

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155501	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/16/2015
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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF BLUFFTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1529 W LANCASTER ST BLUFFTON, IN 46714
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F000000	<p>This visit was for the Investigation of Complaint IN00162298 and IN00162402.</p> <p>Complaint IN00162298-Unsubstantiated due to lack of evidence. Complaint IN00162402-Substantiated, Deficiency cited at F-323.</p> <p>Survey Dates: January 14, 15 & 16, 2015.</p> <p>Facility number: 000465 Provider number: 155501 AIM number: 100273870</p> <p>Survey team: Angela Strass, RN</p> <p>Census bed type: SNF/NF: 49 Total: 49</p> <p>Census payor type: Medicare: 6 Medicaid: 38 Other: 5 Total: 49</p> <p>Sample: 4</p> <p>This deficiency also reflects state findings in accordance with 410 IAC</p>	F000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F000323 SS=D	<p>16.2-3.1.</p> <p>Quality review completed by Debora Barth, RN.</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to ensure a personal alarm was activated for 1 resident (B) in a sample of 4 resident records reviewed who were at risk for falls.</p> <p>Finding includes:</p> <p>On 1/15/115 at 9:30 a.m. review of the clinical record for Resident (B) indicated she was admitted to the facility on 9/24/14 with diagnoses including but not limited to: Dementia with Behavioral Disturbances, Chronic Low Back Pain, History of Multiple Falls, Atrial Fibrillation, Anxiety and Depression.</p>	F000323	<p>F 323 –D It is the intent of the facility to ensure that the residentenvironment remains as free of accident hazards as is possible and eachresident receives adequate supervision to prevent accidents.</p> <p>1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; For Resident B,presure alarm was immediately implemented as intervention for fall prevention.All available staff were immediately in-serviced regarding assuring that allalarms are in place and functioning properly.</p> <p>1.How other residents having the potential to be affected by the same deficient practice will be</p>	01/17/2015

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	<p>Review of nursing notes, dated 10/17/14 at 8:40 p.m., indicated Resident (B) attempted to ambulate to the bathroom from her recliner, fell and sustained a left hip fracture. Review of the facility incident report indicated the staff then implemented "pressure and personal alarms" for the resident.</p> <p>Review of the "Significant Change Minimum Data Set", dated 10/29/14, indicated the resident was non ambulatory after the hip fracture and required extensive assistance with activities of daily living.</p> <p>On 1/15/15 at 10:00 a.m. review of a facility incident report, dated 12/22/14 at 7:30 a.m., indicated Resident (B) was seated in her recliner, attempted to get out of the chair and slid to the floor. The resident did not have any injuries. Further review of the incident indicated the "personal alarm" was not attached to the resident at the time of the incident.</p> <p>Interview with the Director of Nursing, on 1/15/15 at 10:30 a.m., indicated staff had not placed the personal alarm on the resident when she was in her recliner on 12/22/14.</p> <p>On 1/16/15 at 12:35 p.m. review of the Facility Fall Policy, dated 4/2012,</p>		<p>identified and what corrective action will be taken; All residents identified as fall risk have the potential to be effected. 100% chart audit conducted to assure that any resident with orders for fall prevention interventions has the appropriate interventions in place and functioning properly. Care plans reviewed and updated as well as CNA care sheets.</p> <p>1. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice will not recur; Nursing staff in-serviced regarding; 1. Proper placement and monitoring functionality of any resident alarms; 2. Monitoring alarms every shift, after transfers and during rounds to assure they are in place and functioning properly. Staff in-servicing completed on 01/16/2015.</p> <p>1. How the corrective action (s) will be monitored to ensure the deficient practice will not recur; DON and/or designee will monitor all residents with alarms to assure that they are in place and functioning properly daily for three weeks and then weekly on going as part of IDT risk management meeting until substantial compliance achieved. DON and/or designee will monitor all new orders 5 days weekly to monitor for new or discontinued</p>				

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	<p>indicated the following:</p> <p>"It is the intent of this facility to provide residents with assistance and supervision in an effort to minimize the risk of falls and fall related injuries.</p> <p>All residents will have a comprehensive fall risk assessment on admission, quarterly, and with significant change of condition and appropriate care plan interventions will be implemented and evaluated as indicated by the assessment."</p> <p>This Federal Tag is related to complaint IN00162402.</p> <p>3.1-45 (a)(2)</p>		<p>alarm orders and update audit sheet accordingly. All findings from audits will be reported monthly X's 3 months to Performance Improvement Committee to assure substantial compliance is sustained. Addendum 2/10/15 : All findings from audits will be reviewed monthly ongoing per QAPi Committee for further recommendation if indicated</p> <p>1.CEO is responsible to ensure compliance by February 15, 2015.</p> <p>DATE SHIFT RESIDENT UNIT ALARM IN PLACE FUNCTIONING COMPLETED BY</p>	