

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155478	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/22/2016
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NAME OF PROVIDER OR SUPPLIER TIMBERS OF JASPER THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2909 HOWARD DR JASPER, IN 47546
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00193114 and Complaint IN00193329, Complaint IN00193939.</p> <p>Complaint IN00193114 - Substantiated. Federal/State deficiencies related to the allegations are cited at F157, F309 and F323.</p> <p>Complaint IN00193329 - Substantiated. Federal/State deficiencies related to the allegations are cited at F157, F309 and F323.</p> <p>Complaint IN00193939 - Substantiated. Federal/State deficiencies related to the allegations are cited at F157, F309, and F323.</p> <p>Survey dates: February 18, 19, and 22, 2016</p> <p>Facility number: 000314 Provider number: 155478 AIM number: 100274210</p> <p>Census bed type: SNF/NF: 76 Total: 76</p>	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0157 SS=D Bldg. 00	<p>Census payor type: Medicare: 8 Medicaid: 54 Other: 14 Total: 76</p> <p>Sample: 11</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on February 24, 2016 by #02748.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an</p>			

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	<p>existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review, the facility failed to ensure the physician and family were notified timely of a resident's fall, for 1 of 6 residents reviewed for notification of falls, in a sample of 11. Resident D</p> <p>Findings include:</p> <p>On 2/18/16 at 9:40 A.M., during the initial tour, LPN # 1 indicated Resident D had recently fallen.</p> <p>The clinical record of Resident D was reviewed on 2/18/16 at 3:00 P.M. Diagnoses included, but were not limited to, dementia.</p> <p>An annual MDS assessment, dated</p>	F 0157	<p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Certification Desk Review in lieu of a Post Survey Revisit on March 23, 2016. F157 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>The resident affected by the alleged deficient of practice resident D has been identified. MD and family were notified</p>	03/23/2016			

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	<p>12/15/15, indicated Resident D scored a 5 out of 15 for cognition, with 15 indicating no memory impairment. The MDS assessment indicated the resident required extensive assistance of two+ staff for bed mobility and transfer, and did not ambulate. A test for balance indicated, "Not steady, only able to stabilize with staff assistance" while moving from seated to standing position and surface-to-surface transfer.</p> <p>An "Event Report," dated 2/7/16 at 8:45 P.M., indicated, "...Was fall witnessed, No...Describe the position of the resident when first observed after fall...The bed was in high position with HOB [head of bed] all the way up, although when was put to bed, bed was left in low pos [sic] with HOB slightly up. Bed controller was not within reach of res...Describe injuries...Has raised area to L side of head just above forehead, measures 5.5 cm [centimeters] in diameter. Bil [bilateral] knees look red, with L knee having blue tint to it. Resident or witness statement...Res [resident] not a good historian but when asked if just rolled out of bed, said yes, it hurts (rubbing head, stating 'what do I do?'...What intervention (s) was put into place to prevent another fall. Assure bed low, controller out of reach, of coarse that's [sic] how it was in this case...."</p>		<p>regarding fall.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> ·All residents have the potential to be affected by the alleged deficient practice. ·DNS/designee has reviewed all residents with falls for last 30 days to ensure notifications were provided per fall management policy and procedure. Residents identified will be further reviewed to ensure Physician/family notification was completed and timely. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> ·Licensed nurses will be re-educated by the DNS/designee on or before March 23, 2016 on timely notification of physician and family when a fall occurs · Residents with falls/injury/decline will be immediately reported to ED/DNS to ensure notifications of MD/family were completed and documented. ·Non compliance will result on further education including disciplinary action. <p>How the corrective action(s)</p>		

