

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155692	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/27/2014
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NAME OF PROVIDER OR SUPPLIER HERITAGE OF HUNTINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1180 W 500 N HUNTINGTON, IN 46750
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F000000	<p>This visit was for the Investigation of Complaints IN00146007, IN00146074, IN00146410 and IN00146484.</p> <p>Complaint IN00146007 - Substantiated. Federal/State deficiencies related to allegation are cited at F241, F279, F282, F323 and F9999.</p> <p>Complaint IN00146074 - Substantiated. Federal/State deficiencies related to allegation are cited at F9999.</p> <p>Complaint IN00146410 - Substantiated. Federal/State deficiencies related to allegation are cited at F241, F282 and F323.</p> <p>Complaint IN00146484 - Substantiated. Federal/State deficiencies related to allegation are cited at F241.</p> <p>Survey dates: March 24, 25, 26 and 27, 2014</p> <p>Facility number: 002910 Provider number: 155692 AIM number: 200345390</p>	F000000		
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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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	<p>Survey Team: Shelley Reed, RN TC</p> <p>Census bed type: SNF: 17 SNF/NF: 41 Residential: 52 Total: 110</p> <p>Census payor type: Medicare: 11 Medicaid: 15 Other: 84 Total: 110</p> <p>Sample: 11</p> <p>These deficiencies reflect state findings in accordance with 410 IAC 16.2.</p> <p>Quality review completed by Debora Barth, RN.</p>				

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F000241 SS=E	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on interview and record review, the facility failed to respond in a timely manner to assist dependent residents with toileting (Resident D, I and L) and causing incontinent episodes for 2 of 3 residents reviewed for dignity (Resident I and Resident L).</p> <p>Findings include:</p> <p>1). The clinical record for Resident (I) was reviewed on 3/23/14 at 4:30 p.m. Diagnoses for the resident included, but were not limited to, hemiplegia, hemiparesis, hypertension, cardiovascular disease and depressive disorder.</p> <p>During an interview with assistance from her spouse on 3/25/14 at 1:15 p.m., Resident (I) indicated she has to often wait long periods of time for her call light to be answered. She indicated she was two person assist and the wait had caused her incontinent episodes.</p>	F000241	<p>1) The Call light times will be reviewed on all 3 shifts daily Monday through Friday x 4 weeks by DON or designee then 3 times weekly Monday through Friday on all 3 shifts x 4 weeks for Residents I, L, and D. Residents I, L, and D will be interviewed weekly to ensure needs are being met and concerns are being addressed as needed to ensure quality of care.</p> <p>2) All residents have the potential to be affected by this same deficient practice. Call light times will be examined on all 3 shifts daily x 4 weeks by the DON or designee then 3 times weekly x 4 for random residents. Any call light times in excess of 15 minutes will be investigated. The facility has also implemented a 3rd level alarm page to alert Manager's of a call light that has exceeded 12 minutes.</p> <p>3) Call light report will be run weekly at a minimum with any excessive call lights investigated after the monitoring schedule set forth in #'s 1 & 2 are satisfied and no concerns are identified.</p> <p>4) Nursing department will report to QA on all calls in excess of 15 minutes monthly. QA team will</p>	03/30/2014
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	<p>The annual Minimum Data Set (MDS) assessment, dated 1/15/14, indicated Resident (I) was cognitively intact. Resident (I) received the following Activities of Daily Living (ADL) assistance; transfer-extensive assistance with two person assist, dressing, eating, hygiene and bathing-extensive assistance with one person assist, range of motion-one side impairment. Resident (I) was frequently incontinent of bladder.</p> <p>A health care plan problem, dated 8/20/12, indicated Resident (I) required assistance with ADL's due to CVA with left sided hemiparesis. One of the approaches for the problem indicated "transfer with 2 staff assist with gait belt" and "provide any ADL assist as needed".</p> <p>During computer review of the call light response time on 3/26/14 at 3:30 p.m., the call responses from 3/1/14-3/26/14 were reviewed. On 37 different occasions, the call time exceeded ten minutes. The average time for response was 19 minutes and 47 seconds with the responses over ten minutes.</p> <p>On 3/12/14 at approximately 7:11 a.m., Resident (I) placed her</p>		<p>initiate action plan as needed.</p> <p>5) March 30, 2014</p>		

