

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 09/07/2016
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NAME OF PROVIDER OR SUPPLIER PROVIDENCE ANDERSON	STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN 46011
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00208407.</p> <p>Complaint IN00208407- Substantiated. Federal/State deficiencies related to the allegation are cited at F323.</p> <p>Survey dates: September 6 and 7, 2016</p> <p>Facility number: 000005 Provider number: 155005 AIM number: 100270840</p> <p>Census bed type: SNF/NF: 121 SNF: 16 Total: 137</p> <p>Census payor type: Medicare: 11 Medicaid: 103 Other: 23 Total: 137</p> <p>Sample: 3</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed by 11474 on September 9,</p>	F 0000	<p>Preparation and execution of this plan of correction does not constitute an admission of or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This Plan of Correction is prepared and executed solely because Federal and State Law require it. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Correction. Failure to dispute or challenge the alleged deficiencies below is not an admission that the alleged facts occurred as presented in the statements.</p>	

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

TITLE

(X6) DATE

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

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F 0323 SS=G Bldg. 00	<p>2016.</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 interview and record review, the facility failed to ensure appropriate interventions were in place to prevent falls for 1 of 3 residents reviewed for accidents. This deficit practice resulted in the fracture of the left distal clavicle in 1 resident. (Resident B)</p> <p>Findings include:</p> <p>The clinical record for Resident B was reviewed on 9/6/2016 at 12:55 p.m. The diagnoses for Resident B included, but were not limited to, Alzheimer's, anxiety, hypertension chronic obstructive pulmonary disease and hypothyroidism.</p> <p>The most current Quarterly Minimum Data Set (MDS) assessment, dated 7/11/2016, was reviewed on 9/6/2016 at 12:55 p.m. Resident B received the</p>	F 0323	<p>Tag F 323 G Free of Accident Hazards/supervision/devices</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident B- Clinical record was reviewed Director of Nursing September 22, 2016 for fall risk and plan of care was updated with risk factors, measurable goals and appropriate interventions to reduce risk of falls. To include the following: Bed in low position, floor mats at bedside to reduce risk of injury, scoop mattress to provide bed boundaries, specialty chair for</p>	10/07/2016

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	<p>following Activities of Daily Living (ADL) assistance; extensive assist with 1 person physical assist for dressing bathing and hygiene and extensive assist with 1 person physical assist for toileting. Resident B had impaired range of motion in both the upper and lower extremities on 2 sides. Resident B had been assessed as having severe cognitive impairment.</p> <p>Review of the clinical record indicated Resident B fell on the following dates: 7/5/2016 with no injury, 8/1/2016 with no injury and 8/17/2016 with injury (bruising to face and laceration to nose).</p> <p>Review of the hospital discharge notes indicated Resident B had been seen in the emergency room on 8/5/2016 for a fall with injury (fractured clavicle).</p> <p>Review of the nursing notes, dated 8/1/2016 through 8/17/2016, indicated Resident B was found on the floor lying on the left side on 8/1/2016 at 8:50 p.m. The note indicated Resident B was assessed, family and MD were notified. The nursing note lacked any documentation of immediate fall prevention interventions. The nursing notes lacked any documentation of the fall on 8/5/216.</p> <p>Review of a nursing note dated 8/5/2016</p>		<p>proper positioning to reduce risk of fall, resident placed on frequent observations for care and safety needs, coordinate care with hospice services. Resident B-Kardex was updated to include interventions to reduce risk for falls.</p> <p>The Kardex is located Point of Care/Point Click Care and on the Kiosk for CNA access to resident information for care and safety needs.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;</p> <p>A chart review was completed on all residents with falls in the past 60 days the Director of Nursing and designee completed by September 22, 2016. Their clinical record was reviewed for fall risk and their Kardex and plan of care was updated with contributing risk factors, measurable goals and appropriate interventions.</p>	

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	<p>at 2:44 p.m., indicated the NP had been contacted at 10:10 a.m. regarding a bump on the left side of Resident B's head. Orders for an immediate CT of the head was ordered. The note further indicated Resident B was holding the left arm, grimacing [sic] and verbalizing pain. The NP was again notified and Resident B was sent to the emergency room for evaluation and treatment. The nursing note lacked any documentation in regards to how Resident B fell or any interventions put in place after the fall.</p> <p>Review of Resident B's current care plans indicated the following: "Resident is High risk for falls r/t Unaware of safety needs, cognitive impairment, weakness, incontinence:..." This care plan was dated 6/16/2016.</p> <p>The goal indicated for Resident B would not sustain serious injury through the review date. This goal was dated 6/17/2016.</p> <p>Interventions included: "Anticipate and meet opals [sic] needs." Dated 6/16/2016. " The resident needs a safe environment with: a working and reachable call light, the bed in low position at night, personal items within reach." Dated 6/16/2016. "Maintenance to check safety and function of w/c</p>		<p>A chart review of all residents that reside in the facility was completed by the Director of Nursing and designees and completed by September 22, 2016. Their clinical records were reviewed for fall risk and their Kardex and plan of care was updated with contributing risk factors, measurable goals and appropriate interventions.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur;</p> <p>RN/LPN staff will be educated by the Director of Nursing or designee by September 30, 2016 on the fall practice guidelines to include identification of residents that are at risk for falls, contributing factors to fall risk, development of plan of care to include risk factors, measurable goals and appropriate interventions and update up Kardex.</p>		

