

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155022	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/12/2014
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NAME OF PROVIDER OR SUPPLIER  HERITAGE HOUSE OF SHELBYVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 2309 S MILLER ST SHELBYVILLE, IN 46176
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00159841 and IN00159375.</p> <p>Complaint IN00159841-Substantiated. Federal deficiencies related to the allegations are cited at F280 and F309. Complaint IN00159375-Substantiated. Federal deficiencies related to the allegations are cited at F225, F226 and F309.</p> <p>Survey dates: December 3, 4, 8, 9, 10, 11, and 12, 2014</p> <p>Facility number: 000009 Provider number: 155022 AIM number: 100274760</p> <p>Survey team: Karina Gates, Generalist-TC Beth Walsh, RN December 3, 8, 9, 10, 11, and 12, 2014 Tom Stauss, RN</p> <p>Census bed type: SNF/NF: 79 Total: 79</p> <p>Census payor type:</p>	F000000	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law.	

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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F000223 SS=D	<p>Medicare: 12 Medicaid: 57 Other: 10 Total: 79</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on December 22, 2014 by Cheryl Fielden, RN.</p> <p>483.13(b), 483.13(c)(1)(i) <b>FREE FROM ABUSE/INVOLUNTARY SECLUSION</b> The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>Based on interview and record review, the facility failed to ensure a resident was free from verbal abuse for 1 of 3 incidents reviewed for abuse. (Resident #23)</p> <p>Findings include:</p> <p>The 9/19/14 Social Service Progress Note for Resident #23 indicated, "Resident's brother called writer worried about (name</p>	F000223	<p><b>F223 – FREE FROM ABUSE/INVOLUNTARY SECLUSION</b> It is the practice of the facility to ensure that all residents are free from abuse. Resident #23 will be interviewed by Administrator or Designee 3xwk for 6wks then monthly x 12. Utilizing a QA audit tool to ensure no further verbal incidents have occurred. All residents have the potential to be affected by the deficient practice. Residents were interviewed at time of incident and no other residents were</p>	01/11/2015			

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	<p>of Resident) wetting the bed at night. Writer explained it was ok it happens. Resident's brother asked if she could get some pads to help her. I told him I would see that she gets some. Writer informed medical supplies."</p> <p>The 9/24/14 Initial Incident Report Form, regarding Resident #23, was provided by the Administrator on 12/12/14, at 11:00 a.m. It indicated, "Received phone call at approximately 8:55 a.m., on September 23, 2014, from (name of Resident #23's brother), stating that when he was on the phone with her this a.m., at approx (approximately) 5:40 a.m., he overheard someone talking to his sister. The lady talking stated, "Why in the (expletive) can you not get out of that bed, why do you lay there and piss yourself?", stated right after his sister hung up the phone. At approx 9:00 a.m., (name of Director of Nursing), RN, DON and (name of Administrator), Administrator met with (name of Resident #23) in (name of Social Services Director's) office. We talked with (name of Resident #23) and she confirmed the above. Schedule was checked and staff members working her station were notified and told to come in and speak with us. (Name of Resident #23's physician) notified of incident when in facility for round on 9/23/14."</p>		<p>affected. 5 residents a week will be interviewed by Administrator or Designee for 6 wks then monthly x 12. Utilizing a QA audit tool to ensure no further verbal incidents have occurred. At time of incident staff received abuse education; however, they will be re-educated on resident abuse. 5 staff will be interviewed a week for 6wks than monthly x 12 utilizing a QA audit tool. QA committee will review audits weekly x 6 wks then monthly x 12 for compliance.</p>		

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F000225	<p>The 9/23/14 Social Service Progress Note for Resident #23 indicated, "Resident appeared to be anxious &amp; embarrassed about urine incontinence. Reassurance given. Resident stated girl that takes care of her was upset w/her &amp; asked "Why the (expletive) she didn't get up and go to the bathroom." Resident appeared upset, stated she does get up and go, but can't help it."</p> <p>The 9/25/14 Follow-up Incident Report Form, regarding the above incident, was provided by the Administrator on 12/12/14, at 11:00 a.m. It indicated, "Interviews of residents completed, with no one else voicing any concerns. After interviewing of staff that worked that unit and talking with (name of Resident #23) and her brother, it was determined that the staff member involved was likely (name of staff member). (Name of staff member) was terminated."</p> <p>An interview was conducted with the DON and Administrator on 12/12/14, at 11:45 a.m., regarding the incident with Resident #23. The DON indicated, the verbal abuse by a staff member towards Resident #23 was substantiated."</p> <p>3.1-27(b)</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4)</p>						

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SS=D	<p><b>INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</b></p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record review,</p>	F000225	<b>F 225 – INVESTIGATE/REPORT</b>	01/11/2015	

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	<p>the facility failed to timely report and investigate potential abuse as well as a fracture, per facility policy, for 1 of 3 incidents reviewed for abuse.</p> <p>Findings include:</p> <p>The 11/10/14 Initial Incident Report, regarding Resident #A, was provided by the Administrator on 12/9/14, at 10:30 a.m. It indicated, "Resident combative during hs (evening) care, belligerent and attempting to hit at staff. QMA (Qualified Medication Aide) reported she heard a popping sound when resident hit her with her left arm on employees left shoulder. Nurse notified, resident checked without areas noted at this time. Resident complaining of arm hurting on 11/7/14. Order obtained for an x-ray, received results from x-ray at 10:30 p.m., which showed there is a fracture involving the mid ulna with mild displacement. At this time, resident without complaint of pain or discomfort resident sent to ER for eval (evaluation) and treatment, arm was put in cast. On 11/10/14, DON (Director of Nursing) and Administrator notified during morning rounds. During investigation and questioning of employees and staff it is felt that the injury is potentially not self inflicted."</p>		<p><b>ALLEGATIONS/INDIVIDUALS</b></p> <p>It is the practice of the facility not to employ individuals who have been found guilty of abusing, neglecting, or mistreating residents. The facility also ensures that all allegations of abuse are investigated timely and reported to the proper authorities.</p> <p>Resident A's behavior documentation will be audited utilizing a QA audit tool 3xwkly for 6 wks then monthly x 12 by DON or designee. Nurses notes will be audited utilizing QA audit tool 5xwkly for 6 wks then monthly x 12 by DON or designee to ensure all unusual occurrences have been reported timely to Administrator and/or DON.</p> <p>All residents have the potential to be affected by the deficient practice; however, no other residents were affected. Behavior management documentation will be audited 3xwkly for 6 wks then monthly x 12 utilizing QA audit tool by Administrator or Designee.</p>	

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	<p>The 11/14/14 Follow-Up Incident Report, regarding the above incident, was provided by the Administrator on 12/9/14, at 10:30 a.m. It indicated, "After investigation was completed (name of CNA #8) was in-serviced and brought back to work. (Name of QMA #9) was terminated."</p> <p>The 11/6/14, 7:30 p.m., statement, written by QMA #9, and left under the Director of Nursing's door, prior to 6:00 a.m., on 11/7/14, was provided by the Administrator on 12/9/14, at 10:30 a.m. It indicated, "Tonight, (name of CNA #8) and I were toileting (name of Resident #A). She was very combative. She was aiming to hit us in the face. I was taking her shoes off and dodged her hand to my face. I was explaining to her not to hit. She swung again with her left arm. I moved (since I was kneeling down.) Her arm made contact with my left shoulder. I heard a loud "pop". She was saying her arm was broke. She was still swinging at us and moving it. I immediately got the nurse, (name of LPN #10). (Name of LPN #10) assessed her and said it was fine. But that "pop" did not sound fine. She moved her arm &amp; fingers for (name of LPN #10) just fine, but it still worried me. (Name of Resident #A) is tiny and she hit pretty hard I also reported this to (name of LPN #11) when she came on</p>		<p>Resident A's behavior sheets will be audited by Administrator or Designee with each behavior times 12 months. Services will be provided as needed with appropriate behavioral interventions added as needed.</p> <p>Staff received education on abuse, behavior management documentation and the timely reporting with unusual occurrences at time of incident; however, they will be re-educated.</p> <p>QA committee will review audits weekly x 6 wks then monthly x 12.</p>	

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	<p>shift. She said she knew, she had gotten it in report from (name of LPN #10). But on the report sheet it says (name of Resident #A) "accidentally" hit. (Name of Resident #A) was combative. (Name of CNA #12) said (name of Resident #A) hit her in the face the other day. So her being combative has been happening I guess. I just (sic) you to be aware of the (arrow up) in combativeness. And that "pop" when she made contact. Because it just didn't sound good. (Name of Resident #A) went to sleep after put to bed with no other complaints after. The last couple of nights she's been hitting the wall with that left arm also instead of using the call light. I did fill out a behavior sheet and put under (name of Social Services Director-SSD) door regarding both." The statement was also signed by CNA #8 with the disclaimer, "I witnessed all of this!"</p> <p>The 11/6/14, 7:30 p.m., behavior sheet for Resident #A, initiated by QMA #9, was provided by the Administrator on 12/9/14, at 10:30 a.m. It indicated, "Combative. Res also hitting wall during the nights for last few days instead of using call light. Res (resident) combative @ hs care. Attempted to slap staff in face. While trying to redirect, res hit staff with left arm to staff left shoulder. Res arm popped. Chg (charge) nurse</p>			

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	<p>assessed res. Said she was fine. Arm mobile." The intervention indicated on the behavior sheet by the DON was, "Residents bed moved away from wall 11/7/14"</p> <p>An interview was conducted with QMA #9 on 12/9/14 at 4:36 p.m. She indicated, "We locked the brakes outside of the bathroom. We set her down in shower chair over toilet. (Name of Resident #A) starts being combative. I was kneeling down. She swung first at my face, then my shoulder. There was the loudest pop. I immediately went and got the nurse. She came down, assessed her, moved her arm. She (Resident #A) was pointing, and saying her arm hurt. She (LPN # 10)said, she's old. Bones pop. But I know something wasn't right. (Name of CNA #8) and I put her in bed, and she went to sleep. When (name of LPN #11) came on shift, I told her about the situation. (Name of LPN #11) told me (name of LPN #10) charted accidentally, and it wasn't an accident. That made me want to write out my statement. Sometime between 7:30 and 6:00 a.m., I wrote this statement. Then I put it under (name of DON's) door, after I wrote it. (Name of CNA #8) read it, and signed it. I put the behavior sheet after the behavior and put it under Social Service's door. When (name of DON) suspended me on</p>			

