

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155793	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/07/2014
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NAME OF PROVIDER OR SUPPLIER HAMILTON TRACE OF FISHERS	STREET ADDRESS, CITY, STATE, ZIP CODE 11851 CUMBERLAND RD FISHERS, IN 46037
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F000000	<p>This visit was for the Investigation of Complaints IN00157160 and IN00157327.</p> <p>Complaint: IN00157160 - Substantiated. Federal/State finding related to the allegation is cited at F157</p> <p>Complaint IN00157327 - Substantiated. Federal/State findings related to the allegations are cited at F157, F225, and F226.</p> <p>Survey dates: October 3, 6 & 7, 2014</p> <p>Facility Number: 012644 Provider Number: 155793 AIM Number: 201046710</p> <p>Survey Team: Mary Jane G. Fischer RN TC</p> <p>Census Bed Type: SNF: 38 SNF/NF: 64 Residential: 28 Total: 130</p> <p>Census Payor Type: Medicare: 30 Medicaid: 28 Other: 72</p>	F000000	<p>Please find enclosed the Plan of Correction to the Complaint Survey conducted on October 7, 2014. This letter is to inform you that the plan of correction attached is to serve as Hamilton Trace's credible allegation of compliance. We allege compliance on November 6, 2014. We are requesting a desk review for this plan of correction. Submission of this plan of correction in no way constitutes an admission by Hamilton Trace of Fishers or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care or other services provided in this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during a Complaint Survey on October 7, 2014.</p>	
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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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F000157 SS=D	<p>Total: 130</p> <p>Sample: 6</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed 10/10/14 by Brenda Marshall, RN.</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 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</p>						

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	<p>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 record review and interview the facility failed to ensure the resident's physician was notified when a residents refused medications, had a change in condition, and weight gain, the nursing staff failed to notify the resident's physician for possible intervention for 3 of 6 sampled resident's. (Resident's "B", "C" and "D").</p> <p>Findings include:</p> <p>1. The record for Resident "B" was reviewed on 10-03-14 at 10:00 a.m. Diagnoses included, but were not limited to, senile dementia, hypertension, and congestive heart failure. These diagnoses remained current at the time of the record review.</p> <p>At the time the resident was admitted to the facility, physician orders, originally dated 08-05-14 thru 08-14-14, instructed the nursing staff to "Obtain and record daily weight upon rising before breakfast. Notify MD [Medical Doctor] if weight gain is > [greater than] 2 lbs. [pounds] or > 5 lbs. in a week."</p>	F000157	<p>F157</p> <p>I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice. Resident "B" no longer resides at the facility. Resident "E" no longer resides at the facility. Resident "D" was assessed by the physician on 10/7/14 with no new orders. Physician documented resident area greatly improved and encouraged resident to lay in bed when not in therapy. II. The facility will identify other residents that may potentially be affected by the deficient practice. All residents with a weight gain, refusal of medications and skin excoriation have the potential to be effected by the alleged deficient practice. III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur. Progress notes and weights are reviewed daily by Nursing Management to identify changes Monday through Friday and by the Weekend manager on Saturday and Sunday. Any changes in condition will be</p>	11/06/2014

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	<p>A subsequent physician order extended the dates of the original order to include "08-14-14 thru 08-27-14."</p> <p>In addition the resident had physician orders for Lasix (a diuretic) 40 mg (milligrams) daily for congestive heart failure. The original order for this medication indicated to notify the physician. "Special Instruction: for > 2 lbs overnight or > 5 lbs weekly."</p> <p>A review of the daily weights indicated on 08-10-14, the resident weighed 212.4 lbs. The following day the resident weighed 215.6 lbs, a gain of 3.2 lbs. Subsequent review of the daily weights indicated the resident weighed 211.4 lbs on 08-14-14. When this daily weight was transcribed to the following day, 08-15-14, the licensed staff member documented the resident weighed 215.6 lbs, and not the 211.4 lbs. The weight documented for 08-15-14 indicated the resident weighed 214 lbs and the following daily weight was transcribed at 216.2 lbs. - a gain of 2.2 lbs.</p> <p>The record lacked notification the physician had been notified of the weight gains.</p> <p>2. The record for Resident "E" was</p>		<p>reviewed for physician notification. License nursing associates were re-educated on identifying and reporting changes in resident condition including notifying physician of daily weight changes, resident's refusal of medications and worsening skin concerns. IV. The facility will monitor the corrective action by implementing the following measures. An audit tool will be used by DON/Admin/designee when change of condition is identified daily. Any identified concerns from audits will be addressed immediately. Employees not adhering to policy will be re-educated up to and including termination. The results of these audits will be discussed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed V. Plan of Correction completion date. Plan of Completion date is November 6, 2014.</p>		