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	<p>[wheelchair]." Dated 8/17/2016. "Resident to use optima Chair [sic]." Dated 8/22/2016. The care plan lacked any other interventions addressing the root cause of the falls or even addressing the unwitnessed fall of 8/5/16.</p> <p>Review of Resident B's current care plans indicated the following: "The resident has had an actual fall [with no injury] Poor Balance." This care plan was dated 7/5/2016.</p> <p>The goal for this care plan indicated Resident B would resume usual activities without further incident through the review date. This goal was dated 7/5/2016.</p> <p>No interventions or root cause analysis were documented after the fall on 8/5/2016. Interventions added after the fall with injury on 8/9/2016 included the following: "Attempt to keep in a common area while up." Dated 9/6/2016. "Ensure resident has proper cushions in w/c per OT recommendation while up in wheelchair." Dated 8/9/2016. "Scoop mattress to bed." Dated 9/6/2016.</p> <p>Review of the CNA kardex on 9/6/2016 at 2:00 p.m. indicated the Special Instructions lacked any information related to how Resident B transferred or</p>		<p>RN/LPN Staff will be educated by the Director of Nursing or designee by September 30, 2016 on completion of incident reports following a fall, completion of progress notes to include assessment, investigation, root cause, and new intervention to reduce risk of fall.</p> <p>RN/LPN Nurse Manager staff will be educated by the Director of Nursing or designee by September 30, 2016 on completion of fall incident reports, post fall investigation process to include assessment, identification of root cause, update of plan of care with appropriate interventions, update of Kardex for CNA assignments and staff education on as needed.</p> <p>CNA staff will be educated by the Director of Nursing or designee by September 30, 2016 on the fall guidelines to include the role of the CNA in fall prevention, location of interventions on Kardex and reporting.</p> <p>The Quality Assurance Nurse will complete a daily audit of falls Monday thru Friday to ensure there is documentation of incident, clinical assessment,</p>	

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	<p>use of any devices such as a gait belt.</p> <p>During an interview on 9/6/2016 at 1:49 p.m., CNA #1 indicated the CNA's used the information in the task sheets (computer documentation) to know how to provide care for the residents. "We look it up on the kiosk. I always ask if I have a new patient or did someone leave at the beginning of my shift." CNA #1 indicated the information in the kiosk would indicate if the resident required any assistive devices and the number of staff for assist with transfers.</p> <p>During an interview on 9/6/2016 at 2:24 p.m., CNA #4 indicated all the information regarding resident care was in the kiosk.</p> <p>During an interview on 9/7/2016 at 10:46 a.m., RN #3 indicated the resident care information in the kiosk should have been updated routinely. "The information is not complete. There should be information on how the resident transfers, any assistive devices needed like lifts. It should tell how many staff are needed for toileting, transfers and the such."</p> <p>During an interview on 9/7/2016 at 12:23 p.m., CNA #9 indicated resident care information was on the kiosk. "I always</p>		<p>investigation, root cause identification, interventions updated on the Kardex and the plan of care and timely notification to physician and family.</p> <p>Results of the audits will be submitted weekly to the Quality Assurance and Assessment (QAA) committee by the Director of nursing or Quality Assurance nurse. The QAA will review findings and make recommendations and determination for further monitoring and education per the QAA process.</p> <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> <p>The Fall audit findings will be presented to the QAA committee weekly for four weeks and monthly thereafter. Ongoing monitoring will continue for a minimum of six months. The QAA committee will review findings and determine the need for</p>		

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	<p>read the kardex (kiosk) before I start. I can also go to my nurse and ask if I have questions."</p> <p>During an interview on 9/7/2016 at 1:11 p.m., the Assistant Director of Nursing indicated the kardex information for the CNA's in the kiosk was not complete. The ADON acknowledged the information in the kiosk should reflect the current MDS information but did not. "It is a problem I have identified and am currently working on improving. We should have had better interventions in place and followed them. Then perhaps (name of Resident B) might not have fallen the second time. The ADON provided an inservice given to all nursing staff to address the lack of appropriate interventions for fall prevention and documentation. The inservice included the following: "...What is you [sic] new intervention? You need to have an IMMEDIATE intervention for EVERY fall and document it in the nurses note along with notification of MD and family. Look at HOW and WHY they fell. (no shoes, wet floor, self-transfer, etc.)...."</p> <p>During an interview on 9/7/2016 at 1:20 p.m., the Administrator indicated the incident reports lacked any interventions put in place after a fall. "That is</p>		<p>further monitoring and/or education per the QAA process.</p> <p>By what date the systemic changes will be completed? October 7, 2016</p>				

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	something we will address." This Federal tag relates to Complaint IN00208407. 3.1-45(a)(2)				