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	<p>bathroom call light on 17 times from 7:11 a.m. to 7:20 a.m.</p> <p>2). The clinical record for Resident (L) was reviewed on 3/27/14 at 10:15 a.m. Diagnoses for the resident included, but were not limited to, chronic airway obstruction, chronic kidney disease, congestive heart failure, obesity and lower limb amputation.</p> <p>During an interview on 3/27/14 at 11:05 a.m., Resident (L) indicated he had to often wait long periods of time for his call light to be answered. He indicated he was a two person assist and the wait had caused him incontinent episodes.</p> <p>The annual Minimum Data Set (MDS) assessment, dated 3/10/14, indicated Resident (L) was cognitively intact. Resident (L) received the following Activities of Daily Living (ADL) assistance; transfer-extensive assistance with two person assist, dressing-extensive assistance with two person assist, eating, hygiene and bathing-extensive assistance with one person assist, range of motion-one side impairment. Resident (L) was frequently incontinent of bladder and bowel.</p>			
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	<p>A health care plan problem, dated 3/7/14, indicated Resident (L) required assistance with ADL's due to chronic bilateral subdural hematoma and right above knee amputation. Two of the approaches for the problem indicated "transfer to the toilet with 2 staff assist with min/mod assist" and "provide any ADL assist as needed".</p> <p>During computer review of the call light response time on 3/26/14 at 3:30 p.m., the call responses from 3/2/14-3/25/14 were reviewed. On 19 different occasions, the call time exceeded nine minutes. The average time for response was 14 minutes and 7 seconds with the responses over nine minutes.</p> <p>3). The clinical record for Resident (D) was reviewed on 3/24/14 at 10:00 a.m. Diagnoses for the resident included, but were not limited to, hypertension, hyperkalemia, depression and psychotic disorder.</p> <p>The most recent Minimum Data Set (MDS) assessment, dated 3/18/14, indicated Resident (D) was cognitively intact. Resident (D) received the following Activities of Daily Living (ADL) assistance;</p>			
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	<p>transfer-total assist with two person assist, dressing, bathing and hygiene-extensive assistance with two person assist and eating-limited assistance with one person assist. Resident (D) was frequently incontinent of bowel and bladder.</p> <p>A health care plan problem, dated 2/14/11, indicated Resident (D) was a fall risk related to a history of falls and weakness. One of the approaches for the problem indicated "stand lift for transfer with 2 staff assist".</p> <p>During computer review of the call light response time on 3/26/14 at 3:30 p.m., the call responses from 3/3/14-3/22/14 were reviewed. On 6 different occasions, the call time exceeded ten minutes. The average time for response was 13 minutes and 52 seconds with the responses over ten minutes.</p> <p>4. During an interview on 3/26/14 at 3:30 p.m., the Assistant Director of Nursing (ADoN) indicated she reviewed the call response times on 3/25/14. She indicated she noticed the call response for Resident (I) of 65 minutes and 12 seconds on 3/9/14. She indicated she spoke to the maintenance director related to the paging system for the staff. She</p>			

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	<p>indicated he spoke with the company who provided the pagers and stated the pagers stop alarming at 20 minutes. She indicated she was unaware the paging system stopping after 20 minutes.</p> <p>During an interview on 3/26/14 at 4:30 p.m., the Administrator indicated she had been informed of the call response times by the ADoN. She indicated she was unsure if the lights outside the door continue to be lit up, but she thought they did.</p> <p>This Federal tag relates to Complaints IN00146007, IN00146410 and IN00146484.</p> <p>3.1-3(t)</p>				

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F000250 SS=D	<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.</p> <p>Based on record review and interview, the facility failed to identify and care plan interventions for maladaptive behaviors for 1 of ?? residents reviewed for behavior planning. (Resident #)</p> <p>Findings include:</p> <p>The clinical record for Resident (E) was reviewed on 3/24/14 at 2:30 p.m. Diagnoses for the resident included, but were not limited to, Alzheimer's disease, hypertension, asthma and depressive disorder.</p> <p>The quarterly Minimum Data Set (MDS) assessment, dated 3/11/14, indicated Resident (E) was severely cognitively impaired. Resident (E) received the following medications; Lexapro 10 mg daily, Namenda 28 mg daily and Aricept 10 mg daily.</p> <p>Review of the mood and behavior sheets from 2/9-3/9/14, indicated Resident (E) had several episodes of maladaptive behaviors. On 2/2/14, Resident (E) yelled at and pushed</p>	F000250	<ol style="list-style-type: none"> 1) Behavior care plan completed for resident E. 2) Behavior care plan completed for all residents with incidents of behaviors in the past 3 months. 3) Behavior care plan will be reviewed at all MDS reviews as part of the overall nursing care plan 4) Nursing department will randomly select 5 residents with behavior notes in the past 3 months for behavior care plan review and report those findings to the QA committee at the quarterly meeting. 5) March 29, 2014 	03/29/2014	