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	<p>Monday, she said she didn't know anything about this incident, and she did. (Name of Resident #A) became combative right away, in a matter of seconds. When we went in there, (name of Resident #A) called roommate fat. I was already bent down, and said don't hit. She aimed for my face. I backed up. She swung again, and got me on the shoulder. She goes for people's faces. As soon as she hit my shoulder, I heard the pop, and I have never heard a pop like that ever. I was taking her shoes off when I was kneeling. This all happened, in like 10 seconds. I didn't get either of her shoes off. I backed up as far as I could, but it was that quick, lean back, smack." Regarding whether Resident #A had been combative during care prior to the 11/6/14, QMA #9 indicated, "Yes. They are not the best in filling out behavior sheets there. I'm not either. No one is. I had never filled any out on her before. If I had to guess, she's been combative with me a few times. I've been hit by her before. Every time you touch her, she's combative. She doesn't like to be toileted or showered."</p> <p>The 11/10/14 statement, written by CNA #8, was provided by the Administrator on 12/9/14, at 10:30 a.m. It indicated, "Me and (name of QMA #9) went into (name of Resident #A's) room to help her to the</p>			
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	<p>bathroom. (Name of QMA #9) was in the bathroom with (name of Resident #A), and I was on the other side of the pulled curtain with (name of Resident #A's roommate). As I bent down to get (name of Resident #A's roommate's) trash, I heard (name of QMA #9) growl at (name of Resident #A) and say "Oh you better not hit me. That would have been a mistake." Then (name of QMA #9) said (name of Resident #A), I told you don't! And (name of Resident #A) yelled, "Ow, my arm. You broke my arm!" (Name of QMA #9) said No (Name of Resident #A), you did that yourself. She told our nurse (name of LPN #10) and she said "Can she move it? Ok then it's not broke. We put her to bed and she was still crying saying that girl twisted and broke my arm! Later the nurse went back in with (name of LPN #10)."</p> <p>A telephone interview was conducted with CNA #8 on 12/10/14, at 2:26 p.m. She indicated, "Me and (name of QMA #9) were in the room. I was on the other side of the curtain w/(name Resident #A's roommate), fixing her blankets, taking trash, cleaning up. (Name of QMA #9) was in the bathroom with (name of Resident #A). When I bent down to get the trash, I heard (name of QMA #9) say "Ooh (name of Resident #A), that would</p>			

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	<p>have been a mistake. (Name of Resident #A) was still saying whatever she was saying. Then (name of QMA #9) said, (name of Resident #A), I told you don't hit me. Then (name of Resident #A) said, Ow my arm, you broke my arm." Then (name of QMA #9) said, "I just heard it pop." Then (name of QMA #9) said, "Your arm hit my arm to (name of Resident #A). Then she left, and got the nurse. I didn't see anything. (Name of QMA #9) told me to say I was in the bathroom. The curtain was pulled clear around, so (name of Resident #A's roommate) couldn't see anything either. I'm not going to lose my license. I don't think she grabbed and broke her arm on purpose. Based on the sound of what happened, she had a grunt in her voice. (Name of Resident #A) said for hours that girl twisted my arm. (Name of Resident #A) doesn't know how to lie, you know. I didn't read the statement before signing, but I did afterwards. I signed it because she's (QMA #9) my friend....I could hear (name of QMA #9) keep saying that we were both in the bathroom, but we weren't."</p> <p>The 11/11/14 Employee Counseling Record for CNA #8 indicated, "1. Failure to report potential abuse timely. 2. Delaying investigation by not completing above. Employee failed to</p>						

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	<p>properly and timely report potential abuse to DON or Administrator. Employee waited 2 days to provide correct statement during abuse investigation which all allegations are to be reported immediately per facility policy."</p> <p>The 11/7/14, 4:00 a.m., nurse's note, written by LPN #11, indicated, "Res told CNA that her arm hurt because that girl twisted it - checked her (symbol for "left") arm. (Symbol for "no") bruising ROM (range of motion) is as usual. (Symbol for "no") redness, but res screaming about her arm being broke."</p> <p>The 11/13/14 Employee Counseling Record for LPN #11 indicated, "Reported to nurse that resident was making negative statement about an employee. Nurse failed to report to DON and/or administrator."</p> <p>The 11/7/14 Radiology Report for Resident #A indicated, "Results: There is a fracture involving the mid ulna with mild displacement. The elbow and wrist joints are intact in alignment. Osteopenia is present. Conclusion: Mildly displaced left forearm fracture as described. Clinical or repeat examination follow up is advised."</p> <p>The 11/7/14, 10:30 p.m., Nurse Progress</p>			

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	<p>Note, written by LPN #10, indicated, "X-ray report back from (name of radiology company). Resident has fx (fracture involving the mid ulna with mild displacement. (Name of doctor) called....N.O.(new order) to send to ER for eval (evaluation) and tx (treatment)." The note did not indicate the DON or Administrator were notified of Resident #A's fracture.</p> <p>An interview was conducted with the Administrator and DON on 12/9/14, at 12:24 p.m. The Administrator indicated, "I found out about the popping sound on the morning of 11/7/14. The nurses received the results from (name of radiology company) on 11/7/14, at 10:30 p.m. They didn't call (name of DON) or I, so neither of us knew about the fracture until Monday, 11/10/14, when I saw her in a cast or splint. I asked for the x-ray order. Honestly, I didn't think it was going to be a fracture, so I didn't follow up to see if it was. The nurses are supposed to know to call me if it's a fracture, and since they didn't, I figured it was okay over the weekend....(Name of CNA #8) should have told her charge nurse immediately exactly what she heard, and put in her statement about the growling voice, and 'oh you better not hit me' comments made by (name of QMA</p>			

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	<p>#9). (Name of QMA #9) should have told the nurse what happened in the bathroom. I don't think the nurses thought it was broken, but the nurses were made aware of the "popping sound" during care on the night of 11/6/14. The nurses told me they considered what (name of QMA #9) told them as simply being behaviors during care. The time we figured out it could have been something more than behaviors during care was when we figured out (Name of CNA #8) was not in the bathroom at the time. The fracture results we found out about on Monday were what triggered the in depth investigation. (Name of QMA #9's) 11/6/14 statement about the "pop" and swinging during care didn't trigger an investigation because we assessed her arm, and it wasn't swollen, red or bruised at the time. (Name of CNA #8) could not give me a reason why she didn't report it right away, other than (name of QMA #9) told her she put everything in the paper, and she just needed to sign it. (Resident #A) told (LPN #11) the girl had twisted her arm, and she didn't report it to me or anyone. (LPN #11) admitted that to (DON) when she questioned her."</p> <p>An interview was conducted with the DON and Administrator on 12/9/14, at 1:06 p.m. The DON indicated, "When we came in on 11/7 (11/7/14), I saw</p>						

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	<p>where the nurse, (name of LPN #11), wrote about how a CNA reported (name of Resident #A) states arm twisted. I wrote up a counseling record because (name of LPN #11) should have reported to me (name of Resident #A) made negative statements regarding her arm being twisted. Then we could have began an investigation on Friday, not Monday. I had this statement from (name of QMA #9) the morning of 11/7. She did say (name of Resident #A) hit her and heard a pop....She had no range of motion problems, swelling, or anything. (Name of QMA #9) put the statement under my door as a behavior, so we implemented the intervention of move her bed away from the wall. An investigation did not begin on Friday, 11/7/14, because the nurses attributed the situation to a behavior, including myself. Even when (Resident #A) complained of pain in her arm, I still attributed it to behaviors of hitting the wall and being combative, not potential abuse. That didn't come into my head until Monday, after we found out about the fracture, talked to (CNA #8), and knew about (Resident #A's) negative statements." The Administrator indicated, "We would have began an investigation on Thursday night, had (CNA #8) reported right away what she heard (QMA #9) say, (Resident #A's) statements, or if (LPN #11) had</p>			

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	<p>reported the CNA's negative statements."</p> <p>The Employee Time Card for QMA #9 was provided by the Administrator on 12/11/14 at 1:00 p.m. It indicated QMA #9 continued to work after the 11/6/14 incident until 11/7/14, at 6:00 a.m. She also worked from 6:00 p.m., on 11/7/14 until 6:00 a.m., on 11/8/14.</p> <p>The Abuse Prohibition, Reporting, and Investigation policy was provided by the Administrator on 12/3/14, at 1:40 p.m. It indicated, "It is the responsibility of every employee of Heritage House to not only report abuse situations, but also suspicion of abuse and unusual observations and circumstances to their immediate supervisor....All reports of alleged abuse/abuse and all unusual occurrences, must be reported to the Administrator immediately, and to the resident's representative, as soon as feasibly possible, as but no later than within 24 hours of the reporting or discovery of the incident. The individual who witnessed the incident will immediately report the situation to the nurse in charge. If this is not possible, the individual will report the situation to any nurse on duty. The charge nurse is responsible to immediately notify the administrator and Director of Nurses of the situation. Any staff member implicated in the alleged</p>			

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F000226 SS=D	<p>abuse will be removed from the facility at once and will remain suspended until the investigation is completed."</p> <p>The Reporting of Suspicion of Abuse policy was provided by the Administrator on 12/3/14 at 1:40 p.m. It indicated, "Items that the nurse must notify DON or administrator about: 1. All allegations of abuse....5. Any fractures."</p> <p>3.1-28(c) 3.1-28(e)</p> <p>This federal tag relates to Complaint IN00159375.</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to implement their abuse policy by not timely reporting and investigating potential abuse as well as a fracture, for 1 of 3 incidents reviewed for abuse.</p> <p>Findings include:  The 11/10/14 Initial Incident Report, regarding Resident #A, was provided by</p>	F000226	<p><b>F 226 – DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</b></p> <p>It is the practice of the facility to develop and implement policies and procedures that prohibit abuse and reporting of such on a timely basis to the proper authorities.</p>	01/11/2015			

