations. On 12/6/11 staff was in-serviced as to supervision protocol when toileting tasks are taking place with residents at high risk for falls, along with patient family education for need of supervision during toileting task in order to maintain as safe of environment as possible. Nurse aide assignment sheets are updated with supervision interventions. Staff was re-in-serviced on 12/21 thru 12/23/2011 as to facility protocol for 2 qualified staff members presence upon Hoyer lift transfers and supervision of those at risk for falls for phases of activity of daily living tasks.</p> <p><b>Monitoring of corrective actions:</b> The Director of Nursing and/ or her designee is monitoring compliance</p>		

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	<p>During interview with the Director of Nursing on 12/20/11 at 1:00 P.M., indicated only 1 CNA was transferring the resident and indicated the facility policy was to have two staff members for Hoyer transfers.</p> <p>The CNA Core Curriculum, a product of Indiana State Department of Health, dated July 1998, indicated for "transferring," "A mechanical lift is an hydraulic or electric device used to transfer dependent residents in and out of bed, wheelchair or tub..have at least one co-worker assist when using a mechanical lift..."</p> <p>2. On the initial tour, on 12/19/11 at 9:25 A.M., the Assistant Director of Nursing indicated Resident # 62 was not interviewable and was incontinent at times.</p> <p>The clinical record for Resident # 62 was reviewed on 12/19/11 at 10:45 A.M. The record indicated Resident # 62 had diagnoses that included, but were not limited to: dementia, difficulty walking and weakness. The MDS [Minimum Data Set] assessment, dated 9/21/11, indicated Resident # 62 had moderately impaired cognition. Resident # 62 required extensive assistance of two with transfers</p>		<p>to assure proper number of qualified staff is present at time of transfers with a mechanical lift per return demonstrations. Fall rounding audits are being preformed for assurance of proper supervision interventions during phases of activity of daily living tasks. Monitoring of corrective actions are being preformed 5 times weekly for 2 weeks, then 3 times weekly for one month, then monthly times 3 months. The results of this monitoring will be reviewed by the Health Facility Administrator, reported and reviewed by the interdisciplinary team. Compliance will be followed by the Quality Assurance committee quarterly</p> <p><b>Plan of Correction date:</b> <b>12/23/2011</b></p>		

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	<p>and extensive assistance of one with ambulation and toilet use. Resident # 62 had not fallen.</p> <p>A Care plan, dated 8/16/11, indicated a problem of "I am at risk for falls related to my diagnosis of dementia with depression, failure to thrive, weakness, medications and a history of falling and difficulty walking. My fall risk score is 14. I don't like to wait on others so I turn my alarm off and transfer myself placing me at risk for falling." The interventions were "I have a fall risk assessment upon admission, quarterly and PRN [as needed] thereafter. I am on therapy caseload for strengthening. Please keep walkways and paths free from clutter and obstructions. Please offer frequent rest periods during care and activities to lessen fatigue. I have been instructed to call for help if I need assistance. I will be monitored for side effects of any drug that can cause a orthostatic hypotension, weakness, sedation, vertigo and a change in my mental status. I will be provided environmental adaptations such as call light within reach. I will be reminded and reinforced with safety awareness: when rising from a lying position to sit on the side of the bed a few minutes before transferring. I will be assisted with my adl's [activities of daily living] as needed. I will be cues (sic) for safety awareness. I</p>				

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	<p>have bed and chair alarms."</p> <p>A Fall Risk Assessment, dated 9/24/11, indicated a score of 15. The form indicated "Total score above 10 represents HIGH RISK."</p> <p>The Nurses Narrative Notes, dated 9/29/11 at 11:45 P.M., indicated "Bed alarm sounding, CNA entered res [resident] room immediately observed res lying on R [right] side on floor beside bed. Res states I was trying to go to the bathroom reported to this nurse...Noted very superficial abrasion at L [left] upper inner buttock area cleansed with soap et water et noted small skin tear at R [right] outer wrist 0.07 cm long x [by] 0.01 cm wide...Q [every] 30 minute monitoring initiated as a temporary intervention until dayshift here to move res bed against the wall..."</p> <p>The fall care plan was updated on 10/4/11 to include the intervention of "Standby asst [assist] with ambulating and toileting."</p> <p>A Fall Risk Assessment, dated 10/5/11, indicated a score of 19. The form indicated "Total score above 10 represents HIGH RISK."</p> <p>The Nurses Notes, dated 11/6/11 at 12:45</p>				

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	<p>A.M., indicated "Res was sitting in his w/c across from the nurses station alarm in place et activated this nurse witnessed res slid out of w/c and bump his head on the floor upon assessment a goose egg measuring 4 cm by 4 cm developed immediately above R [right] eye...Dysem placed on w/c seat as intervention to prevent future sliding..."</p> <p>The fall care plan was updated on 11/6/11 to include the intervention of "Dysem [sic] placed on w/c seat to help prevent sliding."</p> <p>A Fall Risk Assessment, dated 11/10/11, indicated a score of 19. The form indicated "Total score above 10 represents HIGH RISK."</p> <p>The Nurses Notes, dated 12/6/11 at 4:30 P.M., indicated "Res was placed on toilet. Res req [request] privacy. Aide stepped out of bathroom awaiting res to be finished. Aide waiting outside door aide stepped back in to see if res finished et res sitting on floor. Res states I was reaching for call light et forgot to grab bar et I slid right off the toilet...Staff notified if res req [request] to have privacy explain to res importance of safety et standing by."</p> <p>The Occurrence Investigation, dated 12/6/11, indicated "...Res [resident] was</p>				

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	<p>being toileted by CNA. Res requested aide slip outside door for privacy. Res reaching for call light but forgot to grab bar et [and] slid off toilet no injury noted. Staff education done on not leaving at risk res in bathroom alone."</p> <p>In an interview with the Director of Nursing, on 12/20/11 at 1:00 P.M., she indicated the CNA should not have left Resident # 62 in the bathroom unsupervised.</p> <p>3.1-45(a)(2)</p>				

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

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FORM APPROVED

OMB NO. 0938-0391

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