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	<p>her walker into a staff member. On 2/5/14, Resident (E) was verbally and physically abusive to staff. On 2/6/14, Resident (E) refused care. On 2/18/14, Resident (E) was noted to be displaying public masturbation. On 2/21/14, Resident (E) refused care and hygiene. Resident (E) was again verbally and physically abusive to staff. On 2/25/14, Resident (E) refused numerous medications. On 3/6/14 and 3/18/14, Resident (E) refused medications.</p> <p>During an interview on 3/25/14 at 9:30 a.m., the Director of Nursing (DoN) indicated Resident (E) did not have any care plan for behaviors.</p> <p>Review of the internal incident report, provided by the DoN on 3/26/14 at 10:10 a.m. indicated CNA #4 heard a "slap" and looked over to see Resident (E) and Resident (F) sitting on the love seat. The CNA stated "we do not hit" and Resident (E) stated Resident (F) hit her first. The CNA stated she did not see the slap, but just heard the sound of it.</p> <p>During an interview on 3/28/14 at 2:00 p.m., the SSD indicated Resident (E) was not on any type of behavior medication. She indicated Resident (E)'s behaviors had been</p>			

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	<p>directed towards staff and not other residents. She indicated she was unsure if Resident (E) would benefit from behavior monitoring or care planning, but would discuss it in their morning meeting.</p> <p>Review of a current facility policy dated 10/13, titled "Behavior Management", which was provided by the DoN on 3/26/14 at 1:30 p.m., indicated the following,</p> <p>"Policy: Residents who exhibit problematic behaviors that are distressing or harmful to them self or other residents will be observed in a manner to identify...</p> <p>Procedure: 1-Problematic behaviors... 6-A Behavior Record will be developed. The record will describe the behaviors that the resident is exhibiting and appropriate interventions will be initiated by the Behavior Management Team.</p> <p>This Federal tag related to Complaints IN00146007 and IN00146074.</p> <p>3.1-34(a)</p>						

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F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review, the facility failed to ensure residents who received antidepressant medications had care plans which identified and addressed target behaviors being treated by the medications for 1 of 3 residents reviewed for care planning regarding behavioral symptoms (Resident E).</p> <p>Findings include:</p> <p>The clinical record for Resident (E) was reviewed on 3/24/14 at 2:30 p.m. Diagnoses for the resident included,</p>	F000279	<p>1) Behavior care plan completed for resident E.</p> <p>2) All facility residents were reviewed and a Behavior care plan completed for all residents with anti-depressant medications.</p> <p>3) Behavior care plan will be reviewed at all MDS reviews as part of the overall nursing care plan.</p> <p>4) Nursing department will select 5 residents monthly with anti-depressant medications for behavior care plan review X 3 months then quarterly thereafter and report those findings to the QA committee at the quarterly meeting.</p>	03/29/2014