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	<p>Progress notes included the following notations:</p> <p>2/8/16 at 9:54 A.M.: "This nurse called MD office to make sure MD is aware of res. fall. This nurse left message with MD phone nurse explaining fall and asked for a call back. This nurse also called brother to make sure he was aware of res. fall...Red knot/bruise remains to L side of head/forehead...Bed is in lowest position with bed remote out of reach and call light within reach. Will cont. to monitor."</p> <p>2/8/16 at 10:12 A.M.: "IDT note for fall...Resident was resting in bed when (sic) staff found her lying on floor with gown and gripper socks on. Resident was asked if she rolled out of bed, she stated yes, although resident is a poor historian. Resident c/o pain to head with a raised bruised area noted. Bilateral knees with redness, and slight bruising to L knee...environmental factors noted of bed in high position with head of bed elevated...IDT feel root cause to be residents [sic] change in position in bed along with head of bed being elevated allowed her to roll from bed...MD and family not notified, notifications made by team this am...."</p>		<p>will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> · To ensure compliance, the DNS/Designee is responsible for the completion of the condition change -CQI tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. · DNS/Nurse managers/Designee will round daily using Fall Management CQI tool x 2weeks then weekly x 12 weeks then monthly x 6 months to ensure preventative measures are in place according to care plans. · If a threshold of 95% is not achieved an action plan will be developed. Findings will be reported in continuous quality improvement every month for a minimum of 6 months. <p>Compliance date: March 23, 2016</p>				

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F 0309 SS=G Bldg. 00	<p>On 2/19/16 at 10:00 A.M., the ED provided the current facility policy "Fall Management Program," revised 2/2015. The policy included: "...Post fall...The physician will be contacted immediately, if there are injuries, and orders will be obtained...The family will be notified immediately by the charge nurse of falls with injury. If there are no injuries, notify the family during day or evening hours...."</p> <p>This Federal tag relates to Complaint IN00193114, Complaint IN00193329, and Complaint IN00193939.</p> <p>3.1-5(a)(1)</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.</p>	F 0309	The creation and submission of this	03/23/2016

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	<p>Based on interview, observation and record review, the facility failed to completely assess a resident following a fall, and instead moved, showered, and dressed the resident, resulting in complaints of pain, for 1 of 4 residents reviewed for fall assessments, in a sample of 8. Resident B</p> <p>Findings include:</p> <p>On 2/18/16 at 9:40 A.M., during the initial tour, LPN # 1 indicated Resident B had recently fallen. LPN # 1 indicated Resident B was no longer a resident at the facility.</p> <p>The closed clinical record of Resident B was reviewed on 2/18/16 at 11:15 A.M. Diagnoses included, but were not limited to, dementia.</p> <p>A "significant change" Minimum Data Set (MDS) assessment, dated 11/10/15, indicated Resident B scored a 5 out of 15 for cognition, with 15 indicating no memory impairment. The MDS assessment indicated the resident required extensive assistance of two+ staff for bed mobility and transfer, and did not ambulate. A test for balance indicated "Not steady, only able to stabilize with staff assistance" while</p>				<p>Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p> <p>This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Certification Desk Review in lieu of a Post Survey Revisit on March 23, 2016.</p> <p>F309</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>The resident affected by the alleged deficient of practice resident B has been identified and no longer resides at the facility</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p>		

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	<p>moving from seated to standing position, moving on and off the toilet, and surface-to-surface transfer.</p> <p>A Physician's order, initially dated 1/14/14 and on the February 2015 orders, indicated, "Bed in lowest position."</p> <p>A Physician's order, initially dated 5/15/15 and on the February 2015 orders, indicated, "Bariatric Stage IV air mattress with bolsters."</p> <p>An "Event Report," included: "Event Date: 02/04/2016, 06:15 AM...Was fall witnessed, No. Describe what the resident was doing prior to fall...Lying in bed. Describe the position of the resident when first observed after the fall...Lying on the floor in front of the bed on the right side...Is the resident in pain and or experiencing difficulty in movement of extremities, Yes - c/o [complains of] head hurting. Did the resident hit his/her head, Yes...Describe injuries...hematoma [raised bruise] to above Left eye measuring 7.5 x 5 and a skin tear measuring 5.6 x 1.1 and a hematoma to above right eye measuring 5 x 6.5 and a open area measuring 1.5 x 0.5 and a skin tear to left hand measuring 1.5 x 1.6. Areas cleansed with wound cleanser and strips applied to skin tear above left eye and to skin tear to left hand...What</p>		<p>·All residents have the potential to be affected by the alleged deficient practice.</p> <p>·DNS/designee has reviewed all residents with falls for last 30 days on or before 3/23/16 to ensure services of highest well being provided per fall management policy and procedure</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>·Education on fall management program including completely assessing a resident following a fall has been provided to nursing staff by DNS/Designee by March 23, 2016.</p> <p>·Residents with falls/injury/decline will be immediately reported to ED/DNS to ensure resident completely assessed following a fall.</p> <p>·DNS/designee will review documentation after a fall to ensure complete assessment was provided according to facility fall program</p> <p>·If assessment not completed the nurse responsible will be addressed with further education and disciplinary action if needed.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur,</p>	