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	<p>reviewed on 10-06-14 at 10:40 a.m. Diagnoses included but were not limited to hypertension, pain, blindness in the right eye, anxiety and dementia. These diagnoses remained current at the time of the record review. The resident was admitted to the facility on 09-26-14.</p> <p>The record indicated the resident had a recent hospitalization for a fall. The hospital discharge summary indicated the "patient has history of multiple falls. Her meds [medications] were adjusted. The patient was kept on lisinopril [an antihypertensive medication] 10 mg. daily. She has some blood pressure pills, which she has not been taking for many months."</p> <p>A review of the progress notes indicated the following from the date of admission:</p> <p>"09-27-14 2:52 p.m. - resident not wanting to take meds at this time. 3:14 p.m. Resident will still not take medication."</p> <p>"09-29-14 12:36 a.m. Writer approached resident in room around 8:30 p.m., noted in bed. Writer introduced self and proceeded to administer hs [bedtime] meds. Resident started to yell 'get out.' Writer left room and reapproached later and resident yelled 'just forget the meds'</p>			

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	<p>pursed lips tight. Writer had another staff member approach resident for med. administration and resident still refused meds, vitals and assessments."</p> <p>"09-29-14 8:58 a.m. Resident refused morning meds times 3, she stated that 'she would rather die' when approached. 10:34 p.m. refused PM meds times two."</p> <p>The record indicated the resident was seen by the physician on 09-29-14. A review of the physician notation indicated, "No current facility administered medications on file prior to visit."</p> <p>"09-30-14 9:52 a.m. Resident refused meds."</p> <p>The record lacked documentation the physician had been notified of the resident's continued refusal of medication.</p> <p>During an interview, on 10-07-14 at 1:00 p.m., the Director of Nurses indicated the physician had not been notified of the medication refusal until 10-02-14 - 6 days after admission.</p> <p>Further review of the record indicated the resident continued to refuse medications on 10-03-14, and 10-05-14.</p>						

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	<p>A review of the physician admission orders, dated 09-26-14 instructed the nursing staff to "monitor for increased edema, shortness of breath and lung sound. Notify MD if condition declines. Lasix 40 mg once a day - Special instructions: for weight gain > 2 lbs daily or > 5 lbs. weekly."</p> <p>The record indicated that on 10-06-14 at 8:41 p.m., the resident "had a weight gain of 5.4 lbs in 24 hours. Resident has been refusing meds. Refused meds and PRN [as needed] Lasix [a diuretic] this morning stating, 'I'm not taking them. It doesn't matter anyway's.' Writer tried to educate resident on the importance of her meds, but was still met with refusal."</p> <p>The record lacked documentation the physician had been notified of the continued refusal or the weight gain.</p> <p>3. The record for Resident "D" was reviewed on 10-06-14 at 2:45 p.m. Diagnoses included, but were not limited to, closed head injury, syncope and collapse and urinary tract infection. At the time the resident was admitted to the facility the record indicated the resident had excoriation to periarea, and bilateral buttocks.</p>			

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	<p>The resident had a physician order dated 09-26-14 for Derma-septine ointment - with instructions to "apply to reddened periarea and bilateral buttocks four times a day and as needed after incontinent episodes."</p> <p>A review of the Admission 72 hour nursing assessments indicated the following in regard to the excoriation:</p> <p>"09-27-14 3:38 a.m. - periarea - vaginal discharge." "09-27-14 9:15 a.m. - periarea - deferred." "09-27-14 11:05 p.m. - none of the above in regard to the pericare being excoriated, lesions, rash, rectal discharge, redness, swelling, vaginal discharge, other or deferred." "09-28-14 9:03 a.m. periarea - rash." "09-28-14 7:50 p.m. periarea - deferred."</p> <p>During an observation on 10-06-14 at 2:40 p.m. a request was made to perform a body assessment of the excoriated area. The resident agreed to the assessment.</p> <p>After the resident was positioned in bed by the CNA, the CNA pulled the resident's slacks down to her ankles. The resident had an incontinent brief on. The CNA pulled the brief down and an incontinent feminine pad had been placed</p>			