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	<p>but were not limited to, Alzheimer's disease, hypertension, asthma and depressive disorder.</p> <p>The quarterly Minimum Data Set (MDS) assessment, dated 3/11/14, indicated Resident (E) was severely cognitively impaired. Resident (E) received the following medications; Lexapro 10 mg daily, Namenda 28 mg daily and Aricept 10 mg daily.</p> <p>Review of the mood and behavior sheets from 2/9-3/9/14, indicated Resident (E) had several episodes of behavior. On 2/2/14, Resident (E) yelled at and pushed her walker into a staff member. On 2/5/14, Resident (E) was verbally and physically abusive to staff. On 2/6/14, Resident (E) refused care. On 2/18/14, Resident (E) was noted to be displaying public masturbation. On 2/21/14, Resident (E) refused care and hygiene. Resident (E) was again verbally and physically abusive to staff. On 2/25/14, Resident (E) refused numerous medications. On 3/6/14 and 3/18/14, Resident (E) refused medications.</p> <p>During an interview on 3/25/14 at 9:30 a.m., the Director of Nursing (DoN) indicated Resident (E) did not have any care plan for behaviors.</p>		5) March 29, 2014	
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	<p>Review of the internal incident report, provided by the DoN on 3/26/14 at 10:10 a.m. indicated CNA #4 heard a "slap" and looked over to see Resident (E) and Resident (F) sitting on the love seat. The CNA stated "we do not hit" and Resident (E) stated Resident (F) hit her first. The CNA stated she did not see the slap, but just heard the sound of it.</p> <p>Review of a current facility policy dated 10/13, titled "Behavior Management", which was provided by the DoN on 3/26/14 at 1:30 p.m., indicated the following,</p> <p>"Policy: Residents who exhibit problematic behaviors that are distressing or harmful to them self or other residents will be observed in a manner to identify...</p> <p>Procedure: 1-Problematic behaviors... 6-A Behavior Record will be developed. The record will describe the behaviors that the resident is exhibiting and appropriate interventions will be initiated by the Behavior Management Team.</p> <p>This Federal tag related to Complaints IN00146007 and</p>				

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	IN00146074. 3.1-35(a)				

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on interview and record review, the facility failed to ensure a resident was transferred in accordance with the resident's plan of care to help prevent falls for 1 of 3 residents reviewed for falls (Resident G).</p> <p>Findings include:</p> <p>The clinical record for Resident (G) was reviewed on 3/24/14 at 9:00 a.m. Diagnoses for the resident included, but were not limited to, diabetes mellitus, dementia, Alzheimer's disease and vitamin B12 deficiency.</p> <p>The most recent Minimum Data Set (MDS) assessment, dated 3/18/14, indicated Resident (G) was moderately cognitively impaired. Resident (G) received the following Activities of Daily Living (ADL) assistance; transfer-extensive assistance with two person assist, dressing-extensive assistance with one person assist, ambulation-extensive assistance with one person assist, bathing and</p>	F000282	<p>1) Resident G was not injured by the incorrect transfer technique. The CNA responsible was educated on gait belt use and following assignment sheet. CNA has since been terminated from the facility. Resident G is now a 2 person transfer with gait belt. 2) All residents not independent for transfers have been identified and gait belts added as part of the C.N.A. uniform requirement. Careplans for all facility residents have been reviewed to ensure those dependent on staff for transfers will be transferred with the correct and safest method. 3) All new C.N.A. staff will demonstrate competency of transfers to Staff Development Coordinator, DON, ADON, or Nurse prior to being released from orientation to work independently on an assignment. The facility staff will also be educated for use of a gait belt upon hire and then no less than annually after that. At the time of gait belt and transfer inservice, facility staff will also be educated on following the careplans set forth for transfers and updated as needed with any changes. 4) At least annually, through Staff Development Coordinator, DON,</p>	03/28/2014	

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	<p>hygiene-extensive assistance with two person assist. Resident (G) had impairment to one side and was frequently incontinent of bladder.</p> <p>During review of the clinical records, an incident report, dated 2/1/14, indicated at 12:45 a.m., Resident (G) was being assisted from her wheelchair to her recliner by a CNA. The resident's knees gave out and the resident was lowered to the floor. The report indicated the CNA stated she did not use the gait belt to transfer Resident (G). Resident (G) was assessed and found to have no injuries. The physician and Power of Attorney (POA) were notified.</p> <p>A corrective action, dated 2/1/14 at 1:26 p.m., indicated the staff member was educated to always use a gait belt for residents who do not ambulate independently.</p> <p>A health care plan problem, dated 2/7/14, indicated Resident (G) required assistance with ADL's due to dementia. One of the approaches for the problem indicated "2 staff to assist with transfers".</p> <p>During an interview on 3/26/14 at 10:45 a.m., the Director of Nursing (DoN) indicated Resident (G) was a 1</p>		ADON or designee, every CNA will be observed and required to demonstrate competency of transfers using a gait belt, Sara and Hoyer lifts. 5) March 28, 2014		