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	<p>the Administrator on 12/9/14, at 10:30 a.m. It indicated, "Resident combative during hs (evening) care, belligerent and attempting to hit at staff. QMA (Qualified Medication Aide) reported she heard a popping sound when resident hit her with her left arm on employees left shoulder. Nurse notified, resident checked without areas noted at this time. Resident complaining of arm hurting on 11/7/14. Order obtained for an x-ray, received results from x-ray at 10:30 p.m., which showed there is a fracture involving the mid ulna with mild displacement. At this time, resident without complaint of pain or discomfort resident sent to ER for eval (evaluation) and treatment, arm was put in cast. On 11/10/14, DON (Director of Nursing) and Administrator notified during morning rounds. During investigation and questioning of employees and staff it is felt that the injury is potentially not self inflicted."</p> <p>The 11/14/14 Follow-Up Incident Report, regarding the above incident, was provided by the Administrator on 12/9/14, at 10:30 a.m. It indicated, "After investigation was completed (name of CNA #8) was in-serviced and brought back to work. (Name of QMA #9) was terminated."</p>		<p>Resident A's incident had been reported to ISDH.</p> <p>All residents have the potential to be affected; however no other resident was.</p> <p>Residents were interviewed at time of incident with no other allegations being made. 5 resident interviews will be done a week for 6 wks then monthly x 12 by Administrator or designee, utilizing QA audit tool to ensure no unusual occurrence has occurred.</p> <p>5 staff interviews will be done weekly for 6wks then monthly x 12, utilizing QA audit tool by Administrator or designee to ensure no unusual occurrences have occurred.</p> <p>All staff was educated after incident; however, will re-educate staff regarding unusual occurrences, reporting of timely to Administrator/DON, Elder Justice Act and Resident Abuse.</p>	

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	The 11/6/14, 7:30 p.m. statement, written by QMA #9, and left under the Director of Nursing's door, prior to 6:00 a.m., on 11/7/14, was provided by the Administrator on 12/9/14, at 10:30 a.m. It indicated, "Tonight, (name of CNA #8) and I were toileting (name of Resident #A). She was very combative. She was aiming to hit us in the face. I was taking her shoes off and dodged her hand to my face. I was explaining to her not to hit. She swung again with her left arm. I moved (since I was kneeling down.) Her arm made contact with my left shoulder. I heard a loud "pop". She was saying her arm was broke. She was still swinging at us and moving it. I immediately got the nurse, (name of LPN #10). (Name of LPN #10) assessed her and said it was fine. But that "pop" did not sound fine. She moved her arm & fingers for (name of LPN #10) just fine, but it still worried me. (Name of Resident #A) is tiny and she hit pretty hard I also reported this to (name of LPN #11) when she came on shift. She said she knew, she had gotten it in report from (name of LPN #10). But on the report sheet it says (name of Resident #A) "accidentally" hit. (Name of Resident #A) was combative. (Name of CNA #12) said (name of Resident #A) hit her in the face the other day. So her being combative has been happening I guess. I just (sic) you to be aware of the		QA committee will review audits weekly x 6 wks then monthly x 12.	

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	<p>(arrow up) in combativeness. And that "pop" when she made contact. Because it just didn't sound good. (Name of Resident #A) went to sleep after put to bed with no other complaints after. The last couple of nights she's been hitting the wall with that left arm also instead of using the call light. I did fill out a behavior sheet and put under (name of Social Services Director-SSD) door regarding both." The statement was also signed by CNA #8 with the disclaimer, "I witnessed all of this!"</p> <p>The 11/6/14, 7:30 p.m., behavior sheet for Resident #A, initiated by QMA #9, was provided by the Administrator on 12/9/14, at 10:30 a.m. It indicated, "Combative. Res also hitting wall during the nights for last few days instead of using call light. Res (resident) combative @ hs care. Attempted to slap staff in face. While trying to redirect, res hit staff with left arm to staff left shoulder. Res arm popped. Chg (charge) nurse assessed res. Said she was fine. Arm mobile." The intervention indicated on the behavior sheet by the DON was, "Residents bed moved away from wall 11/7/14"</p> <p>An interview was conducted with QMA #9 on 12/9/14 at 4:36 p.m. She indicated, "We locked the brakes outside of the</p>			

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	<p>bathroom. We set her down in shower chair over toilet. (Name of Resident #A) starts being combative. I was kneeling down. She swung first at my face, then my shoulder. There was the loudest pop. I immediately went and got the nurse. She came down, assessed her, moved her arm. She (Resident #A) was pointing, and saying her arm hurt. She (LPN # 10)said, she's old. Bones pop. But I know something wasn't right. (Name of CNA #8) and I put her in bed, and she went to sleep. When (name of LPN #11) came on shift, I told her about the situation. (Name of LPN #11) told me (name of LPN #10) charted accidentally, and it wasn't an accident. That made me want to write out my statement. Sometime between 7:30 and 6:00 a.m., I wrote this statement. Then I put it under (name of DON's) door, after I wrote it. (Name of CNA #8) read it, and signed it. I put the behavior sheet after the behavior and put it under Social Service's door. When (name of DON) suspended me on Monday, she said she didn't know anything about this incident, and she did. (Name of Resident #A) became combative right away, in a matter of seconds. When we went in there, (name of Resident #A) called roommate fat. I was already bent down, and said don't hit. She aimed for my face. I backed up. She swung again, and got me on the shoulder.</p>			
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	<p>She goes for people's faces. As soon as she hit my shoulder, I heard the pop, and I have never heard a pop like that ever. I was taking her shoes off when I was kneeling. This all happened, in like 10 seconds. I didn't get either of her shoes off. I backed up as far as I could, but it was that quick, lean back, smack."</p> <p>Regarding whether Resident #A had been combative during care prior to the 11/6/14, QMA #9 indicated, "Yes. They are not the best in filling out behavior sheets there. I'm not either. No one is. I had never filled any out on her before. If I had to guess, she's been combative with me a few times. I've been hit by her before. Every time you touch her, she's combative. She doesn't like to be toileted or showered."</p> <p>The 11/10/14 statement, written by CNA #8, was provided by the Administrator on 12/9/14, at 10:30 a.m. It indicated, "Me and (name of QMA #9) went into (name of Resident #A's) room to help her to the bathroom. (Name of QMA #9) was in the bathroom with (name of Resident #A), and I was on the other side of the pulled curtain with (name of Resident #A's roommate). As I bent down to get (name of Resident #A's roommate's) trash, I heard (name of QMA #9) growl at (name of Resident #A) and say "Oh you better not hit me. That would have been</p>			

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	<p>a mistake." Then (name of QMA #9) said (name of Resident #A), I told you don't! And (name of Resident #A) yelled, "Ow, my arm. You broke my arm!" (Name of QMA #9) said No (Name of Resident #A), you did that yourself. She told our nurse (name of LPN #10) and she said "Can she move it? Ok then it's not broke. We put her to bed and she was still crying saying that girl twisted and broke my arm! Later the nurse went back in with (name of LPN #10)."</p> <p>A telephone interview was conducted with CNA #8 on 12/10/14, at 2:26 p.m. She indicated, "Me and (name of QMA #9) were in the room. I was on the other side of the curtain w/(name Resident #A's roommate), fixing her blankets, taking trash, cleaning up. (Name of QMA #9) was in the bathroom with (name of Resident #A). When I bent down to get the trash, I heard (name of QMA #9) say "Ooh (name of Resident #A), that would have been a mistake. (Name of Resident #A) was still saying whatever she was saying. Then (name of QMA #9) said, (name of Resident #A), I told you don't hit me. Then (name of Resident #A) said, Ow my arm, you broke my arm." Then (name of QMA #9) said, "I just heard it pop." Then (name of QMA #9) said, "Your arm hit my arm to (name of</p>			

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	<p>Resident #A). Then she left, and got the nurse. I didn't see anything. (Name of QMA #9) told me to say I was in the bathroom. The curtain was pulled clear around, so (name of Resident #A's roommate) couldn't see anything either. I'm not going to lose my license. I don't think she grabbed and broke her arm on purpose. Based on the sound of what happened, she had a grunt in her voice. (Name of Resident #A) said for hours that girl twisted my arm. (Name of Resident #A) doesn't know how to lie, you know. I didn't read the statement before signing, but I did afterwards. I signed it because she's (QMA #9) my friend....I could hear (name of QMA #9) keep saying that we were both in the bathroom, but we weren't."</p> <p>The 11/11/14 Employee Counseling Record for CNA #8 indicated, "1. Failure to report potential abuse timely. 2. Delaying investigation by not completing above. Employee failed to properly and timely report potential abuse to DON or Administrator. Employee waited 2 days to provide correct statement during abuse investigation which all allegations are to be reported immediately per facility policy."</p> <p>The 11/7/14, 4:00 a.m., nurse's note, written by LPN #11, indicated, "Res told</p>			

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	<p>CNA that her arm hurt because that girl twisted it - checked her (symbol for "left") arm. (Symbol for "no") bruising ROM (range of motion) is as usual. (Symbol for "no") redness, but res screaming about her arm being broke."</p> <p>The 11/13/14 Employee Counseling Record for LPN #11 indicated, "Reported to nurse that resident was making negative statement about an employee. Nurse failed to report to DON and/or administrator."</p> <p>The 11/7/14 Radiology Report for Resident #A indicated, "Results: There is a fracture involving the mid ulna with mild displacement. The elbow and wrist joints are intact in alignment. Osteopenia is present. Conclusion: Mildly displaced left forearm fracture as described. Clinical or repeat examination follow up is advised."</p> <p>The 11/7/14, 10:30 p.m., Nurse Progress Note, written by LPN #10, indicated, "X-ray report back from (name of radiology company). Resident has fx (fracture involving the mid ulna with mild displacement. (Name of doctor) called....N.O.(new order) to send to ER for eval (evaluation) and tx (treatment)." The note did not indicate the DON or Administrator were notified of Resident</p>			

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	<p>A's fracture.</p> <p>An interview was conducted with the Administrator and DON on 12/9/14, at 12:24 p.m. The Administrator indicated, "I found out about the popping sound on the morning of 11/7/14. The nurses received the results from (name of radiology company) on 11/7/14, at 10:30 p.m. They didn't call (name of DON) or I, so neither of us knew about the fracture until Monday, 11/10/14, when I saw her in a cast or splint. I asked for the x-ray order. Honestly, I didn't think it was going to be a fracture, so I didn't follow up to see if it was. The nurses are supposed to know to call me if it's a fracture, and since they didn't, I figured it was okay over the weekend...(Name of CNA #8) should have told her charge nurse immediately exactly what she heard, and put in her statement about the growling voice, and 'oh you better not hit me' comments made by (name of QMA #9). (Name of QMA #9) should have told the nurse what happened in the bathroom. I don't think the nurses thought it was broken, but the nurses were made aware of the "popping sound" during care on the night of 11/6/14. The nurses told me they considered what (name of QMA #9) told them as simply being behaviors during care. The time</p>			