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	<p>intervention (s) was put into place to prevent another fall, neuro checks started. 15 min [minute] checks...Physician Notified: Date/Time: 02/04/2016, 07:43 AM, Family Notified: Yes, Date/Time: 02/04/2016. Vitals...Pulse 84/per minute [Time 07:09 AM]...Blood Pressure, 128/94 [Time 07:09 AM]...."</p> <p>A Discharge/Transfer form, dated 2/4/16 at 7:20 A.M., indicated: "...Reason for transfer, Res [resident] rolled out of bed and is c/o [complaining of] pain and guarding right shoulder...."</p> <p>An ambulance report, dated 2/4/16 at 7:43 A.M., indicated, "...Chief Complaint...Pain to right shoulder and neck...Staff states that the pt. [patient] fell out of bed and was found at 0615 [6:15 A.M.]...Arrived to find pt. seated in wheel chair...Noted bandaging to pt. arms and forehead. Noted improvised sling to pt. right arm...."</p> <p>A hospital emergency room history, dated 2/4/16 at 8:19 A.M., indicated, "...Fell (pt was found by the NH [nursing home] on the floor and the staff thought pt rolled out of bed onto the floor. NH staff had already gotten the pt up off the floor and into the wheelchair and they had steri stripped the forehead lacerations...Rt [right] shoulder X-ray: right distal</p>		<p>i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> To ensure compliance, the DNS/Designee is responsible for the completion of the fall program and condition change -CQI tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. DNS/Nurse managers/Designee will round daily using Fall Management CQI tool x 2weeks then weekly x 12 weeks then monthly x 6 months to ensure preventative measures are in place according to care plans. If a threshold of 95% is not achieved an action plan will be developed. Findings will be reported in continuous quality improvement every month for a minimum of 6 months. <p>Compliance date: March 23, 2016</p>	

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	<p>clavicle [collarbone] fx [fracture]...Clinical Impression: Fall, closed head injury, right distal clavicle fx, left forehead superficial laceration steri strip repaired...."</p> <p>On 2/18/16 at 11:30 A.M., during an interview with Resident B's family member, she indicated she was phoned on 2/4/16 at 7:45 A.M., and was informed that Resident B was on the way to the hospital with severe head injuries and a broken collarbone.</p> <p>On 2/18/16 at 1:20 P.M., during an interview with LPN # 1, she indicated she was working the morning of 2/4/16. She indicated she had "just gotten report" at approximately 6:15 A.M., when a CNA alerted her that Resident B had rolled out of the bed. LPN # 1 indicated the resident had bleeding and a hematoma on her head. LPN # 1 indicated the resident was lying on her right side, and so "was unable to do range of motion on that side." She indicated she did "shine a flashlight in her eyes, and that was ok." She did not indicate that she took the resident's vital signs. LPN # 1 indicated when they rolled the resident over, "you could tell something was wrong with her right arm." She indicated the resident's arm was "drooping," and she thought it might be broken. She indicated 4 staff</p>			

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	<p>members lifted the resident to a wheelchair, and the CNAs took the resident to the shower to "wash the blood out of her hair." LPN # 1 indicated when the resident was in the shower, staff noticed a bruise on the resident's right upper arm, and she was guarding her arm. She indicated she was not the primary nurse of Resident B on that day.</p> <p>On 2/18/16 at 1:30 P.M., during an interview with LPN # 2, she indicated, "We had just got report when the restorative aide yelled. [LPN # 1] went in first." LPN # 2 indicated the resident was found lying on the floor on her right side. She indicated the resident "had 2 knots on her left and right forehead," and she applied steri-strips to those areas. She indicated, "4 of us got her up with a gait belt. She was complaining of a headache." She indicated staff took the resident to the shower "to get the blood out," and that staff noticed a bruise on the resident's shoulder area. She indicated the resident was complaining of pain in the right arm, and that she called the physician and received orders to transfer the resident to the hospital.</p> <p>On 2/18/16 at 1:40 P.M., during an interview with CNA # 1, she indicated she found Resident B on the floor at approximately 6:15 A.M. on 2/4/16. She</p>			