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	<p>person assist with a gait belt. She indicated the CNA failed to follow the care plan as written, resulting in a fall. She indicated the resident was now a 2 person assist.</p> <p>Review of a current facility policy, dated 10/2012, titled "Gait Belt", which was provided by the DoN on 3/26/14 at 1:40 p.m., indicated the following:</p> <p>"Purpose: The gait belt is intended for use when lifting, ambulating or transferring residents. It is not to be used as a restraint in the wheelchair, chairs of any kind or in bed.</p> <p>Policy: A gait belt...</p> <p>Procedure: Step Action 1. Place belt...</p> <p>Important: Before ambulating, transferring or lifting resident, be certain that you have the physical capability of supporting the resident...</p> <p>This Federal tag related to Complaints IN146007 and IN00146410.</p> <p>3.1-35(g)(2)</p>				

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F000323 SS=G	<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 interview and record review, the facility failed to ensure residents who were transferred using a mechanical lift were transferred with sufficient staff assistance to prevent accident and injury for 1 of 3 residents reviewed for accidents. This failure resulted in a tibia and fibula fracture of the left leg of the resident (Resident D).</p> <p>Findings include:</p> <p>The clinical record for Resident (D) was reviewed on 3/24/14 at 10:00 a.m. Diagnoses for the resident included, but were not limited to, hypertension, hyperkalemia, depression and psychotic disorder.</p> <p>The most recent Minimum Data Set (MDS) assessment, dated 3/18/14, indicated Resident (D) was cognitively intact. Resident (D) received the following Activities of Daily Living (ADL) assistance; transfer-total assist with two person</p>	F000323	<p>1) The CNA responsible was immediately educated on correct transfer technique and following assignment sheet. CNA has since been terminated from the facility.</p> <p>2) The CNA responsible was immediately educated on correct transfer technique and following assignment sheet. CNA has since been terminated from the facility. Careplans for all facility residents have been reviewed to ensure those dependent on staff for transfers will be transferred with the correct and safest method.</p> <p>3) All new C.N.A. staff will demonstrate competency of transfers to Staff Development Coordinator, DON, ADON, or Nurse prior to being released from orientation to work independently on an assignment. The facility staff will also be educated for use of a gait belt upon hire and then no less than annually after that. At the time of gait belt and transfer inservice, facility staff will also be educated on following the careplans set forth for transfers and updated as needed with any changes.</p> <p>4) At least annually, each C.N.A. staff will be observed/required by</p>	03/28/2014			

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	<p>assist, dressing, bathing and hygiene-extensive assistance with two person assist and eating-limited assistance with one person assist. Resident (D) was frequently incontinent of bowel and bladder.</p> <p>During review of the clinical record, a progress note, dated 3/11/14 at 7:54 p.m., indicated CNA #5 was transferring Resident (D) to the bathroom via Sara lift. Resident (D)'s foot was not completely on the platform and she began to fall. The CNA pulled the cord for assistance and staff responded. Resident (D) was moved from the bathroom to the bed. She had an observed skin tear to her left upper arm measuring 4.0 cm x 3.0 cm. The physician and Power of Attorney (POA) for Resident (D) were notified.</p> <p>A progress note, dated 3/12/14 at 3:44 a.m., indicated Resident (D) complained of knee pain. She again complained of pain at 8:32 a.m. The physician was notified and an order for an x-ray was received. The x-ray was obtained on 3/12/14 at 10:45 a.m. The x-ray noted a fracture of the left fibula. Resident (D) was seen by an orthopedic physician and returned to the facility on 3/12/14 at 2:45 p.m. Resident (D)'s left leg was</p>		<p>nurse or Staff Development Coordinator, DON, ADON or Nurse to demonstrate competency of use of a gait belt, Sara and Hoyer lifts. The facility staff will also be inserviced for use of a gait belt upon hire and then no less than annually after that. At the the of gait belt and transfer inservice, facility nursing staff will also be educated on following the careplans for transfers.</p> <p>5) March 28, 2014</p>		