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	<p>we figured out it could have been something more than behaviors during care was when we figured out (Name of CNA #8) was not in the bathroom at the time. The fracture results we found out about on Monday were what triggered the in depth investigation. (Name of QMA #9's) 11/6/14 statement about the "pop" and swinging during care didn't trigger an investigation because we assessed her arm, and it wasn't swollen, red or bruised at the time. (Name of CNA #8) could not give me a reason why she didn't report it right away, other than(name of QMA #9) told her she put everything in the paper, and she just needed to sign it. (Resident #A) told (LPN #11) the girl had twisted her arm, and she didn't report it to me or anyone. (LPN #11) admitted that to (DON) when she questioned her."</p> <p>An interview was conducted with the DON and Administrator on 12/9/14, at 1:06 p.m. The DON indicated, "When we came in on 11/7 (11/7/14), I saw where the nurse, (name of LPN #11), wrote about how a CNA reported (name of Resident #A) states arm twisted. I wrote up a counseling record because (name of LPN #11) should have reported to me (name of Resident #A) made negative statements regarding her arm being twisted. Then we could have began an investigation on Friday, not</p>			

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	<p>Monday. I had this statement from (name of QMA #9) the morning of 11/7. She did say (name of Resident #A) hit her and heard a pop....She had no range of motion problems, swelling, or anything. (Name of QMA #9) put the statement under my door as a behavior, so we implemented the intervention of move her bed away from the wall. An investigation did not begin on Friday, 11/7/14, because the nurses attributed the situation to a behavior, including myself. Even when (Resident #A) complained of pain in her arm, I still attributed it to behaviors of hitting the wall and being combative, not potential abuse. That didn't come into my head until Monday, after we found out about the fracture, talked to (CNA #8), and knew about (Resident #A's) negative statements." The Administrator indicated, "We would have began an investigation on Thursday night, had (CNA #8) reported right away what she heard (QMA #9) say, (Resident A's) statements, or if (LPN #11) had reported the CNA's negative statements."</p> <p>The Employee Time Card for QMA #9 was provided by the Administrator on 12/11/14 at 1:00 p.m. It indicated QMA #9 continued to work after the 11/6/14 incident until 11/7/14, at 6:00 a.m. She also worked from 6:00 p.m., on 11/7/14 until 6:00 a.m., on 11/8/14.</p>						

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	<p>The Abuse Prohibition, Reporting, and Investigation policy was provided by the Administrator on 12/3/14, at 1:40 p.m. It indicated, "It is the responsibility of every employee of Heritage House to not only report abuse situations, but also suspicion of abuse and unusual observations and circumstances to their immediate supervisor....All reports of alleged abuse/abuse and all unusual occurrences, must be reported to the Administrator immediately, and to the resident's representative, as soon as feasibly possible, as but no later than within 24 hours of the reporting or discovery of the incident. The individual who witnessed the incident will immediately report the situation to the nurse in charge. If this is not possible, the individual will report the situation to any nurse on duty. The charge nurse is responsible to immediately notify the administrator and Director of Nurses of the situation. Any staff member implicated in the alleged abuse will be removed from the facility at once and will remain suspended until the investigation is completed."</p> <p>The Reporting of Suspicion of Abuse policy was provided by the Administrator on 12/3/14 at 1:40 p.m. It indicated, "Items that the nurse must notify DON or administrator about: 1. All allegations</p>			

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F000250 SS=D	<p>of abuse....5. Any fractures."</p> <p>3.1-28(a)</p> <p>This federal tag relates to Complaint IN00159375.</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on interview and record review, the facility failed to ensure a Resident had a dental exam as recommended by the Resident's PASRR (Pre-Admission Screening/Annual Resident Review) for 1 of 1 residents reviewed for PASRR. (Resident #89)</p> <p>Findings include:</p> <p>The clinical record for Resident #89 was reviewed on 12/9/14 at 1:15 p.m. The diagnoses for Resident #89 included, but were not limited to, cerebral palsy, spastic quadriplegia, and mild mental retardation. Resident #89 was admitted on 2/3/14.</p> <p>A PASRR (Pre-Admission Screening/Annual Resident Review) for Resident #89, dated 1/22/14, indicated the recommendation, "...[Name of</p>	F000250	<p><b>F 250 – PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</b> It is the practice of the facility to provide medically-related social services to attain or maintain the highest practical physical, mental and psychosocial well being of each resident. Resident # 89 dental consent has been signed and dental office notified; however, office closed until Monday Jan. 5, 2015, for holiday break. Dental office to be called on Jan, 5, 2015 for an appointment. All residents have the potential to be affected. Social Service Director or designee will audit all residents charts to ensure that all have dental consents on file; if they do not have a consent form one will be mailed to the responsible party. All resident charts will be audited to ensure they have been seen in the last 12 months. Audit will be done utilizing QA audit tool. All new residents will</p>	01/11/2015			

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	<p>Resident #89] may benefit from routine vision and dental exams as she has not had one in some time...."</p> <p>Oral Assessments, dated 10/31/14 &amp; 11/23/14, indicated Resident #89 had debris or food present in their oral cavity during the assessment.</p> <p>Dental service notes or a consent/denial of dental services was not located in the clinical record.</p> <p>During an interview with the Social Services Director (SSD), on 12/9/14 at 1:30 p.m., she indicated she did not see any dental service notes or a denial of dental services in Resident #89's clinical record. The SSD further indicated she will look in some of her other paperwork to determine when Resident #89 was last seen by the dentist.</p> <p>At 2:18 p.m., on 12/9/14, the SSD indicated Resident #89 does not have a denial/consent for dental services, nor does Resident #89 have paperwork to indicate the last time she saw a dentist. The SSD further indicated she was unsure why Resident #89 had not been seen a dentist, even though her current PASRR recommended her to have routine dental visits.</p>		<p>have dental consents signed upon admission. Social Services Director or designee will utilize audit tool ongoing to ensure compliance with dental services and consents. QA committee will review audits weekly x 6 weeks then monthly x 12.</p>	

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F000278 SS=D	<p>On 12/10/14 at 10:44 a.m., the SSD further indicated Resident #89's guardian was coming in the next day to sign a consent for dental services, as the guardian would like for Resident #89 to be seen. The SSD also provided a list of dates when the dental service company was in facility to provide services. The SSD indicated the dentist's visits were 6/4/14, 7/10/14, 8/6/14, 9/3/14, 10/1/14, 11/11/14, &amp; 12/2/14. The SSD indicated she will put Resident #89 on the dentist's visit list, once the consent was signed.</p> <p>3.1-34(a)</p> <p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money</p>			

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	<p>penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on observation, interview, and record review, the facility failed to ensure accuracy of a resident's MDS assessment, regarding his oral status, for 1 of 1 residents reviewed for dental status and services. (Resident #83)</p> <p>Findings include:</p> <p>The clinical record for Resident #83 was reviewed on 12/4/14, at 1:00 p.m. The diagnoses for Resident #83 included, but were not limited to, chronic kidney disease.</p> <p>An interview was conducted with Resident #83 on 12/4/14, at 1:06 p.m., regarding whether he had any tooth problems, gum problems, mouth sores, or denture problems. He indicated, "Yes. I have broken teeth, and I need to see the dentist. I need them pulled and everything.</p> <p>An observation of Resident #83's oral cavity was made on 12/4/2014, at 1:24</p>	F000278	<p><b>F 278 – ASSESSMENT ACCURACY/COORDINATION/ CERTIFIED</b></p> <p>It is the practice of the facility to ensure that assessments accurately reflect the resident's status.</p> <p>Resident #83 to have updated oral assessment with and dental office notified; however, office closed until Monday Jan. 5, 2015, for holiday break. Dental office to be called on Jan, 5, 2015 for an appointment.</p> <p>All residents have the potential to be affected. All residents will receive an updated oral assessment and quarterly ongoing.</p> <p>DON or designee to utilize a QA audit tool to ensure that resident's</p>	01/11/2015

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F000280 SS=D	<p>p.m. He was missing several top teeth. Other teeth were yellow and decayed.</p> <p>The 1/24/14 Annual MDS (minimum data set) assessment for Resident #83 indicated he had no obvious or likely cavities and no broken natural teeth.</p> <p>An observation of Resident #83's oral cavity was made with the MDS Coordinator on 12/11/14, at 12:30 p.m. She looked in his mouth and stated, "He's missing top teeth and has a nub. The MDS assessment should say obvious or likely cavity or broken natural teeth."</p> <p>3.1-31(d) 3.1-31(c)(9)</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident,</p>		<p>MDS and oral assessments correspond.</p> <p>QA committee will review weekly x 6 wks then monthly x 12.</p>		

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	<p>the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on interview and record review, the facility failed to revise a potential for skin breakdown care plan for a resident who had a history of a decubitus ulcer. This had potential to affect 1 of 25 residents reviewed for care plans. (Resident #D)</p> <p>Findings include:</p> <p>The clinical record for Resident #D was reviewed on 12/9/14 at 10:35 a.m. The diagnoses for Resident #D included, but were not limited to, multiple sclerosis, bilateral lower extremity edema, lower extremity deep vein thrombus, renal insufficiency, and history of decubitus ulcer.</p> <p>A Braden Scale, dated 10/29/14, indicated a score of 12, which was indicative of high risk for pressure ulcer.</p> <p>A Potential for Skin Breakdown care plan, dated 11/25/14, did not indicate an intervention of weekly skin assessments.</p> <p>During an interview with the Director of Nursing, on 12/12/14 at 11:03 a.m., she indicated she did not see an intervention of weekly skin assessments on Resident</p>	F000280	<p><b>F280 – RIGHT TO PARTICIPATE PLANNING CARE – REVISE CP</b></p> <p>It is the practice of the facility to implement a plan of care within 7 days after admission and review and update as needed when care changes.</p> <p>Resident D's potential for skin breakdown care plan and interventions updated and will be reviewed and updated as needed. Resident will continue to receive weekly skin assessments.</p> <p>All residents have the potential to be affected by the deficient practice. All residents Braden Scores were audited utilizing QA audit tool by DON or designee. If Braden Score revealed resident at high risk potential/actual skin breakdown care plan interventions were reviewed and updated as needed.</p> <p>All new admissions Braden Score will be audited and if resident reveals</p>	01/11/2015			

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F000309 SS=D	<p>#D's Potential for Skin Breakdown care plan. The Director of Nursing further indicated weekly skin assessments should be an intervention on the care plan.</p> <p>This Federal Tag relates to Complaint #IN00159841.</p> <p>3.1-35(d)(2)(B)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, interview, and record review, the facility failed to report a new skin issue to the wound nurse to initiate treatment, to follow skin/wound treatment orders for 1 of 3 residents reviewed for skin issues, and to implement interventions to address a resident's behaviors for 1 of 3 residents reviewed for abuse. (Resident #A and D)</p>	F000309	<p>high risk care plan will be implemented as indicated. Weekly skin assessments will continue to be completed on all residents and any new interventions added to care plan.</p> <p>Licensed nurses will receive education on the Braden Scale and the adding of interventions on care plans.</p> <p>QA committee will review weekly x 6 wks then monthly x 12.</p> <p><b>F 309 - PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</b></p> <p>It is the practice of the facility provides the necessary care and services to each resident to attain or maintain the highest practical physical, mental and psychosocial</p>	01/11/2015