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	<p>inside of the incontinent brief. A small amount of blood was on the feminine pad. The resident's perineal area was bright red in appearance. The CNA assisted the resident to turn to the right side. The resident's bilateral buttocks appeared bright red and gaulded in appearance. Along the buttocks crease were numerous raised areas. During this observation the resident indicated "sometimes it burns and itches when I go to the bathroom."</p> <p>During this observation, the licensed nurse indicated she was unaware of the decline in the condition of the resident's "excoriation."</p> <p>The record lacked documentation the physician had been notified of the decline in the resident's condition.</p> <p>A review of the facility policy on 10-06-14 at 10:00 a.m., titled "Change in a Resident's Condition or Status," and dated as "revised October 2010," indicated the following:</p> <p>"Policy Statement - Our facility shall promptly notify the residents, his or her Attending Physician, and representative (sponsor) of changes in the residents medical/mental condition and/or status (e.g. changes in level of care,</p>			

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	<p>billing/payments, residents rights etc.)."</p> <p>"Policy Interpretation and Implementation - 1. The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been: d. A significant change in the resident's physical / emotional / mental condition; e. A need to alter the resident's medical treatment significantly; h. Instructions to notify the physician of changes in the resident's condition."</p> <p>"2. A "significant change" of condition is a decline or improvement in the resident's status that: a. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not "self limiting"); b. Impacts more than one area of the resident's health status; and c. Requires interdisciplinary review and/or revision to the care plan. d. The final decision regarding what constitutes a significant change in status is based on the judgment of the clinical staff and the guidelines outlined in the Resident Assessment Instrument and 42 CFR 483.20(b)(ii)."</p> <p>This Federal tag relates to Complaints IN00157160 and IN00157327.</p>						

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F000225 SS=D	<p>3.1-5(a)</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must</p>						

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	<p>be taken.</p> <p>Based on observation, record review and interview the facility failed to ensure injuries of unknown origin were thoroughly investigated, in that when resident's had bruising, and extensive skin tears, the facility failed to fully investigate and have resolution for the root cause, and possible interventions implemented to prevent recurrence for 3 of 6 sampled resident's. (Resident's "C", "E", and "F").</p> <p>Findings include:</p> <p>1. The record for Resident "C" was reviewed on 10-03-14 at 1:50 p.m. Diagnoses included, but were not limited to, dementia, glaucoma, scoliosis and muscle weakness. These diagnoses remained current a the time of the record review.</p> <p>The resident's plan of care, originally dated 09-11-14 indicated the resident "required extensive assist of two with ADL's [Activities of Daily Living] secondary to ADL deficit related to being nonambulatory."</p> <p>A review of the Minimum Data Set Assessment, dated 09-30-14, indicated the resident had severe cognitive impairment, required extensive assistance</p>	F000225	<p>F225 I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice. C N A #21 for resident "C" was re-educated on transfers and following resident plan of care. Resident "E" no longer resides at this facility. Nurse Managers were re-educated on complete and thorough investigations by the Corporate Clinical Specialist.</p> <p>II. The facility will identify other residents that may potentially be affected by the deficient practice. Residents who have injuries of unknown origin could potentially be affected.</p> <p>III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur. Any injury of unknown origin will be investigated immediately per the facility policy for Reporting Accident/Incidents. Nurse Managers were re-educated on complete and thorough investigations by the Corporate Clinical Specialist. Nursing associates were re-educated on reporting of incidents/accidents and complete and thorough investigations by the Staff Development Coordinator.</p> <p>IV. The facility will monitor the corrective action by implementing the following</p>	11/06/2014	