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	<p>immobilized related to a tibia and fibula fracture. Resident (D) was to remain non-weight bearing, no bending of left knee and bed rest at all times except for meal time.</p> <p>A health care plan problem, dated 2/14/11, indicated Resident (D) was a fall risk related to a history of falls and weakness. One of the approaches for the problem indicated "stand lift for transfer with 2 staff assist".</p> <p>During an interview on 3/26/14 at 10:45 a.m., the Director of Nursing (DoN) indicated Resident (D) was a 2 person assist. She indicated the CNA failed to follow the care plan as written, resulting in a fall and fracture.</p> <p>Review of the PRN (as necessary) medication report from 3/11/14 to 3/27/14, Resident (D) received the following medications for pain relief;</p> <p>hydrocodone-acetaminophen 5-325 mg 0.5 tablet- 3/11/14 at 8:36 p.m., 3/13/14 at 4:40 a.m., 3/14/14 at 8:25 a.m., 3/14/14 at 10:02 a.m., 3/15/14 at 2:52 p.m., 3/16/14 at 7:59 p.m., 3/17/14 at 2:49 p.m., 3/18/14 at 1:25 a.m., 3/21/14 at 1:23 a.m. and 3/22/14 at 1:47 a.m.</p> <p>hydrocodone-acetaminophen 5-325</p>						

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	<p>mg 1 tablet- 3/12/14 at 3:44 a.m., 3/12/14 at 8:32 a.m., 3/12/14 at 4:45 p.m., 3/13/14 at 10:57 a.m., 3/13/14 at 5:06 p.m., 3/14/14 at 2:00 p.m., 3/14/14 at 9:26 p.m., 3/15/14 at 10:09 a.m., 3/15/14 at 9:34 p.m., 3/16/14 at 3:44 p.m., 3/17/14 at 12:33 a.m., 3/17/14 at 11:26 a.m., 3/17/14 at 9:12 p.m., 3/19/14 at 12:41 a.m., 3/21/14 at 12:21 p.m., 3/22/14 at 5:29 p.m., 3/25/14 at 6:20 p.m. and 3/26/14 at 11:27 a.m.</p> <p>Resident (D) was also receiving Methadone (synthetic opioid) 5 mg, 1/2 tablet every 12 hours for back pain with a start date of 3/20/14.</p> <p>During an interview on 3/26/14 at 2:00 p.m., 5 family members of Resident (D) gathered in the facility to discuss concerns related to the recent fall. One family member indicated the resident had significant pain and discomfort since the fall. The family member also indicated the resident had been less oriented and alert. In addition, the family member indicated the resident was sleepier and more confused since the fall.</p> <p>Resident (D) was observed on 3/24/14 at 7:50 a.m., asleep in bed. She was again observed on 3/25/14 at 7:45 a.m., dressed and seated in</p>			
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	<p>her wheelchair with eyes closed. She was observed at 7:50 a.m., seated at the assist table for breakfast with her eyes closed. On 3/27/14 at 11:10 a.m., Resident (D) was asleep in bed.</p> <p>Review of a current facility policy, dated 5/11, titled "Sara Lift", which was provided by the DoN on 3/26/14 at 1:30 p.m., indicated the following:</p> <p>"PURPOSE: Mechanical lifts are used to lift residents...</p> <p>PROCEDURE: STEP ACTION 1. Explain the procedure... 8. Ensure the resident's feet are supported evenly and flat on the foot rest plate."</p> <p>This Federal tag relates to Complaint IN00146007 and IN00146410.</p> <p>3.1-45(a)(2)</p>				