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	<p>Findings include:</p> <p>The clinical record for Resident #D was reviewed on 12/9/14 at 10:35 a.m. The diagnoses for Resident #D included, but were not limited to, multiple sclerosis, bilateral lower extremity edema, lower extremity deep vein thrombus, renal insufficiency, and history of decubitus ulcer.</p> <p>A review of Resident #D's Skin Condition Report indicated "Area 1" was located near the right upper thigh/lower buttocks and was Stage 3 pressure ulcer, with the measurements of 2.3 cm (centimeter) x (by) 2.5 cm x 1.3 cm, starting on 7/8/14. The Skin Condition Report indicated "Area 1" had the measurements of 2.0 cm x 1.5 cm x 0.1 cm and was re-termed as MASD (moisture associated skin dermatitis) on 10/8/14 by [name of wound care provider]. The Skin Condition Report also indicated on 10/21/14, "Area 2" developed with the measurements, 2.4 cm x 0.7 cm x 0.1cm and was termed as an abrasion/MASD. A Skin Condition Report, dated 12/3/14, indicated "Area 1" had the measurements 0.8 cm x 0.2 cm x less than 0.1 cm. A Skin Condition Report, dated 12/3/14, indicated "Area 2" was healed.</p>		<p>well-being.</p> <p>Resident D has treatment orders for all skin alterations. All residents have the potential to be affected by the deficient practice. All residents with skin alterations charts will be reviewed to ensure there is a current physicians order for a treatment if needed.</p> <p>All new skin alterations will be audited utilizing a QA audit tool weekly x 6 then monthly x 12 to ensure new skin alterations have treatments ordered timely.</p> <p>CNAs will be educated on reporting of skin alterations to nurses. Licensed Nurses will be educated on skin alterations, obtaining immediate treatment and immediate notification to DON/Skin nurse.</p> <p>Resident A's behavior documentation will be audited utilizing a QA audit tool 3xwkly for 6 wks then monthly x 12 by DON or designee. Nurses notes will be audited utilizing QA audit tool 5xwkly for 6 wks then monthly x 12 by DON or designee to ensure all unusual occurrences have been</p>				

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	<p>On 12/10/14, at 10:15 a.m., a wound care observation of Resident #D's wound was done with LPN #1. After LPN #1 removed Resident #D's briefs, a dark red open area was noted on the right upper posterior (back) thigh. Another smaller area that was medium pink, with layers of skin peeled from the center, was noted adjacent to the the above open area. An area of white discolored skin was noted to start near the dark red area and extended to the smaller area</p> <p>During an interview with LPN #1, at 12/10/15 at 10:15 a.m., she indicated "Yeah, there's two open areas." LPN #1 proceeded to cleanse the open areas with normal saline applied to gauze. Bordered Optifoam (dressing) was placed over both open areas.</p> <p>A review of the December 2014 Physician's Orders indicated a wound treatment order with a start date of 8/22/14. The wound treatment indicated, "Skin Prep Mis Spray normal saline (=0.9%) cleanse to right gluteal fold, place collagen inside the wound [sic] apply topically around wound and cover with boardered [sic] optifoam 1 x [time] daily." The Physician's Order also indicated the wound treatment should be completed during the "hour [sic] 7 [a.m.] -3 [p.m]."</p>		<p>reported timely to Administrator and/or DON.</p> <p>All residents have the potential to be affected by the deficient practice; however, no other residents were affected. Behavior management documentation will be audited 3xwkly for 6 wks then monthly x 12 utilizing QA audit tool by Administrator or Designee.</p> <p>Resident A's behavior sheets will be audited by Administrator or Designee with each behavior times 12 months. Services will be provided as needed with appropriate behavioral interventions added as needed.</p> <p>Staff received education on abuse, behavior management documentation and the timely reporting with unusual occurrences at time of incident; however, they will be re-educated.</p> <p>QA committee will review audits wkly x 6 than monthly x 12.</p>	

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	<p>A Physician Order, dated 12/10/14, indicated a clarification of order dated 8/22/14. The Physician's Order indicated, "NS [Normal Saline] cleanse. Pat dry. Apply skin prep spray peri [around] wound. Place collagen on wound bed. Cover [symbol for with] bordered Optifoam."</p> <p>The last skin assessment for Resident #D, performed by the Wound Nurse, was requested from the Director of Nursing (DON), on 12/11/14 at 11:00 a.m.</p> <p>During an interview with the Wound Nurse, on 12/11/14 at 1:30 p.m., the Wound Nurse indicated Resident #D only has 1 open area right now and she last assessed Resident #D on 12/9/14. The Wound Nurse further indicated she did not receive any notification of any other areas on Resident #D that would need treatment. The Wound Nurse indicated she will do a skin assessment of Resident #D when Resident #D lays back down, that afternoon. The Wound Nurse also indicated if there was another open area on Resident #D's upper thigh, she should've been told immediately about it, so a treatment plan can be put in place.</p> <p>A policy titled, Decubitus Ulcer-Prevention, no date, was received</p>			

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	<p>from the DON on 12/11/14 at 2:22 p.m. The policy indicated, "...8. Inspect skin for redness/open areas during routine care. 9. If redness does not readily disappear, the charge nurse should be notified. 10. The Resident's Physician shall be notified at the earliest sign of a pressure sore or other skin breakdown. Such notification shall be documented in the clinical record...."</p> <p>A wound observation of Resident #D was done on 12/11/14 at 3:20 p.m., with the Wound Nurse. When the Wound Nurse pulled Resident #D's brief down, there was no dressing in place on Resident #D's upper right thigh. Resident #D indicated at this time that she did not recall if a new dressing was placed on her thigh that day and Resident #D also indicated she did not have her brief recently changed. A dark red open area was observed on Resident #D's upper posterior thigh. Another smaller dark purple area was observed adjacent to the dark red area, on Resident #D's upper posterior thigh. The Wound Nurse indicated the dark purple area was slightly open and the area was not there on her last assessment. The Wound Nurse cleansed the wounds with normal saline, Skin Prep spray was applied around both areas, collagen was placed over both areas and the Optifoam dressing was</p>			

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	<p>placed on top of both areas.</p> <p>During an interview with the Wound Nurse, on 12/10/14 at 3:25 p.m., she indicated the Skin Prep spray had been ordered for a long time for the wound and it helps keep the dressing in place.</p> <p>On 12/10/14 at 3:33 p.m., LPN #1 indicated she did not get a chance to do the wound treatment on Resident #D that day.</p> <p>At 3:45 p.m., on 12/10/14, LPN #1 indicated she did not use the Skin Prep Spray during the wound treatment observation on 12/10/14.</p> <p>The Wound Nurse indicated, on 12/11/14 at 3:48 p.m., she clarified the wound treatment order the previous day.</p> <p>On 12/12/14 at 10:00 a.m., the Wound Nurse indicated she did not get an order for the collagen to be placed on the second open area, but she planned to. The Wound Nurse further indicated she was unsure on how she would classify the second opened area. The Wound Nurse also indicated she did not note the second area to be dark purple, she only noted the area to be open. The Wound Nurse indicated she was "working on the floor" that day, but she will do a skin</p>			

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	<p>assessment with the Director of Nursing (DON) to verify/clarify the second area description.</p> <p>At 10:05 a.m., on 12/12/14, the DON indicated she was made aware there was an open area to Resident #D that was not reported to the Wound Nurse. The DON further indicated new skin issues needed to be addressed with the Wound Nurse immediately so a treatment plan can be put in place. The DON also indicated she was made aware that the wound treatment for Resident #D was not done as ordered.</p> <p>A wound observation of Resident #D was done on 12/12/14 at 10:40 a.m., with the DON, the ADON (Assistant Director of Nursing), the Wound Nurse, and LPN #2. The DON indicated she observed a dark purple non-blanchable (skin that turned white when touched) area adjacent to a dark red area noted above. The DON further indicated the area appeared to be closed, so she would consider this area a Stage 1 Pressure Ulcer.</p> <p>A Physician's Order, dated 12/12/14 at 11:10 a.m., indicated to, "Apply skin prep to [symbol for right] gluteal [sic] fold stage 1 pressure area proximal to open area twice a day for 14 days and then re-eval."</p>			

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	<p>The last skin assessment for Resident #D completed by the Wound Nurse, on or around 12/9/14, was not received by the time of final exit on 12/12/14.</p> <p>2. The clinical record for Resident #A was reviewed on 12/9/14, at 10:30 a.m. The diagnoses for Resident A included, but were not limited to, dementia.</p> <p>The 10/19/14, 5:29 a.m. nurses note for Resident #A indicated, "Res (resident) noted to yell out many x's (times) t/o (throughout) NOC (night) &amp; pounding on walls. When helping res, she curses @staff. When rolling her for bedpan or changing, she screams. Wakes roommate &amp; others up."</p> <p>The 11/10/14 Initial Incident Report, regarding Resident #A, was provided by the Administrator on 12/9/14, at 10:30 a.m. It indicated, "Resident combative during hs (evening) care, belligerent and attempting to hit at staff. QMA (Qualified Medication Aide) reported she heard a popping sound when resident hit her with her left arm on employees left shoulder. Nurse notified, resident checked without areas noted at this time. Resident complaining of arm hurting on 11/7/14. Order obtained for an x-ray, received results from x-ray at 10:30 p.m. which showed there is a fracture</p>			

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	<p>involving the mid ulna with mild displacement. At this time, resident without complaint of pain or discomfort resident sent to ER for eval (evaluation) and treatment, arm was put in cast. On 11/10/14, DON (Director of Nursing) and Administrtor notified during morning rounds. During investigation and questioning of employees and staff it is felt that the injury is potentially not self inflicted."</p> <p>An interview was conducted with the SSD (Social Services Director) on 12/9/14, at 2:40 p.m. She indicated, "The only incident of being combative is the 11/6/14 incident. I don't know of any incidents prior involving her being combative with staff. I haven't known her to be combative with staff since the incident. Anxious, but not combative, worried she might get hurt. Right after it happened, she was worried about her arm. When she needed to use restroom, she would say no, no because she was worried she'd get hurt. She was hesitant. CNA's told me. I told them behavior slips need filled out if she's hesitant. I haven't received any."</p> <p>An interview was conducted with the Administrator on 12/9/14, at 2:54 p.m. She indicated, "I remember discussing 4 or 5 times in weekly meetings about</p>			