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	<p>of two staff members, for transfer, bed mobility, toileting and was not steady with moving from seated to standing position, walking, moving on and off toilet and surface to surface transfer.</p> <p>During an observation on 10-03-14 at 9:15 a.m., the resident was observed seated in a wheelchair adjacent to her bed. The resident's left lower leg was wrapped in a dressing which spanned from the knee to the ankle. The Unit Manager licensed nurse # 3 indicated the resident had a "skin tear." When interviewed how the skin tear occurred the nurse indicated the resident "moved her legs around a lot and that's how we think she got it."</p> <p>During an interview on 10-06-14 at 12:30 p.m., the Unit Manager indicated the skin tear measured 7.6 cm (centimeters) by .1 cm by less than .1 cm in depth. The Unit Manager indicated the skin tear had been "closed with steri-strips."</p> <p>During an interview on 10-06-14 at 1:30 p.m., Licensed Nurse #21 indicated, "I was here the day it happened. The Aide [certified nurse aide] came to get me because [name of resident] nurse was on break. When I got in there it looked circular, like the skin was torn and then pushed down. I had to get another nurse</p>		<p>measures. DNS/or designee will complete CQI audit tool on injuries of unknown origin the next business day following an incident. Investigation results will be given to the Administrator for review when completed. Results of the reviews will be presented at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. V. Plan of Correction completion date. Plan of Completion date is November 6, 2014.</p>				

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	<p>to help me put the steri-strips on it because of the shape it was. [Name of certified nurse aide # 17] was the one who found her."</p> <p>During an observation on 10-06-14 at 1:45 p.m., the resident was observed in bed and gave permission to observe the area. The resident's lower leg had been wrapped in a thick dressing. Licensed Nurse #21 unwrapped the resident's lower leg and revealed the skin tear. The resident's entire lower leg was bruised and slightly swollen around the ankle area. Approximately midpoint of the resident's lower leg, the skin tear edges were approximated with steri-strips, with dried blood, and the skin tear appeared to be 3/4 of a circle. The resident complained the area was painful.</p> <p>During an interview on 10-06-14 at 2:00 p.m., certified nurse aide #17 indicated the resident needed to use the bathroom. "She hit the call light to go to the restroom. I got her in there and stood her up, but not fast enough, and she had a bm [bowel movement] accident. I sat her down and removed her pants and I could see she had blood on her sock and when I pulled it [the sock] down I could see the skin tear. I think she is a one person transfer because she can bear weight. I went and got the nurse."</p>						

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	<p>A review of the facility "Accident Investigation Form - Unusual Occurences <sic>," dated 09-27-14 at 2:30 p.m., indicated the following:</p> <p>"[Name of licensed nurse #22] - Did not see s/t [skin tear] - around 12:15 p.m. d/t [due to] applying socks and shoes. Noted after lunch while assisting with care CNA [certified nurse aide] noted s/t."</p> <p>"[Name of licensed nurse #21] - called to resident room after lunch r/t [related to] CNA reporting s/t. CNA not aware of how s/t occurred. Resident did not know how it happened."</p> <p>"[Name of certified nurse #17] - answered call light et [and] assisted with change of clothing. Noted blood on sock. Asked res. [resident] what happened. Res. was unable to say how area occurred. Did not c/o [complained of] pain during change of clothing or sock removal."</p> <p>Further review of this form indicated the resident was "not able to tell what happened due to dementia. Resident stated she gave self shower. Noted decreased mobility and resident extensive assist times 2 staff was asked if assisted to RR [restroom] and bump lower leg</p>				

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	<p>while being transferred. Area cleaned pat dried, steri strips applied to approximate skin. Corrective action: monitor limbs with transfer, give enough space so limbs won't get bumped. Avoid shearing resident skin with transfers, positioning and turning if possible."</p> <p>An additional document attached to the form and completed by licensed nurse #23 indicated "[Name of licensed nurse] spoke with [name of resident] re [regarding] her skin tear on LL [left lower] shin. When I came into the room she told me not to touch anything. I looked at her skin and asked her how she received her skin tear. She said she didn't know. I asked her if she hit it on something. She said no maybe in the shower. I checked with nursing staff. She had not been in the shower this day."</p> <p>The investigation did not indicate additional staff members who cared for the resident were interviewed in efforts to determine if someone was aware of how the injury occurred.</p> <p>2. The record for Resident "E" was reviewed on 10-06-14 at 10:40 a.m. Diagnoses included, but were not limited to, glaucoma, blindness of the right eye, dementia, and anxiety. These diagnoses remained current at the time of the record</p>						