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F009999	<p style="text-align: center;">State Findings:</p> <p>3.1-13(g) The administrator is responsible for the overall management of the facility but shall not function as a departmental supervisor, for example, director of nursing or food service supervisor, during the same hours. The responsibilities of the administrator shall include, but are not limited to, the following:</p> <p>(1) Immediately informing the division by telephone, followed by written notice within (24)twenty-four hours, of unusual occurrences that directly threaten the welfare, safety, or health of the resident or residents....</p> <p>This state rule was not met as evidence by:</p> <p>Based on record review and interview, the facility failed to ensure the Administrator reported within (24)twenty-four hours, a post-fall fracture (Resident D). The Administrator also failed to report an allegation of sexual abuse related to a resident (Resident B) making a statement in regard to a male CNA and resident to resident contact</p>	F009999	<ol style="list-style-type: none"> 1) Incidents all reported to ISDH. No residents have been harmed as a result of the deficient practice. 2) Staff with knowledge of alleged incidents educated on requirement to report all allegations to administrator (or designee). 3) All-staff education regarding reporting all unusual occurrences to administrator (or designee) included in annual in-services. 4) Reportable unusual occurrences will be reviewed by Administrator (or designee) to note time reported to ISDH. Administrator will take any incident exceeding 24 hours to QA committee for action plan. 5) March 28, 2014 	03/28/2014
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	<p>(Resident E and F) to the ISDH in accordance with state regulation and facility policy.</p> <p>Findings include:</p> <p>1). Review of the "Incident reports", provided by the Director of Nursing (DoN) on 3/24/14 at 10:15 a.m., indicated the following:</p> <p>"3. Description added- 3/14/14. On 3/11/14 at approximately 7:50 pm Resident (D)...". The date submitted indicated 3/14/14 at 11:31:09.</p> <p>During an interview on 3/26/14 at 2:30 p.m., the DoN indicated the fall occurred on 3/11/14 and the fracture was noted on 3/12/14. She indicated the incident was reported to ISDH on 3/14/14. She indicated she was out of the office on 3/13/14.</p> <p>The DoN indicated the Administrator was aware the report was submitted late.</p> <p>The incident report was submitted on 3/14/14.</p> <p>The clinical record for Resident (D) was reviewed on 3/24/14 at 10:00 a.m.</p> <p>Diagnoses for the resident included,</p>			
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	<p>but were not limited to, hypertension, hyperkalemia, depression and psychotic disorder.</p> <p>The most recent Minimum Data Set (MDS) assessment, dated 3/18/14, indicated Resident (D) was cognitively intact. Resident (D) received the following Activities of Daily Living (ADL) assistance; transfer-total assist with two person assist, dressing, bathing and hygiene-extensive assistance with two person assist and eating-limited assistance with one person assist. Resident (D) was frequently incontinent of bowel and bladder.</p> <p>During record review on 3/24/14 at 10:00 a.m., the progress notes, dated 3/11/14 at 7:54 p.m., indicated a CNA was transferring Resident (D) to the bathroom via a Sara lift. Resident (D)'s foot slid from the Sara lift and the resident began to fall. The CNA pulled the cord for assistance and the resident was moved from the bathroom to the bed by four additional people. The resident was noted to have a left upper arm skin tear. The physician was notified and an order for topical medication was received.</p> <p>On 3/12/14 at 3:44 a.m., Resident (D)</p>						

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	<p>complained of left knee pain. The resident again complained of pain at 8:32 a.m. and the physician was notified. The facility received an order for an x-ray of the left leg.</p> <p>On 3/12/14 at 10:45 a.m., the x-ray indicated a fracture of the left fibula. The physician was notified at that time.</p> <p>2.) During an interview with CNA #1 on 3/24/14 at 2:00 p.m., CNA # 1 indicated she had heard of a concern between Resident (E) and Resident (F). She thought the incident was around time of the change of shift.</p> <p>During an interview on 3/24/14 at 2:05 p.m., LPN #2 indicated Resident (E) and Resident (F) did have a recent issue. She indicated that no staff member saw either resident hit one another, but someone heard a "slap" and Resident (E)'s hand was up in the air.</p> <p>Review of the internal incident report, provided by the DoN on 3/26/14 at 10:10 a.m. indicated CNA #4 heard a "slap" and looked over to see Resident (E) and Resident (F) sitting on the love seat. The CNA stated "we do not hit" and Resident (E) stated Resident (F) hit her first. The</p>						

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NAME OF PROVIDER OR SUPPLIER HERITAGE OF HUNTINGTON				STREET ADDRESS, CITY, STATE, ZIP CODE 1180 W 500 N HUNTINGTON, IN 46750			
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	<p>CNA stated she did not see the slap, but just heard the sound of it. SSD #2 indicated she heard a "slap-sound" and turned to see CNA #4 intervening and stating "we don't hit". She indicated neither resident appeared distressed. LPN #3 indicated she heard Resident (E) state Resident (F) hit her first while talking to CNA #4. She indicated she had her back to the residents then left to answer an alarm. She indicated both residents were assessed and found to have no apparent injuries.</p> <p>During an interview on 3/26/14 at 10:20 a.m., CNA #4 indicated she heard a "slap" and was not sure where Resident (E) slapped Resident (F). She indicated an incident report was filled out.</p> <p>The clinical record for Resident (E) was reviewed on 3/24/14 at 2:30 p.m. Resident (E) resided on the memory center. Diagnoses for the resident included, but were not limited to, Alzheimer's disease, hypertension, asthma and depressive disorder.</p> <p>The quarterly Minimum Data Set (MDS) assessment, dated 3/11/14, indicated Resident (E) was severely cognitively impaired. Resident (E)</p>						