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	<p>(name of Resident #A) being resistive or combative during care. I remember an incident where she kicked, but it was usually slapping at the staff."</p> <p>An interview was conducted with QMA #9 on 12/9/14, at 4:36 p.m. She indicated, "They are not the best in filling out behavior sheets there. I'm not either. No one is. I had never filled any out on her (Resident #A) before. If I had to guess, she's been combative with me a few times. I've been hit by her before. Every time you touch her, she's combative. She doesn't like to be toileted or showered."</p> <p>An interview was conducted with the SSD on 12/10/14, at 10:36 a.m. She indicated, "She (Resident #A) stated she would whop staff, if they were ever combative with her. She said that a while ago, prior to this (11/6/14) incident. I told her if anyone gave her a reason to hit them, she should let us know."</p> <p>An interview was conducted with CNA #14 on 12/10/14, at 11:05 a.m. She indicated, "She's combative when you get her out of bed, any time you touch her. No one has ever told me specifically how to deal with her. I just come back later or have someone else go in there. She's moved rooms multiple times because all</p>			

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	<p>of her roommates complain about her screaming all night."</p> <p>An interview was conducted with LPN #13 on 12/10/14, at 11:09 a.m. She indicated, "I heard through the night, she (Resident #A) can be combative. She'll hit stuff. She gets anxious during the day."</p> <p>An interview was conducted with Resident #B, Resident A's roommate, on 12/10/14, at 1:40 p.m. She indicated, "She was always swinging at someone, always slapping them girls. She's a mean girl. She swung at (name of QMA #9)...She grabbed one girl's breast, and about pulled it off...I saw her whack (name of another CNA) one night. I didn't have anything to do with (name of Resident #A). I was afraid she'd come hit me. She'd beat against the wall every night at 3 a.m., screaming.</p> <p>There was no information in the clinical record to indicate Resident #A's behaviors of yelling, cussing, slapping, and pounding on the wall were addressed or care planned prior to her broken arm found on 11/7/14.</p> <p>An interview was conducted with the SSD on 12/11/14, at 3:30 p.m. She indicated Resident #A first received</p>			

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F000323	<p>mental health services after the incident on 11/6/14. Regarding why she hadn't received mental health services prior to the 11/6/14 incident, the SSD indicated, "There was nothing alarming before. I don't have the behavior sheets to back up the behaviors. Even just a few times (of exuding behaviors), I would absolutely have them seen."</p> <p>An interview was conducted with Psychology Doctor #15 on 12/11/14, at 4:00 p.m. She indicated, "I saw her (Resident #A) to assess her distress secondary to potential abuse. She had her cast on, but didn't know she did. She was unaware of what happended, no distress or anxiety. I would have seen her sooner if I'd been aware of any verbal or physical aggression, which would be a reason for an initial psyche consult....The biggest frustration is lack of documentation. I can't really do anything if nothing is documented. There probably needs to be some inservicing with nursing staff on the importance of documentation."</p> <p>3.1-37(a)</p> <p>This Federal Tag relates to Complaint #IN00159375 and #IN00159841.</p> <p>483.25(h)</p>						

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SS=D	<p><b>FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</b></p> <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 interview and record review, the facility failed to ensure 2 CNA's assisted a resident as required to prevent a fall for 1 of 3 residents reviewed for falls. (Resident #3)</p> <p>Findings include:</p> <p>Resident #3's record was reviewed on 12/9/14 at 11:48 a.m. The resident's diagnoses included, but were not limited to, anxiety, aphasia, and hypertension.</p> <p>Nursing progress notes, dated 11/12/14, indicated Resident #3 fell off her bed while one CNA (Certified Nursing Assistant) was attempting to provide care for the resident. The note indicated the resident sustained an injury (laceration) measuring 1-1.5 inches long "with bleeding."</p> <p>On 12/10/14 at 10:52 a.m., during an interview, the DON (Director of Nursing) indicated CNA #6 was attempting to provide incontinent care for Resident #3 on 11/12/14 without assistance from</p>	F000323	<p><b>F323 – FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</b></p> <p>It is the practice of the facility to ensure each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>The CNA that provided care to resident # 3 without assistance was immediately terminated. All residents have the potential to be affected by the deficient practice; however, none were.</p> <p>All residents have the potential to be affected. DON or designee will audit all residents plan of care and cna assignment sheets to ensure they reflect the assistance the resident requires. They will utilize audit tool.</p> <p>CNAs will be educated on transfers,</p>	01/11/2015

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	<p>another nursing staff member as care planned and according to care requirements for the resident as outlined by a CNA assignment sheet. The DON indicated shortly after the fall, she (DON) walked into the room and observed CNA #6 staying with the resident and the CNA indicated to the DON that she did not use another nursing staff member to provide care to the Resident #3. The DON indicated the CNA involved was terminated on 11/12/14.</p> <p>A fall investigation sheet indicated the resident was sent to an acute care hospital on 11/12/14 for a injury to the resident's head related to a fall sustained on 11/12/14. The report indicated the resident sustained a "4 cm laceration" to her forehead at the time of the fall.</p> <p>Nursing progress notes dated 11/12/14 indicated Resident #3 was transported by emergency medical personnel to an acute care hospital for evaluation after the above referenced fall.</p> <p>Hospital records dated 11/12/14 indicated a discharge diagnosis of "head injury" resulting in sutures placed along a 4cm forehead laceration. The same discharge record indicated "5 sutures" were placed to close the wound on Resident #3's forehead.</p>		<p>bed mobility and ADL assistance and use of CNA assignment sheet.</p> <p>DON or designee will audit resident transfer and assistance needs to ensure accuracy with CNA assignment sheets utilizing QA audit tool 3xwkly for 6weeks then monthly x 12.</p> <p>QA committee will review weekly x 6wks then monthly x 12.</p>	

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	<p>On 12/10/14 at 11:25 a.m., during an interview, Resident #3's LPN #7 indicated Resident #3 required the use of a mechanical lift for transfers. The nurse indicated she has been at the facility for over a year and indicated Resident #3 required total staff assistance for bed mobility for at least a year prior to 12/10/14.</p> <p>A 10/7/14 MDS assessment indicated Resident #3 required total staff assistance "every time" including 2 person staff assistance for bed mobility.</p> <p>A CNA (Certified Nursing Assistant) assignment sheet, dated 11/12/14, indicated Resident #3 required a mechanical lift for transfers.</p> <p>On 12/10/14 at 1:54 p.m., during an interview, the DON indicated all CNA staff is trained upon hire that any resident requiring a mechanical lift for transfers requires 2 persons as staff assistance for any bed mobility task the resident requires.</p> <p>A facility policy, undated and titled "HOYER LIFT" was received from the DON on 12/10/14 at 2:29 p.m. She identified the policy as the facility policy regarding mechanical lift usage. The</p>			
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F000329 SS=D	<p>policy indicated "...A Hoyer lift is never to be used without (2) staff members present..."</p> <p>A care plan for fall risk, created 3/20/14 and in place at the time of Resident #3's 11/12/14 fall, indicated Resident #3 required 2 person staff assistance for bed mobility.</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 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>			

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	<p>Based on interview and record review, the facility failed to provide non-medicinal approaches prior to the administration of an anti-anxiety medication for 2 of 6 residents reviewed for unnecessary medication. (Resident #9 and 98)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #9 was reviewed on 12/10/14 at 10:45 a.m. The diagnoses for Resident #9 included, but were not limited to, schizophrenia, severe mental retardation, bipolar disease, and depression.</p> <p>A Physician's Order, dated 12/1/14, indicated an order for Ativan (anti-anxiety medication) 0.5 mg (milligrams) 1/2 tab to 1 tab by mouth every 8 hours as needed (PRN).</p> <p>The 2014 MAR (Medication Administration Record) indicated PRN Ativan was given on 12/3/14 and 12/6/14. No indication was noted in the clinical record for the amount administered, why the medication was administered, or if non-medicinal interventions were attempted/provided prior to the administration of the anti-anxiety on the dates above.</p>	F000329	<p><b>F 329 – DRUG REGIEN IS FREE FROM UNNECESSARY DRUGS</b></p> <p>It is the practice of the facility to ensure each resident’s drug regimen is free from unnecessary drugs.</p> <p>Corrective actions will be accomplished for resident #9 and #98. DON or designee will audit resident 9 and 98 MAR controlled substance sheets to ensure that 3 non-medical interventions have been attempted and documented appropriately. Utilization of QA audit tool will be used 3xwkly for 6wks then monthly x 12.</p> <p>All residents have the potential to be affected. DON or designee to audit all resident’s MARs controlled substance sheets to ensure 3 non medical interventions have been attempted and documented before administering a PRN medication. Audit will be done utilizing QA audit tool.</p> <p>All orders for anti-anxiety medications will be given to the Social Services Director to review and assess resident.</p>	01/11/2015

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	<p>During an interview with LPN #4, on 12/10/14 at 11:40 a.m., LPN #4 indicated all non-medicinal approaches attempted prior to PRN (as needed) anti-anxiety medication administration should be documented on the back of the MAR.</p> <p>On 12/10/14, at 11:50 a.m., LPN #5 indicated all non-medicinal approaches attempted prior to the administration of a PRN anti-anxiety medication should be documented on the MAR or in the Nurse's Notes.</p> <p>At 11:58 a.m., on 12/10/14, the Social Services Director (SSD) indicated she was not aware that Resident #9 had an order for a PRN anti-anxiety medication. The SSD further indicated Nursing staff should let her know when there was a new order for any anti-anxiety medication and when PRN anti-anxiety medication was given to a Resident.</p> <p>During an interview with the Director of Nursing (DON), on 12/10/14 at 12:06 p.m., the DON indicated all non-medicinal approaches attempted prior to the administration of a PRN anti-anxiety medication should be documented in the Resident's clinical record. The DON further indicated ideally the documentation/interventions should be written on the back of the</p>		<p>Nurses will receive education on administering and documentation of PRN medications after 3 failed attempts of a non-medicine intervention.</p> <p>QA committee will review weekly x 6wks then monthly x 12.</p>	