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	<p>review.</p> <p>A review of the hospital discharge summary, dated 09-27-14, indicated the resident had been admitted to the hospital with "multiple falls."</p> <p>The Event notation in the resident's record, dated 09-29-14 at 5:36 p.m., indicated the resident was "found on the bathroom floor when CNA went back to check on her, resident was assessed and no pain or deformity in extremities, resident has a skin tear on the right elbow that appears to be reopened from previous wound. Resident c/o [complained of] pain to her middle finger on right hand." The report further indicated the resident "lost balance and was found on the floor of the bathroom - ambulated to bathroom - confused."</p> <p>During an interview on 10-07-14 at 11:00 a.m., the Director of Nurses indicated that at the time of admission a "bed and chair alarm" had been implemented as an assistive device to alert the staff of unassisted ambulation or transfer. The Director of Nurses indicated she was unaware how the resident fell, if she had been left unattended in the bathroom or if the alarm was functioning to alert the staff of unassisted ambulation.</p>			

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	<p>During further interview the Director of Nurses indicated an investigation had not been conducted in efforts to determine if someone was aware of how the resident fell.</p> <p>3. The record for Resident "F" was reviewed on 10-06-14 at 11:45 a.m. Diagnoses included, but were not limited to, Alzheimers dementia, adult failure to thrive, and communication deficit. These diagnoses remained current at the time of the record review.</p> <p>A review of the resident's Minimum Data Set Assessment, dated 08-20-14 indicated the resident had severe cognitive impairment and required extensive assistance with transfers with two staff members.</p> <p>A review of the resident's record indicated the resident was found with a skin tear to the left elbow. The progress note, dated 09-23-14 at 7:00 p.m., indicated "CNA [certified nurse aide] alerted writer to ST [skin tear] on left elbow. Area not bleeding at the time. Area bruised. Resident denies pain. [Measurements] 3.4 cm [centimeters] by 3.4 cm by less than 0.1 cm."</p> <p>A review of the facility "Accident Investigation Form - Unusual</p>						

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	<p>Occurrences <sic>," report, dated 09-23-14, indicated "skin tear to left elbow. Exact location of the accident/incident: room, no witnesses. [Name of licensed nurse #7] - CNA alerted writer to skin tear on left elbow. Bleeding contained with bandage. Resident denies pain. Resident unaware of how skin tear took place."</p> <p>The facility failed to conduct a thorough investigation into how this dependent resident sustained the skin tear.</p> <p>A review of the facility policy on 10-03-14 at 10:00 a.m., titled "Abuse Prevention," and dated 08-21-13, indicated the following:</p> <p>"Policy Statement - It is the policy of CarDon & Associates to provide each resident with an environment that is free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. We have established policies and procedures that will provide facility personnel with the knowledge and training to further ensure each resident is treated with individual respect and dignity. The following guidelines outline the components of our Abuse Prevention Program."</p> <p>"Reporting Abuse to Administrator:</p>			

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	<p>Policy Statement - It is the responsibility of our employees, facility consultants attending physicians, family members, visitors etc., to immediately report any incident or suspected incident of neglect or resident abuse, including injuries of an unknown source, and theft or misappropriation of resident property to the Administrator or Designee if the Administrator is unavailable. 4. When an alleged or suspected case of mistreatment, neglect, injuries of an unknown source, or abuse is reported, the facility administrator, or his/her designee, he/she will ensure the resident will be protected from harm and removed from any potential abusive situation immediately (within a reasonable amount of time) and then notify the following persons or agencies of such incident when applicable... "</p> <p>A review of the facility policy on 10-06-14 at 3:00 p.m., titled "Accidents & Incidents Investigating & Reporting," and undated, indicated the following:</p> <p>"Policy Statement: All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises must be investigated and reported to the Administrator."</p> <p>"Procedure: 1. Reporting of</p>			

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	<p>Accident/Incidents - Regardless of how minor an accident or incident may be, including injuries of an unknown source, it must be reported to the department supervisor as soon as such accident/incident is discovered or when information of such accident/incident is learned. An Accident or Incident Report Form must completed for all reported accidents or incidents. An employee witnessing an accident or incident involving a resident ,employee, visitor, etc., must report such occurrence to his or her immediate supervisor as soon as practical. Do not leave an accident victim unattended unless it is absolutely necessary to summon assistance; and the nurse supervisor/charge nurse must be immediately informed of accidents or incidents so that medical attention can be provided. 4. Investigative Action: The nurse supervisor/change nurse and/or the department director or supervisor must conduct an immediate investigation of the accident or incident. The following data, as it may apply, must be included on the Incident Report Form: The date and time of accident occurred, the nature of the injury/illness, the circumstances surrounding the accident/incident, where the accident/incident occurred, the name(s) of witnesses and their accounts of the accident/incident, the injured person's account of the accident/incident,</p>			