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	<p>received the following medications; Lexapro 10 mg daily, Namenda 28 mg daily and Aricept 10 mg daily.</p> <p>Review of the mood and behavior sheets from 2/9-3/9/14, indicated Resident (E) had several episodes of maladaptive behaviors. On 2/2/14, Resident (E) yelled at and pushed her walker into a staff member. On 2/5/14, Resident (E) was verbally and physically abusive to staff. On 2/6/14, Resident (E) refused care. On 2/18/14, Resident (E) was noted to be displaying public masturbation. On 2/21/14, Resident (E) refused care and hygiene. Resident (E) was again verbally and physically abusive to staff. On 2/25/14, Resident (E) refused numerous medications. On 3/6/14 and 3/18/14, Resident (E) refused medications.</p> <p>The clinical record for Resident (F) was reviewed on 3/25/14 at 9:15 a.m. Resident (F) resided on the memory center. Diagnoses for the resident included, but were not limited to, renal failure, depressive disorder, dementia with behaviors and depression.</p> <p>The most recent Minimum Data Set (MDS) assessment, dated 2/19/14, indicated Resident (F) was severely</p>						

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	<p>cognitively impaired. Resident (F) received the following Activities of Daily Living (ADL) assistance; transfer-extensive assistance with one person assist, dressing, bathing and hygiene-extensive assistance with one person assist and eating-limited assistance with one person assist. Resident (F) was occasionally frequently of bladder.</p> <p>3). During an interview on 3/24/14 at 2:00 p.m., CNA #1 indicated a female resident and her family were uncomfortable with the male CNA who worked in the memory center. The resident and her family requested to have only female staff provide personal care. She had no knowledge of Resident (B) expressing a concern related to the male CNA.</p> <p>The clinical record for Resident (B) was reviewed on 3/25/14 at 9:30 a.m. Resident (B) resided on the memory center. Diagnoses for the resident included, but were not limited to, cardiomyopathy, hypertension, depressive disorder, anxiety, and persistent mental disorder.</p> <p>The most recent Minimum Data Set (MDS) assessment, dated 3/13/14, indicated Resident (B) was</p>			
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	<p>moderately cognitively impaired. Resident (B) received the following Activities of Daily Living (ADL) assistance; transfer-limited assistance with one person assist, dressing, bathing and hygiene-extensive assistance with one person assist and eating-limited assistance with one person assist. Resident (B) was occasionally incontinent of bladder.</p> <p>During an interview on 3/24/14 at 5:05 p.m., the Administrator, DoN and Assistant Director of Nursing (ADoN) indicated they had no recent concerns from any staff member or resident related to allegations of sexual abuse on the memory center.</p> <p>During an interview on 3/25/14 at 2:00 p.m., SSD #2 indicated she was aware of a concern from Resident (B). She indicated the resident had made a statement in January related to a male CNA undressing her and getting her naked. She indicated the other resident only stated the male CNA "scared" her. She indicated she was told of the incident from a former nurse who worked in the memory center. She indicated the information was then given to the DoN.</p> <p>During an interview on 3/25/14 at</p>			
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	<p>2:38 p.m., the ADoN indicated she was not aware of any concern related to an allegation of sexual abuse from any resident on the memory unit. She indicated she had not received any written information related to any allegation. She indicated if she had received information, she would assume it would need to have been reported.</p> <p>During an interview on 3/25/14 at 2:54 p.m., the DoN indicated she did recall an email from the SSD dated 1/28/14. The email was sent to the DoN and ADoN.</p> <p>A copy of the email was provided on 3/26/14 at 9:35 a.m. by the DoN. The email indicated a recap statement from the SSD related to Resident (B) stating the male CNA made her get naked in the middle of the night. Another resident expressed a dislike for and being scared of the male CNA.</p> <p>The incident report was not submitted.</p> <p>4.) During an interview with the Administrator on 3/26/14 at 4:30 p.m., she indicated the facility needed to improve on the information that was reported and in a timely</p>				

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	<p>manner. She indicated she was not made aware of the allegation of sexual abuse. She indicated she was aware of the potential resident to resident contact, but after investigating, felt it did not meet the requirements to submit an incident report.</p> <p>This Federal tag relates to Complaints IN00146007 and IN00146074.</p>				