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	<p>indicated, "Her face was awful. She had 2 big hematomas on each side of her head, and blood was dried on her head." She indicated when staff sat the resident up, they noticed a bruise on her right shoulder. She indicated the CNAs informed the nurses about the bruise. CNA # 1 indicated, "They only checked her eyes." CNA # 1 indicated they were told to give the resident a shower. CNA # 1 indicated the resident complained about head and shoulder pain. She indicated that following the shower, the resident's bruise appeared bigger, and she informed the nursing staff and the Director of Nursing. She indicated LPN # 1 indicated, "We need to send her out."</p> <p>On 2/18/16 at 1:50 P.M., during an interview with CNA # 2, she indicated at approximately 6:10-6:15 A.M., she and CNA # 1 went to Resident B's room, and did not see the resident in bed. She indicated the resident was found on the floor "with dried blood all over her, and 2 giant hematomas over her head." She indicated, "The nurse said to put her in the chair." CNA # 2 indicated, "[LPN # 1] looked in her eyes." CNA # 2 indicated the resident was transferred with a stand-aid mechanical lift to the shower chair from the wheelchair and back, and the resident "had a hard time lifting her arm." She indicated the</p>			

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	<p>resident kept stating, "Please don't hurt me." CNA # 2 indicated the resident had a dark bruise on her right upper arm. She indicated CNA # 1 and herself notified the nurses of the resident's bruising and pain, and that she was sent to the emergency room. She indicated, "Thinking back, no one ever took her vitals or anything until after the shower."</p> <p>On 2/19/16 at 10:00 A.M., the Executive Director (ED) provided the current facility policy "Fall Management Program," revised 2/2015. The policy included: "Post Fall, 1. Any resident experiencing a fall will be assessed immediately by the charge nurse for possible injuries and provide necessary treatment. A neurological assessment will be initiated on all un-witnessed falls. A neurological assessment will be initiated on all residents hitting their head. 2. If the resident experienced an injury from the fall, contact facility DNS [Director of Nursing Service]/ ED per facility policy. The physician will be contacted immediately, if there are injuries, and orders will be obtained...The family will be notified immediately by the charge nurse of falls with injury...."</p> <p>The ED and DNS indicated at that time that they had recently inserviced nursing staff on fall assessment, documentation,</p>			

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	and interventions post fall. This Federal tag relates to Complaint IN00193114, Complaint IN00193329, and Complaint IN00193939. 3.1-37(a)			
F 0323 SS=G Bldg. 00	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.			

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	<p>Based on interview and record review, the facility failed to provide supervision to prevent falls; failed to ensure residents' bed mattresses had bed bolsters and were in the lowest position as care planned and/or ordered by the physician, resulting in a fall from bed which resulted in head lacerations and a collarbone fracture; and utilized alarms in place of supervision, resulting in a fall with a head laceration, for 3 of 6 residents reviewed for falls, in a sample of 11. Resident B, Resident F, Resident G</p> <p>Findings include:</p> <p>1. On 2/18/16 at 9:40 A.M., during the initial tour, LPN # 1 indicated Resident B had recently fallen. LPN # 1 indicated Resident B was no longer a resident at the facility.</p> <p>The closed clinical record of Resident B was reviewed on 2/18/16 at 11:15 A.M. Diagnoses included, but were not limited to, dementia.</p> <p>A "significant change" Minimum Data Set (MDS) assessment, dated 11/10/15, indicated Resident B scored a 5 out of 15 for cognition, with 15 indicating no memory impairment. The MDS assessment indicated the resident required extensive assistance of two+</p>	F 0323	<p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p> <p>This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Certification Desk Review in lieu of a Post Survey Revisit on March 23, 2016.</p> <p>F323</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>· The resident affected by the alleged deficient of practice resident B has been identified and no longer resides in the facility.</p> <p>· Resident F and D affected by the alleged deficient of practice has been identified and care plans, profiles and fall interventions have been updated with staff following the preventative fall interventions.</p>	03/23/2016			