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F000226 SS=D	<p>the time the injured person's attending physician was notified, as well as the time the physician responded with instructions, the date and time the injured person's next of kin was notified and by whom, the condition of the injured person, including vital signs, the disposition of the injured person, any corrective action taken, follow up information, other pertinent data as necessary or required, the signature and title of the person completing the form."</p> <p>This Federal tag relates to Complaint IN00157327.</p> <p>3.1-28(c) 3.1-28(d)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on observation, record review and interview, the facility failed to ensure the implementation of their policy, in that when resident's had injuries of unknown origin the nursing staff failed to fully investigate the circumstances of the occurrence for 3 of 5 residents reviewed for injuries of unknown origin in a sample of 6. (Residents "C", "E" and</p>	F000226	F 226 I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice. C N A #21 for resident "C" was re-educated on transfers and following resident plan of care. Resident "E" no longer resides at this facility. Nurse Managers were re-educated on complete and	11/06/2014

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	<p>"F").</p> <p>Findings include:</p> <p>1. The record for Resident "C" was reviewed on 10-03-14 at 1:50 p.m. Diagnoses included, but were not limited to, dementia, glaucoma, scoliosis and muscle weakness. These diagnoses remained current a the time of the record review.</p> <p>The resident's plan of care, originally dated 09-11-14 indicated the resident "required extensive assist of two with ADL's [Activities of Daily Living] secondary to ADL deficit related to being nonambulatory."</p> <p>A review of the Minimum Data Set Assessment, dated 09-30-14, indicated the resident had severe cognitive impairment, required extensive assistance of two staff members, for transfer, bed mobility, toileting and was not steady with moving from seated to standing position, walking, moving on and off toilet and surface to surface transfer.</p> <p>During an observation on 10-03-14 at 9:15 a.m., the resident was observed seated in a wheelchair adjacent to her bed. The resident's left lower leg was wrapped in a dressing which spanned</p>		<p>thorough investigations by the Corporate Clinical Specialist. II. The facility will identify other residents that may potentially be affected by the deficient practice. Residents who have injuries of unknown origin will be potentially be affected. III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur. Any injury of unknown origin will be investigated immediately per the facility policy for Reporting Accident/Incidents. Nurse Managers were re-educated on complete and thorough investigations by the Corporate Clinical Specialist. Nursing associates were re-educated on reporting of incidents/accidents and complete and thorough investigations by the Staff Development Coordinator. IV The facility will monitor the corrective action by implementing the following measures. DNS/or designee will complete CQI audit tool on injuries of unknown origin the next business day following an incident. Investigation results will be given to the Administrator for review when completed. Results of the reviews will be presented at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. V. Plan of</p>				

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	<p>from the knee to the ankle. The Unit Manager licensed nurse # 3 indicated the resident had a "skin tear." When interviewed how the skin tear occurred the nurse indicated the resident "moved her legs around a lot and that's how we think she got it."</p> <p>During an interview on 10-06-14 at 12:30 p.m., the Unit Manager indicated the skin tear measured 7.6 cm (centimeters) by .1 cm by less than .1 cm in depth. The Unit Manager indicated the skin tear had been "closed with steri-strips."</p> <p>During an interview on 10-06-14 at 1:30 p.m., Licensed Nurse #21 indicated, "I was here the day it happened. The Aide [certified nurse aide] came to get me because [name of resident] nurse was on break. When I got in there it looked circular, like the skin was torn and then pushed down. I had to get another nurse to help me put the steri-strips on it because of the shape it was. [Name of certified nurse aide # 17] was the one who found her."</p> <p>During an observation on 10-06-14 at 1:45 p.m., the resident was observed in bed and gave permission to observe the area. The resident's lower leg had been wrapped in a thick dressing. Licensed Nurse #21 unwrapped the resident's</p>		<p>Correction completion date. Plan of Completion date is November 6, 2014.</p>				