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	<p>MAR. Documentation of non-medicinal approaches attempted prior to the administration of PRN Ativan on 12/3/14 and 12/6/14 was requested at this time.</p> <p>On 12/10/14, at 12:55 p.m., the DON indicated the order for Ativan came from an outside physician (a physician that normally doesn't see Resident #9) that the family took Resident #9 to. The DON further indicated she reviews all new Physician's Orders to ensure the order was appropriately initiated. The DON indicated she did not recall if she reviewed the order for the Ativan and the DON also indicated she can assume no one questioned the reason for the Ativan, since the medication was given. The DON also indicated the SSD should be made aware of all new orders for psychoactive medications. The Physician Visit Note regarding the new order for Ativan was requested at this time.</p> <p>A policy titled, Psychoactive Medications, no date, was received from the DON on 12/10/14 at 1:45 p.m. The policy indicated, "...5. Psychoactive medications may be used on a PRN basis only under the following conditions: a. The use is listed in the resident's comprehensive careplan [sic] to occur only after one or more individualized</p>			

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	<p>behavioral interventions have been attempted and have failed to produce the desired outcome....</p> <p>c. Each occurrence is documented in the clinical record regarding the specific reason for use including events leading to that intervention, alternative interventions tried, and the outcome of the pharmacologic [sic] intervention."</p> <p>The non-medicinal approaches attempted prior to the administration of above PRN Ativan and the Physician Visit Note regarding the order for Ativan was not received prior to final exit from the facility, on 12/12/14.</p> <p>2. Resident #98's record was reviewed on 12/9/14 at 11:41 a.m. The Resident's diagnoses included, but were not limited to, atrial fibrillation, osteoporosis, dementia, anxiety. The resident's medications included, but were not limited to, lasix, lorazepam, and hydralazine.</p> <p>On 12/10/14 at 2:38 p.m., during an observation, Resident #98 was in her room in a bedside chair watching television. She was alert and in no distress. She was not agitated, anxious, or sedate.</p> <p>On 12/11/14 at 10:08 a.m., during an</p>						

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	<p>observation, Resident #98 was lying in her recliner with her eyes closed. She was not anxious or in distress.</p> <p>On 12/12/14 at 9:51 a.m., during an observation, Resident #98 was in her room watching television. She was alert, not anxious or sedate.</p> <p>Physician's admission orders, dated 8/2/14, indicated for Resident #98 to receive "Ativan 0.5 mg" every 6 hrs as needed for anxiety.</p> <p>A quarterly MDS assessment, dated 11/9/14, indicated Resident #98 took diuretic and antibiotic medications. The assessment did not indicate the resident used anxiolytic medications.</p> <p>On 12/11/14 at 1:25 p.m., during an interview, the DON (Director of Nursing) indicated nursing staff was expected to attempt "three" non-pharmacological interventions prior to the administration of an anxiolytic medication. She indicated the nursing staff would normally document those attempts at non-pharmacological interventions on the "back of the MAR (medication administration record)" in nursing progress notes, or on an associated behavior monitoring record.</p>			

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	<p>Nursing progress notes, dated 8/9/14, 8/27/14, and 11/3/14 indicated nursing staff administered Ativan for anxiety related behaviors without evidence of 3 non-pharmacological interventions being attempted according to facility policy and as care planned.</p> <p>On 12/11/14 at 2:01 p.m., Resident #98's psychologist indicated she assessed the resident on 10/21/14. She indicated not being aware Resident #98 did not have any anxiety related behavioral events during October 2014. She indicated if she had known Resident #98 had not had any adverse behaviors in October of 2014 she would have recommended decreasing the resident's Ativan dosage to 0.25 mg or even eliminating the medication.</p> <p>A care plan for Ativan use, dated 8/29/14, indicated "...Lowest effective dose to be used..."</p> <p>On 12/11/14 at 2:07 p.m., during an interview, the SSD indicated there were no documented behaviors for which Resident #98 would have received Ativan since her admission to the facility on 8/2/14.</p> <p>Nursing progress notes, dated, 8/9/14 indicated "...noted (increased) anxiety..." and "...PRN Ativan admin (administered)</p>			

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	<p>for (increased) anxiety..."</p> <p>An 8/27/14 nursing progress note indicated "...Res (Resident #98) having (increased) anxiety - gave Ativan (at) this time..."</p> <p>On 12/11/14 at 2:35 p.m., during an interview, the DON indicated facility nurses did not perform 3 non pharmacologic interventions prior to Resident #98 being administered PRN (as needed) Ativan on 8/9/14, 8/27/14, and 11/3/14. She indicated the nurses should have performed 3 non pharmacologic interventions prior to administering any anxiolytic medication according to facility medication administration policy.</p> <p>A facility policy, undated and titled "PSYCHOACTIVE MEDICATIONS" indicated "...Psychoactive medications may be used on a PRN basis only under the following conditions: a. The use is listed in the resident's comprehensive careplan (sic) to occur only after one or more individualized behavioral interventions have been attempted and have failed to produce the desired outcome..."</p> <p>3.1-48(a)(1) 3.1-48(a)(3) 3.1-48(a)(6)</p>			

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F000333 SS=G	<p>3.1-48(b)(2)</p> <p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. Based on interview and record review, the facility failed to ensure a resident was free from a significant medication error, resulting in a 3 day hospitalization for an inadvertent drug overdose with medications that were not her own, for 1 of 6 residents reviewed for unnecessary medications. (Resident #52)</p> <p>Findings include:</p> <p>The clinical record for Resident #52 was reviewed on 12/11/14, at 10:30 a.m. The diagnoses for Resident #52 included, but were not limited to, chronic pain, type 2 diabetes, and chronic obstructive pulmonary disease.</p> <p>An interview was conducted with Resident #52 on 12/10/14, at 1:40 p.m. She indicated, "One nurse gave me someone else's pills, and near about killed me....I had to go to the hospital for 4 days. They pumped my stomach. She got fired, (name of nurse), when the facility found out how bad it was. She looked high all the time. I know the cup</p>	F000333	<p><b>F333 – RESIDENTS FREE OF SIGIFICANT MED ERRORS</b></p> <p>It is the practice of the facility to ensure that residents are free of any significant medication errors.</p> <p>Incident was reported to ISDH and nurse involved was terminated. All other residents that had the potential to be affected were not.</p> <p>Will continue to do background checks and drug test upon hire. Nurses and QMAs will be educated on medication administration.</p> <p>Medication pass observations will be completed 3xwk for 6 wks then monthly x 12 utilizing QA audit tool.</p> <p>QA committee to review weekly x 6 wks then monthly x 12.</p>	01/11/2015			

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	<p>was about full. The doctor said I was that close (Resident #52 put her thumb and index finger in the air, and pinched them almost together) to dying." I was out of it at the hospital. I don't remember nothing (sic). One of the aides found me, I guess. I don't even remember going to the hospital. I guess I fought the people at the hospital, because I was so out of it."</p> <p>An interview was conducted with the DON (Director of Nursing) on 12/11/14, at 11:00 a.m., regarding whether there was an unusual occurrence with Resident #52 a few months prior. She indicated, "There was an unusual occurrence with her. We had an impaired nurse in the building, and she was definitely impaired, because I came in and saw her. It was (full name of nurse). I immediately took her off the floor. I asked her to do a drug test, and she wouldn't. She was escorted out of the building. Later on that night, (name of Resident #52) said she wasn't feeling right, so we sent her out to the hospital. I told them to do a drug screen. The only meds (medications) we found missing at that time were benzos (benzodiazapines). She tested negative for benzos. She did test positive for tricyclics. Cymbalta (not a tricyclic) is on her scheduled med (medication) list. The nurse was scheduled from 3-11</p>			

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	<p>(p.m.). I escorted her out of the building at 8:30 or 9:00 (p.m.). Another staff member called me to say she was impaired. (Name of Resident #52) said she didn't feel good....Her psyche doctor said she may have had a psyche reaction. I counted all the meds, all the narcotics, put a new system in place. I think the discharge summary said she potentially got too many meds. Her own doctor, (name of Resident #52's doctor) said it was oxycontin. I know cymbalta is not a tricyclic, but there is some sort of relationship to that. I never thought about that she could have received someone else's meds and that person didn't get there's, in which case our count wouldn't be off, but any of those residents would have told me, if they didn't get their meds. The impaired nurse is the one who gave (name of Resident #52) her evening meds."</p> <p>The 8/25/14, 3:00 a.m., Hospital Emergency Room records indicated the following: "Physician Comments:...presents to the emergency department with altered mental status. According to report from EMS (emergency medical staff), the patient might have been given an extra dose of medication this evening. EMS states that the nurse reports that she had one dose of medicine at her usual time. A second</p>						

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	nurse then came to give her medication later in the evening. According to report from EMS, patient told the nurse that she had already received her evening medications but took the second set of medications as well. It is unknown what was given at that time. Unfortunately the nurse to distribute these medicines has gone missing. The patient was found at 2:30 in the morning to be unresponsive. According to nursing staff, she will usually easily aroused (sic) when they turn the lights on. They were unable to wake her up this morning. EMS reports that the patient was difficult to arouse. They did not check an oxygen saturation initially. It is unknown what her respiratory rate was. EMS reports that she did have pinpoint pupils. EMS gave 0.5 mg of Narcan. Patient then violently awoke and became extremely confused and combative. She is very anxious and hallucinating. She had episodes of dry heaves but has not vomited. She was incontinent of urine. The patient cannot articulate any specific complaints at this time, stating only that she has pain all over and feels very cold. She takes oxycodone and scheduled and prn (as needed). She also has a fentanyl patch....Medical Decision Making:...Differential includes narcotic overdose, medication reaction, polypharmacy, infection, intercranial			

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	hemorrhage among others....Progress Notes: Patient continues to have severe agitation with tremors, tachycardia and hypertension. We will give additional dose of Ativan. After additional dosing of Ativan, patient continues to be very symptomatic. I was concerned that she might have received other medications I cannot detect. We will give an additional dose of Ativan as well as IV fluids. I did attempt to contact the nursing staff at (name of nursing facility). I spoke to (name of nurse) who is the patient's night shift nurse. She reports that there were several discrepancies in the system tonight but does not know the exact medications. She suggested that I call the director of nursing, (name of DON). I did speak to (name of DON) and she states that there was a call tonight because of concern about an impaired nurse. It (sic) this nurse was taking care of my patient. She was given 2 medication cups tonight, but is not known what medications the patient actually received. Initially this sounded like a narcotic overdose for polypharmacy. The patient had a very severe reaction to Narcan and has prolonged symptoms and apartment now. It appears the only major discrepancies that workup tonight were with narcotics and 3 missing benzodiazapines. The director of nursing is unsure if there are			