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	<p>staff for bed mobility and transfer, and did not ambulate. A test for balance indicated "Not steady, only able to stabilize with staff assistance" while moving from seated to standing position, moving on and off the toilet, and surface-to-surface transfer.</p> <p>A Physician's order, initially dated 1/14/14 and on the February 2015 orders, indicated, "Bed in lowest position."</p> <p>A Physician's order, initially dated 5/15/15 and on the February 2015 orders, indicated, "Bariatric Stage IV air mattress with bolsters."</p> <p>Progress Notes included the following notations:</p> <p>1/2/16 at 7:30 P.M.: "This nurse et [and] CNA were right outside resident's room et heard a loud crash...This nurse went into room et saw large amount of blood near resident's head et R [right] arm...Resident has large hematoma et deep laceration to R side of head. Resident also has skin tear to RAC [right inner elbow area]. MD notified et new order to sent resident to ER to eval et treat...."</p> <p>1/3/16 at 1:23 A.M.: "Resident returned from ER...transferred to bed by 4 staff</p>		<p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by the alleged deficient practice · Entire facility audit on falls was completed by the DNS/designee on or before 3/23/16 for the past 30 days to ensure the Fall Management Program was followed and intervention in place to prevent further accidents/injuries. Those residents identified without current plan of care/profile/interventions were further reviewed with appropriate interventions implemented. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> · Education on fall management program has been provided to nursing staff by DNS/Designee on or before March 23, 2016. · DNS/designee will conduct rounds each shift to ensure fall interventions/supervision are in place per plan of care/c.n.a. assignment 				

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	<p>members...showing s/s [signs/symptoms] of pain, facial grimacing, gaurding [sic], and crying out...resident got 6-7 stitches to right forehead and mepitel one dressing to right elbow."</p> <p>An "Event Report," included: "Event Date: 02/04/2016, 06:15 AM...Was fall witnessed, No. Describe what the resident was doing prior to fall...Lying in bed. Describe the position of the resident when first observed after the fall...Lying on the floor in front of the bed on the right side...Is the resident in pain and or experiencing difficulty in movement of extremities, Yes - c/o [complains of] head hurting. Did the resident hit his/her head, Yes...Describe injuries...hematoma [raised bruise] to above Left eye measuring 7.5 x 5 and a skin tear measuring 5.6 x 1.1 and a hematoma to above right eye measuring 5 x 6.5 and a open area measuring 1.5 x 0.5 and a skin tear to left hand measuring 1.5 x 1.6. Areas cleansed with wound cleanser and strips applied to skin tear above left eye and to skin tear to left hand...What intervention (s) was put into place to prevent another fall, neuro checks started. 15 min [minute] checks...Physician Notified: Date/Time: 02/04/2016, 07:43 AM, Family Notified: Yes, Date/Time: 02/04/2016. Vitals...Pulse 84/per minute [Time 07:09 AM]...Blood Pressure,</p>		<p>sheet.</p> <ul style="list-style-type: none"> The CARE representatives will observe assigned residents daily for fall prevention interventions per care plan and any incorrect observation will be corrected immediately and reported to the DNS/designee. The DNS/designee will review daily report/progress notes/Physician orders and CARE rep. rounding logs daily to ensure supervision needs are adequate and or if fall interventions are needed <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> To ensure compliance, the DNS/Designee is responsible for the completion of the fall program -CQI tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. 	

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	<p>128/94 [Time 07:09 AM]...."</p> <p>A Discharge/Transfer form, dated 2/4/16 at 7:20 A.M., indicated: "...Reason for transfer, Res [resident] rolled out of bed and is c/o [complaining of] pain and guarding right shoulder...."</p> <p>An ambulance report, dated 2/4/16 at 7:43 A.M., indicated, "...Chief Complaint...Pain to right shoulder and neck...Staff states that the pt. [patient] fell out of bed and was found at 0615 [6:15 A.M.]...Arrived to find pt. seated in wheel chair...Noted bandaging to pt. arms and forehead. Noted improvised sling to pt. right arm...."</p> <p>A hospital emergency room history, dated 2/4/16 at 8:19 A.M., indicated, "...Fell (pt was found by the NH [nursing home] on the floor and the staff thought pt rolled out of bed onto the floor. NH staff had already gotten the pt up off the floor and into the wheelchair and they had steri stripped the forehead lacerations...Rt [right] shoulder X-ray: right distal clavicle [collarbone] fx [fracture]...Clinical Impression: Fall, closed head injury, right distal clavicle fx, left forehead superficial laceration steri strip repaired...."</p> <p>A facility progress note, dated 2/5/16 at</p>		<p>Compliance date: March 23, 2016</p>				