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	<p>lower leg and revealed the skin tear. The resident's entire lower leg was bruised and slightly swollen around the ankle area. Approximately midpoint of the resident's lower leg, the skin tear edges were approximated with steri-strips, with dried blood, and the skin tear appeared to be 3/4 of a circle. The resident complained the area was painful.</p> <p>During an interview on 10-06-14 at 2:00 p.m., certified nurse aide #17 indicated the resident needed to use the bathroom. "She hit the call light to go to the restroom. I got her in there and stood her up, but not fast enough, and she had a bm [bowel movement] accident. I sat her down and removed her pants and I could see she had blood on her sock and when I pulled it [the sock] down I could see the skin tear. I think she is a one person transfer because she can bear weight. I went and got the nurse."</p> <p>A review of the facility "Accident Investigation Form - Unusual Occurrences <sic>," dated 09-27-14 at 2:30 p.m., indicated the following:</p> <p>"[Name of licensed nurse #22] - Did not see s/t [skin tear] - around 12:15 p.m. d/t [due to] applying socks and shoes. Noted after lunch while assisting with care CNA [certified nurse aide] noted s/t."</p>						

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	<p>"[Name of licensed nurse #21] - called to resident room after lunch r/t [related to] CNA reporting s/t. CNA not aware of how s/t occurred. Resident did not know how it happened."</p> <p>"[Name of certified nurse #17] - answered call light et [and] assisted with change of clothing. Noted blood on sock. Asked res. [resident] what happened. Res. was unable to say how area occurred. Did not c/o [complained of] pain during change of clothing or sock removal."</p> <p>Further review of this form indicated the resident was "not able to tell what happened due to dementia. Resident stated she gave self shower. Noted decreased mobility and resident extensive assist times 2 staff was asked if assisted to RR [restroom] and bump lower leg while being transferred. Area cleaned pat dried, steri strips applied to approximate skin. Corrective action: monitor limbs with transfer, give enough space so limbs won't get bumped. Avoid shearing resident skin with transfers, positioning and turning if possible."</p> <p>An additional document attached to the form and completed by licensed nurse #23 indicated "[Name of licensed nurse]"</p>			

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	<p>spoke with [name of resident] re [regarding] her skin tear on LL [left lower] shin. When I came into the room she told me not to touch anything. I looked at her skin and asked her how she received her skin tear. She said she didn't know. I asked her if she hit it on something. She said no maybe in the shower. I checked with nursing staff. She had not been in the shower this day."</p> <p>The investigation did not indicate additional staff members who cared for the resident were interviewed in efforts to determine if someone was aware of how the injury occurred.</p> <p>2. The record for Resident "E" was reviewed on 10-06-14 at 10:40 a.m. Diagnoses included, but were not limited to, glaucoma, blindness of the right eye, dementia, and anxiety. These diagnoses remained current at the time of the record review.</p> <p>A review of the hospital discharge summary, dated 09-27-14, indicated the resident had been admitted to the hospital with "multiple falls."</p> <p>The Event notation in the resident's record, dated 09-29-14 at 5:36 p.m., indicated the resident was "found on the bathroom floor when CNA went back to</p>						

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	<p>check on her, resident was assessed and no pain or deformity in extremities, resident has a skin tear on the right elbow that appears to be reopened from previous wound. Resident c/o [complained of] pain to her middle finger on right hand." The report further indicated the resident "lost balance and was found on the floor of the bathroom - ambulated to bathroom - confused."</p> <p>During an interview on 10-07-14 at 11:00 a.m., the Director of Nurses indicated that at the time of admission a "bed and chair alarm" had been implemented as an assistive device to alert the staff of unassisted ambulation or transfer. The Director of Nurses indicated she was unaware how the resident fell, if she had been left unattended in the bathroom or if the alarm was functioning to alert the staff of unassisted ambulation.</p> <p>During further interview the Director of Nurses indicated an investigation had not been conducted in efforts to determine if someone was aware of how the resident fell.</p> <p>3. The record for Resident "F" was reviewed on 10-06-14 at 11:45 a.m. Diagnoses included, but were not limited to, Alzheimers dementia, adult failure to thrive, and communication deficit. These</p>			