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	<p>any other medications like sedatives, hypnotics or other medications that could cause anticholinergic type symptoms. We will continue to monitor. Patient will likely need admission to the hospital. Urine drug screen reveals positive opiates with positive oxycodone. This is on the patient's chronic medication list. Surprisingly, the patient also tested positive for tricyclics. This medicine is not on the patient's list. Poison Center was contacted. Patient's medicine list was reviewed for possible evidence of medications that would test positive for tricyclic antidepressants. Again none of her prescription medicines would test positive. Medications were also reviewed to evaluate for possible anticholinergic effects. I believe the patient's symptoms were more like anticholinergic effects including severe agitation, tremors, tachycardia, dry mouth and hallucinations. Patient is also taking a lot of items. Poison Center reports the appropriate on (sic) can cause anticholinergic symptoms. They report Cymbalta can also cause tachycardia, hypertension, confusion, seizures, and tremors. They also state that over the counter medicines like Benadryl can cause a positive tricyclic screen as well as anticholinergic symptoms. Also after reviewing the EMS report, it appears that the patient was found to be tachycardic</p>			

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	<p>with initial set of vital signs before Narcan was given. I am concerned that she might have already been having a toxydrome at this time."</p> <p>The 8/25/14, 4:10 p.m., History and Physical from the hospital indicated the following: "History: ...In the emergency room, she was quite obtunded. She did test positive for tricyclics, which she is not prescribed. There is apparently quite a bit of suspicion that she was given the wrong medications by an impaired nurse. Detail: Patient is too obtunded to really answer any questions. Her family says that 24 hours prior to her hospitalization she seemed "fine." Labs: Urine opiates screen was positive for Oxycodone and Tricyclics. Assessment: 1. Significantly altered mental status likely secondary to medication error.... Plan: 1. General supportive care with IV fluids and close observation. 2. Sliding scale insulin. 3. Will hold essentially all of her medicines including her pain medicine at this point. 4. Broad-spectrum antibiotics for skin infection pending culture results."</p> <p>The 8/27/14, 2:15 p.m. Hospital Discharge Summary indicated the following: "Discharge Diagnosis: 1. Inadvertent drug overdose with medications that were not her own. 2. Acute altered mental</p>			

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F000412 SS=D	<p>status secondary to the above.... 4. Fevers felt to be secondary to medication effect."</p> <p>3.1-25(b)(9) 3.1-48(c)(2)</p> <p>483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS</p> <p>The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.</p> <p>Based on observation, interview, and record review, the facility failed to obtain dental services, as needed, for 1 of 1 residents reviewed for dental status and services. (Resident #83)</p> <p>Findings include:</p> <p>The clinical record for Resident #83 was reviewed on 12/4/14, at 1:00 p.m. The diagnoses for Resident #83 included, but were not limited to, chronic kidney disease.</p> <p>An interview was conducted with</p>	F000412	<p><b>F 412 – ROUTINE/EMERGENCY DENTAL SERVICES IN NFS</b></p> <p>It is the practice of the facility to provide or obtain routine and emergency dental services to meet the needs of all residents.</p> <p>Oral assessment completed on resident 83. Dental office notified however, office closed until Monday Jan. 5, 2015, for holiday break. Dental office to be called on Jan, 5,</p>	01/11/2015

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	<p>Resident #83 on 12/4/14, at 1:06 p.m., regarding whether he had any tooth problems, gum problems, mouth sores, or denture problems. He indicated, "Yes. I have broken teeth, and I need to see the dentist. I need them pulled and everything.</p> <p>An observation of Resident #83's oral cavity was made on 12/4/2014, at 1:24 p.m. He was missing several top teeth. Other teeth were yellow and decayed.</p> <p>The 1/24/14 Annual MDS (minimum data set) assessment for Resident #83 indicated he had no obvious or likely cavities and no broken natural teeth.</p> <p>An observation of Resident #83's oral cavity was made with the MDS Coordinator on 12/11/14, at 12:30 p.m. She looked in his mouth and stated, "He's missing top teeth and has a nub. The MDS assessment should say obvious or likely cavity or broken natural teeth."</p> <p>The December, 2014 Physician's Orders for Resident #83 indicated, "Patient may be seen by dentist, podiatrist, or eye doctor of choice as needed.</p> <p>Verification of the most recent dental visit was provided by the SSD (Social Services Director) on 12/11/14, at 11:00</p>		<p>2015 for an appointment. MDS to correspond with assessment.</p> <p>All residents have the potential to be affected. Oral assessments will be completed on every resident then quarterly ongoing. MDS's will be audited to ensure oral assessment corresponds with MDS. All charts will be audited to ensure dental consent in place and signed and that they have been seen by the dentist in the past year. Appointments will be made if needed.</p> <p>DON or designee will audit all new admissions to ensure that oral assessment and MDS correspond utilizing QA audit tool.</p> <p>Social Services Director or designee will audit all new admissions to ensure that they have a dental consent signed utilizing QA audit tool.</p> <p>Social Services Director or designee will audit to ensure all residents have dental services yearly utilizing QA audit tool.</p>	

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	<p>p.m. The SSD indicated this was the only dental treatment verification the facility had for Resident #83. It was entitled Initial Oral Assessment. It indicated, "Final diagnosis and treatment plan determined by dentist during comprehensive oral examination following enrollment into the (name of dental company) oral health maintenance program."</p> <p>On 12/11/14, at 12:43 p.m., a telephone interview was conducted with the Indiana State Coordinator for the dental company indicated on Resident #83's Initial Oral Assessment. She indicated, "The oral assessment was a quick look inside his mouth. We don't touch the patient. The final diagnosis and treatment plan would occur after enrollment. It looks like he was not fully enrolled. I don't see a reason for cancellation of enrollment on 7/1/14...My company coordinates care with patients and (name of dental provider)."</p> <p>An interview was conducted with the SSD on 12/11/14, at 12:58 p.m. She indicated, "I took over ancillary services in June of 2014. I don't know what happened with his dental care process. I have a letter going out to families for dental consent. I haven't sent a letter out to his family yet. I'm hoping around the</p>		QA committee will review audits weekly x 6wks then monthly x 12.				

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F000441 SS=F	<p>first of the year, all letters will go out. After that comes back, he can be seen." She looked through her resident dental consents, and stated, "He currently has a consent. I'm going to call his POA (Power of Attorney), and see why it was canceled." The SSD picked up the telephone and called Resident #83's POA. After she concluded her phone call, she indicated, "She said she didn't cancel it, and he (Resident #83) also told her he wants to see the dentist." The SSD indicated the only way she would know of a cancellation of a resident's enrollment for dental services was for the company to inform her. She stated, "I know there's a problem with our dental process and I'm trying to get it done."</p> <p>3.1-24(a)(1)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility;</p>			
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	<p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview, and record review, the facility failed to maintain an infection control log to adequately monitor, investigate, and analyze infections in the facility. This had the potential to affect 79 of 79 residents residing in the facility. The facility also failed to discard soiled/contaminated gloves before raising a resident's bed side rails for 1 of 4 skin assessments observed. (Resident #65).</p> <p>Findings include:</p>	F000441	<p><b>F441 – INFECTION CONTROL. PREVENT SPREAD. LINENS</b></p> <p>It is the practice of the facility to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection, and to maintain and Infection Control Program.</p> <p>Infection control log will be</p>	01/11/2015

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	<p>1. The clinical record for Resident #65 was reviewed on 12/10/14 at 2:05 p.m. The diagnoses for Resident #65 included, but were not limited to, atrial fibrillation, history of prostate cancer, dementia, and urinary incontinence.</p> <p>A review of the Patient Discharge Summary Report from the hospital indicated a discharge date of 11/25/14 and a medical problem of C. (Clostridium) difficile diarrhea.</p> <p>The December Physician's Orders indicated an order for contact isolation.</p> <p>During an interview with the Director of Nursing (DON), on 12/12/14 at 11:50 a.m., she indicated Resident #65 was still having loose stools but the episodes have slowed considerably.</p> <p>During an observation of Resident #65's skin with the DON, on 12/12/14 at 11:57 a.m., the DON asked/assisted Resident #65 to roll on his left side. Resident #65 started grasping at the lowered left side rail and Resident #65 indicated it would be easier to roll to his side if the side rail was raised. Resident #65 was able to be assisted to his left side by the DON and the side rail remained down. Resident #65's briefs were lowered by the DON and the DON used her gloved hand to</p>		<p>completed timely and audited by Administrator or designee weekly for 6wks then monthly x 12. A facility surveillance log will be utilized.</p> <p>All residents have the potential to be affected.</p> <p>Staff education to be provided regarding preventing the spread of c-diff and infection control practices.</p> <p>QA committee will review weekly x 6 wks then monthly x 12.</p>	

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	<p>determine if Resident #65's skin was blanchable (skin that turns white when touched) near his buttocks. Resident #65's briefs were raised back up over his buttocks. Resident #65 then attempted to raise the left side rail again, while he was still on his left side. The DON raised the left side rail with the contaminated gloves and then went over to the right side and also raised that side rail with the contaminated gloves.</p> <p>On 12/12/14 at 12:15 p.m., the DON indicated she should've changed gloves before raising the bed side rails, but she was concerned about the resident's safety. The DON further indicated the Resident touches the side rails, so the spread of C. diff was not a factor. A policy regarding infection control practices were requested at this time.</p> <p>A policy regarding removal of gloves prior to touching resident's equipment was not provided by the time of final exit from the building, on 12/12/14.</p> <p>2. The infection control log binder, from December, 2013 to present, was requested from and provided by the DON (Director of Nursing) on 12/11/14 at 10:30 a.m. There was no information in the binder from December 2013 through March 2014. The infection control log for November 2014 contained information</p>			

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	<p>on resident's infections, but there was no analysis of the information to determine trends within the facility.</p> <p>An interview was conducted on 12/11/14 at 11:05 a.m., with the DON regarding the infection control binder. She indicated that she was not employed with the facility at the time of December 2013 through March 2014 and is unable to explain the missing information in the infection control log binder. She indicated she knew tracking logs were needed because of prior experience and began monitoring after her employment began with the facility.</p> <p>The infection and control policy was provided by the DON on 12/11/14 at 12:30 p.m. The policy, "General Polcies" indicated "to refer to the Surveillance and Reporting Section of this manual for more detail." The DON indicated at this time she is unable to provide this section of the policy and does not have a policy related to the infection control tracking process.</p> <p>3.1-18(a) 3.1-1.8 (a) (1) (A)</p>			