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	<p>10:31 A.M., indicated: "...Resident was found by morning shift on floor next to bed...IDT [Interdisciplinary team] feels root cause to be resident rolling to side and air mattress continuing momentum, causing resident to fall to floor...."</p> <p>On 2/18/16 at 11:30 A.M., during an interview with Resident B's family member, she indicated she was phoned on 2/4/16 at 7:45 A.M., and was informed that Resident B was on the way to the hospital with severe head injuries and a broken collarbone.</p> <p>On 2/18/16 at 1:20 P.M., during an interview with LPN # 1, she indicated she was working the morning of 2/4/16. She indicated she had "just gotten report" at approximately 6:15 A.M., when a CNA alerted her that Resident B had rolled out of the bed. LPN # 1 indicated the resident had bleeding and a hematoma on her head. LPN # 1 indicated the resident was lying on her right side, and so "was unable to do range of motion on that side." She indicated she did "shine a flashlight in her eyes, and that was ok." LPN # 1 indicated when they rolled the resident over, "you could tell something was wrong with her right arm." She indicated the resident's arm was "drooping," and she thought it might be broken. She indicated 4 staff members</p>			

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	<p>lifted the resident to a wheelchair, and the CNAs took the resident to the shower to "wash the blood out of her hair." LPN # 1 indicated when the resident was in the shower, staff noticed a bruise on the resident's right upper arm, and that she was guarding her arm. She indicated she was not the primary nurse of Resident B on that day. LPN # 1 indicated the resident had been on an air mattress, but that the bed was not in the low position.</p> <p>On 2/18/16 at 1:30 P.M., during an interview with LPN # 2, she indicated, "We had just got report when the restorative aide yelled. [LPN # 1] went in first." LPN # 2 indicated the resident was found lying on the floor on her right side. She indicated the resident "had 2 knots on her left and right forehead," and she applied steri-strips to those areas. LPN # 1 indicated the bed was not in the lowest position. She indicated, "4 of us got her up with a gait belt. She was complaining of a headache." She indicated staff took the resident to the shower "to get the blood out," and that staff noticed a bruise on the resident's shoulder. She indicated the resident was complaining of pain in the right arm, and that she called the physician. She indicated the resident was transferred to the emergency room.</p> <p>On 2/18/16 at 1:40 P.M., during an</p>			

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	<p>interview with CNA # 1, she indicated she found Resident B on the floor at approximately 6:15 A.M. on 2/4/16. She indicated, "Her face was awful. She had 2 big hematomas on each side of her head, and blood was dried on her head." She indicated when staff sat the resident up, they noticed a bruise on her right shoulder. She indicated the CNAs informed the nurses about the bruise. CNA # 1 indicated, "They only checked her eyes." CNA # 1 indicated they were told to give the resident a shower. CNA # 1 indicated the resident complained about head and shoulder pain. She indicated that following the shower, the resident's bruise appeared bigger, and she informed the nursing staff and the Director of Nursing. She indicated LPN # 1 indicated, "We need to send her out." CNA # 1 indicated the resident's bed was not in the lowest position, but was at "normal height."</p> <p>On 2/18/16 at 1:50 P.M., during an interview with CNA # 2, she indicated at approximately 6:10-6:15 A.M., she and CNA # 1 went to Resident B's room, and did not see her in bed. She indicated the resident was found on the floor "with dried blood all over her, and 2 giant hematomas over her head." She indicated, "The nurse said to put her in the chair." CNA # 2 indicated, "[LPN #</p>			