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NAME OF PROVIDER OR SUPPLIER HAMILTON TRACE OF FISHERS				STREET ADDRESS, CITY, STATE, ZIP CODE 11851 CUMBERLAND RD FISHERS, IN 46037			
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	<p>diagnoses remained current at the time of the record review.</p> <p>A review of the resident's Minimum Data Set Assessment, dated 08-20-14 indicated the resident had severe cognitive impairment and required extensive assistance with transfers with two staff members.</p> <p>A review of the resident's record indicated the resident was found with a skin tear to the left elbow. The progress note, dated 09-23-14 at 7:00 p.m., indicated "CNA [certified nurse aide] alerted writer to ST [skin tear] on left elbow. Area not bleeding at the time. Area bruised. Resident denies pain. [Measurements] 3.4 cm [centimeters] by 3.4 cm by less than 0.1 cm."</p> <p>A review of the facility "Accident Investigation Form - Unusual Occurrences <sic>," report, dated 09-23-14, indicated "skin tear to left elbow. Exact location of the accident/incident: room, no witnesses. [Name of licensed nurse #7] - CNA alerted writer to skin tear on left elbow. Bleeding contained with bandage. Resident denies pain. Resident unaware of how skin tear took place."</p> <p>The facility failed to conduct a thorough</p>						

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	<p>investigation into how this dependent resident sustained the skin tear.</p> <p>A review of the facility "Accident Investigation Form - Unusual Occurrences <sic>," report, dated 09-23-14, indicated "skin tear to left elbow. Exact location of the accident/incident: room, no witnesses. [Name of licensed nurse #7] - CNA alerted writer to skin tear on left elbow. Bleeding contained with bandage. Resident denies pain. Resident unaware of how skin tear took place."</p> <p>A review of the facility policy on 10-03-14 at 10:00 a.m., titled "Abuse Prevention," and dated 08-21-13, indicated the following:</p> <p>"Policy Statement - It is the policy of CarDon & Associates to provide each resident with an environment that is free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. We have established policies and procedures that will provide facility personnel with the knowledge and training to further ensure each resident is treated with individual respect and dignity. The following guidelines outline the components of our Abuse Prevention Program."</p>				

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	<p>"Reporting Abuse to Administrator: Policy Statement - It is the responsibility of our employees, facility consultants attending physicians, family members, visitors etc., to immediately report any incident or suspected incident of neglect or resident abuse, including injuries of an unknown source, and theft or misappropriation of resident property to the Administrator or Designee if the Administrator is unavailable. 4. When an alleged or suspected case of mistreatment, neglect, injuries of an unknown source, or abuse is reported, the facility administrator, or his/her designee, he/she will ensure the resident will be protected from harm and removed from any potential abusive situation immediately (within a reasonable amount of time) and then notify the following persons or agencies of such incident when applicable... ."</p> <p>A review of the facility policy on 10-06-14 at 3:00 p.m., titled "Accidents & Incidents Investigating & Reporting," and undated, indicated the following:</p> <p>"Policy Statement: All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises must be investigated and reported to the Administrator."</p>						

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	"Procedure: 1. Reporting of Accident/Incidents - Regardless of how minor an accident or incident may be, including injuries of an unknown source, it must be reported to the department supervisor as soon as such accident/incident is discovered or when information of such accident/incident is learned. An Accident or Incident Report Form must completed for all reported accidents or incidents. An employee witnessing an accident or incident involving a resident, employee, visitor, etc., must report such occurrence to his or her immediate supervisor as soon as practical. Do not leave an accident victim unattended unless it is absolutely necessary to summon assistance; and the nurse supervisor/charge nurse must be immediately informed of accidents or incidents so that medical attention can be provided. 4. Investigative Action: The nurse supervisor/change nurse and/or the department director or supervisor must conduct an immediate investigation of the accident or incident. The following data, as it may apply, must be included on the Incident Report Form: The date and time of accident occurred, the nature of the injury/illness, the circumstances surrounding the accident/incident, where the accident/incident occurred, the name(s) of witnesses and their accounts of the accident/incident, the injured				

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	<p>person's account of the accident/incident, the time the injured person's attending physician was notified, as well as the time the physician responded with instructions, the date and time the injured person's next of kin was notified and by whom, the condition of the injured person, including vital signs, the disposition of the injured person, any corrective action taken, follow up information, other pertinent data as necessary or required, the signature and title of the person completing the form."</p> <p>This Federal tag relates to Complaint IN00157327.</p> <p>3.1-28(a)</p>						