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	<p>1] looked in her eyes." CNA # 2 indicated the resident was transferred with a stand-aid mechanical lift to the shower chair from the wheelchair and back, and the resident "had a hard time lifting her arm." She indicated the resident kept stating, "Please don't hurt me." CNA # 2 indicated the resident had a dark bruise on her right upper arm. She indicated CNA # 1 and herself notified the nurses of the resident's bruising and pain, and that she was sent to the emergency room.</p> <p>On 2/19/16 at 9:15 A.M., during an interview with the Executive Director (ED) and the Director of Nursing Services (DNS), the DNS indicated Resident B's bed was not in the lowest position as ordered, and the mattress did not have bolsters. The DNS indicated he did "write up" the nurse. The DNS and ED indicated staff are to check their CNA assignment sheets, located in the computerized kiosk, prior to starting care, to determine which residents required beds in the lowest position.</p> <p>2. On 2/18/16 at 9:40 A.M., during the initial tour, LPN # 1 indicated Resident F had recently fallen.</p> <p>The clinical record of Resident F was reviewed on 2/19/16 at 11:50 A.M.</p>				

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	<p>Diagnoses included, but were not limited to, unspecified dementia and paraplegia.</p> <p>An admission MDS assessment, dated 12/29/15, indicated Resident F scored a 5 out of 15 for cognition, with 15 indicating no memory impairment. The MDS assessment indicated the resident required extensive assistance of two+ staff for bed mobility and transfer, and did not ambulate. A test for balance indicated, "Not steady, only able to stabilize with staff assistance" while walking, moving on and off toilet, and surface-to-surface transfer.</p> <p>Resident Progress Notes included the following notations:</p> <p>12/30/15 at 1:26 A.M.: "Resident's roommate put on call light to alert staff of resident's fall. Resident was found laying on left side with R leg still partially on the bed. Resident had pillow still remaining under head...assisted back to bed with 3 assist...Pad alarm placed on bed as immediate intervention...Will cont [continue] to monitor."</p> <p>12/30/15 at 9:58 A.M.: "IDT note...IDT feels root cause to be residents [sic] position on low air loss mattress causing her to slide off onto floor...Future interventions include leaving pad alarm</p>			

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	<p>to bed...and bolster to mattress...."</p> <p>1/15/16 at 6:00 A.M.: "Resident was observed lying on L [left] side on floor next to bed with head in trash can. Noted blood on floor from skin tear on R thumb. When asked what resident was doing she stated 'I was just in this bed.'...Noted red mark to L side of neck, and skin tear to R thumb...Area to R thumb skin approximated and steri strips applied after cleansed. Mat placed on floor next to L side of bed...."</p> <p>Documentation regarding an alarm sounding was not found in the clinical record.</p> <p>Progress notes continued:</p> <p>1/15/16 at 10:23 A.M.: "IDT note...IDT feels root cause to be decreased safety awareness and noncompliance with assist level. Resident has been observed attempting to sit on edge of bed without assistance and has been informed of the dangers...Future interventions included bed in lowest position, mat to right side of bed, and bed to be placed with left side against wall...."</p> <p>1/22/16 at 2:02 A.M.: "This nurse et CNA were at the nursing station...heard resident yell that she was falling. This</p>			

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	<p>nurse ran into resident's room et resident was laying on forehead with coccyx on the mattress wing. Resident has a laceration on R side of forehead measuring 3 cm x 0.4 cm. Resident c/o [complains of] lower back et R hip pain...."</p> <p>1/22/16 at 10:15 A.M.: "IDT note for unwitnessed fall...Prior to fall resident had been seen sitting up in bed...Rsd [resident] has pressure pad alarm, but rsd. had removed battery from alarm box prior to falling. Immediate intervention was to send rsd. to ED [emergency department] for evaluation et replace alarm...Future interventions to include: low bed frame, change alarm to wireless alarm...."</p> <p>1/22/16 at 3:46 P.M.: "...Area to head above right eye stitches and dressing remains intact...."</p> <p>On 2/22/16 at 9:30 A.M., Resident F was observed lying in bed, with a bedside table in front of her. The bed was at standard height. The bed control pad was in the resident's bed, within reach of the resident. At that time, CNA # 4 was alerted, and indicated, "Her bed is supposed to be at the lowest height. The girl must have forgotten to lower it." CNA # 4 immediately lowered the bed.</p>			

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	<p>On 2/22/16 at 12:30 P.M., during an interview with the ED and DNS, the DNS indicated he was unable to find documentation regarding whether or not the resident's alarm sounded on 1/15/16. He indicated the resident removed the batteries from the alarm box on 1/22/16 herself, and so he had to assume the resident's alarm was in place on 1/15/16.</p> <p>3. On 2/18/16 at 9:40 A.M., during the initial tour, LPN # 1 indicated Resident D had recently fallen.</p> <p>The clinical record of Resident D was reviewed on 2/18/16 at 3:00 P.M. Diagnoses included, but were not limited to, dementia.</p> <p>An annual MDS assessment, dated 12/15/15, indicated Resident D scored a 5 out of 15 for cognition, with 15 indicating no memory impairment. The MDS assessment indicated the resident required extensive assistance of two+ staff for bed mobility and transfer, and did not ambulate. A test for balance indicated, "Not steady, only able to stabilize with staff assistance" while moving from seated to standing position and surface-to-surface transfer.</p> <p>An "Event Report," dated 2/7/16 at 8:45</p>			

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	<p>P.M., indicated, "...Was fall witnessed, No...Describe the position of the resident when first observed after fall...The bed was in high position with HOB [head of bed] all the way up, although when was put to bed, bed was left in low pos [sic] with HOB slightly up. Bed controller was not within reach of res...Describe injuries...Has raised area to L side of head just above forehead, measures 5.5 cm [centimeters] in diameter. Bil [bilateral] knees look red, with L knee having blue tint to it. Resident or witness statement...Res [resident] not a good historian but when asked if just rolled out of bed, said yes, it hurts (rubbing head, stating 'what do I do?'...What intervention (s) was put into place to prevent another fall. Assure bed low, controller out of reach, of coarse that's [sic] how it was in this case...."</p> <p>Progress notes included the following notations:</p> <p>2/8/16 at 9:54 A.M.: "This nurse called MD office to make sure MD is aware of res. fall. This nurse left message with MD phone nurse explaining fall and asked for a call back. This nurse also called brother to make sure he was aware of res. fall...Red knot/bruise remains to L side of head/forehead...Bed is in lowest position with bed remote out of reach and</p>			

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	<p>call light within reach. Will cont. to monitor."</p> <p>2/8/16 at 10:12 A.M.: "IDT note for fall...Resident was resting in bed when (sic)staff found her lying on floor with gown and gripper socks on. Resident was asked if she rolled out of bed, she stated yes, although resident is a poor historian. Resident c/o pain to head with a raised bruised area noted. Bilateral knees with redness, and slight bruising to L knee...environmental factors noted of bed in high position with head of bed elevated...IDT feel root cause to be residents [sic] change in position in bed along with head of bed being elevated allowed her to roll from bed...MD and family not notified, notifications made by team this am...."</p> <p>2/8/16 at 12:27 P.M.: "MD called facility back and gave orders to send res. to [name of hospital] to have CT of head done...."</p> <p>A resident care plan, initially dated 2/20/8 and updated with a goal target date of 10/29/15, indicated, "Resident is at risk for all due to: Dx [diagnosis] of arthritis...use of assistive devices, Hx [history] of falls...non-compliance with asking for help...poor safety awareness, confusion...has frequent attempts to try</p>			

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	<p>and stand w/o [without] assistance." The approaches included: "2/8/16 Pressure redistribution mattress with side bolsters. 7/8/15 Pull tab alarm to W/C [wheelchair]. 7/17/15 Bed in lowest position. 11/26/14 Pad alarm afixed [sic] to upper portion of the bed."</p> <p>On 2/19/16 at 10:00 A.M., the ED provided the current facility policy "Fall Management Program," revised 2/2015. The policy included: "It is the policy of [name of corporation] to ensure residents residing within the facility will maintain maximum physical functioning through the establishment of physical, environmental, and psychosocial guidelines to prevent injury related to falls... A care plan will be developed at time of admission specific to each resident's fall risk factors. A resident specific care requirements will be communicated to the assigned caregiver utilizing resident profile or CNA assignment sheet...."</p> <p>The ED and DNS indicated at that time that they had recently inserviced nursing staff on fall assessment, documentation, and interventions post fall. The DNS indicated they provided staff with a list of interventions other than alarms to try to prevent falls.</p>			

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	<p>This Federal tag relates to Complaint IN00193114, Complaint IN00193329, and Complaint IN00193939.</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p>			