

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/07/2011
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NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN46203
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F0000	<p>This visit was for a Post Survey Revisit to the Investigation of Complaint IN00094742, which resulted in an Immediate Jeopardy, completed on 08-19-11.</p> <p>This visit was in conjunction with the Post Survey Revisit to the Post Survey Revisit to the Investigation of Complaint IN00092695 completed on 07-07-11.</p> <p>This visit included the Investigation of Complaints IN00096109, IN00097319 and IN00097468.</p> <p>Complaint IN00094742 - not corrected</p> <p>Survey dates: September 29, 30 and October 4, 5 & 7, 2011</p> <p>Facility number: 004700 Provider number: 155741 AIM number: 100266630</p> <p>Survey team:</p>	F0000		

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>Mary Jane G. Fischer RN</p> <p>Census Bed Type: SNF/NF: 44 Total: 44</p> <p>Census Payor Type: Medicare: 2 Medicaid: 39 Other: 3 Total: 44</p> <p>Sample: 11 Supplemental sample: 7</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 10/17/11 by Suzanne Williams, RN</p>				

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F0157 SS=D	<p>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 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, the facility failed to inform a resident's physician for possible intervention when a resident appeared to have significant weight loss, for 2 of 3 residents sampled for weight loss in a sample of 11. [Residents "B" and "E"].</p>	F0157	Resident B no longer resides in the facility. Resident E has been weighed weekly since the survey, his weight has been discussed with the Registered Dietitian, and the resident has improved to where he requests "shakes" (ensure supplement). All residents in the facility are identified as having potential to be affected. All	11/04/2011	

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	<p>Findings include:</p> <p>1. The record for Resident "B" was reviewed on 09-29-11 at 10:05 a.m. Diagnoses included but were not limited to anoxic brain injury, seizures, dysphasia, and respiratory failure. The record indicated the resident had a tracheostomy and a gastrostomy feeding tube. These diagnoses remained current at the time of the record review.</p> <p>The resident's plan of care, dated 08-12-11, indicated the resident's "nutrition and hydration needs will be met through next review AEB [as evidenced by] no significant weight changes." Interventions to this plan of care instructed the nursing staff to monitor for tolerance of feeding and report diarrhea or vomiting, "monitor lab and weights as ordered. Report loss or abnormal, feeding as ordered, monitor fluid intake and skin turgor."</p> <p>Review of the "Monthly Weight Report," on 10-05-11 at 12:00 p.m., indicated the resident weighed 102.5 lbs. [pounds] in July 2011, 120.4 lbs in August 2011, and 96.4 lbs in September 2011. However, review of the weekly weights, dated 09-14-11, indicated the resident weighed 88.6 lbs, and the next available recorded weight was 88.3 lbs. on 09-28-11.</p>		<p>facility scales have been calibrated. Going forward they will be calibrated monthly on the last Friday of each month. Nursing staff was inserviced on 10/28/11 regarding proper use of facility scales. A return demonstration has been initiated and will continue until all staff have demonstrated how to accurately weigh a resident. Handouts were reviewed related to accurate weight and height measurements, calculating for amputees (when needed), and the importance of weighing a resident, each time, with catheters, additional clothing, shoes, etc. out of the way. Weekly weights will be completed by Tuesday each week, and will be reviewed by the Director of Nursing and the Dietary Manager. Any significant weight changes will trigger a re-weight which will be done by Wednesday each week. Monthly weights will be completed by the 7 th of each month, and will be reviewed by the Director of Nursing and the Dietary Manager. Any significant weight changes will trigger a reweight which will be done within 24 hours of the weight in question. Any significant weight changes that are confirmed with a reweight will be reported to the resident and/or responsible parties, and the resident's physician. The weights, along with skin and nutrition will be discussed in the S.W.A.T. (an interdisciplinary meeting), held on</p>		

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	<p>Further review of the facility Nutrition Assessment notations, dated 08-15-11 indicated the resident was "dependent on g-tube feedings due to persistent vegetative state and inability to chew and swallow." The assessment indicated the resident's BUN (blood urea nitrogen - lab test) was 14, and dehydration concerns were not noted. The 09-12-11 notation indicated "Post hosp. [hospitalization] for UTI [urinary tract infection]. Hosp. d/c [discharge] noted feeding of Replete. Suggest continue TF [tube feeding] as prior to hosp. Fibersource HN 320 mg 5 times a day, followed by 100 ml of water. Sept [September] wt. recorded at 96.4 lbs, [arrow down] of 24 lbs. / 19.9% in one month ?? questionable. July [2011] weight recorded at 102.5 lbs. Request weekly wt. [weight] until stable wt. noted."</p> <p>The resident's record lacked documentation the physician was notified of the resident's weight loss.</p> <p>2. The record for Resident "E" was reviewed on 09-29-11 at 12:10 p.m. The resident's admission weight was documented as 154.6 lbs. on 09-09-11. On 09-21-11 the resident's weight was documented at 142.7 lbs, and on 09-28-11 the resident weighed 142.4 lbs. The</p>		<p>Thursday afternoons. The timeliness and accuracy of resident weights will be discussed in the Quality Assurance meeting monthly X 3 months and quarterly thereafter to monitor effectiveness of obtaining and recording accurate resident weights. The Administrator and Director of Nursing are responsible for compliance. Date of Completion November 4, 2011. Addendum: The staff in-service on 10/28/2011 included when to notify physicians and families of changes in condition, including significant weight changes.</p>		

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	<p>record lacked any indication the resident had been reweighed or the physician notified of the resident's presumed weight loss. On 10-04-11, a request was made to re-weigh the resident. The resident weighed 133.5 lbs.</p> <p>Review of facility policy titled "Weighing Residents," on 09-30-11 at 11:40 a.m., and dated as revised on 11-98 indicated the following:</p> <p>"PURPOSE [bold type and underscored] Weighing residents regularly allows the nursing staff, dietitian, and physician to observe weight loss or gain."</p> <p>"POLICY [bold type and underscored] A resident's weight is taken on admission to the facility and at least monthly thereafter, or more often if ordered by the physician. The resident should be weighed at approximately the same week of the month, every month, to ensure true "monthly" weights are obtained. A weight loss of 5 % in 30 days or 10 % in 180 days should be reported to the charge nurse as well as the physician."</p> <p>5. Review of facility policy titled "Notification of changes - Policy/Procedure," on 10-05-11 at 12:00 p.m., and dated 09-20-2007, indicated the following:</p>				

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	<p>"POLICY [bold type and underscored] Resident and/or responsible parties will be notified of changes in resident conditions/care."</p> <p>"PURPOSE [bold type and underscored] To inform the resident and/or responsible party of care."</p> <p>"PROCEDURE [bold type and underscored] The facility will 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: (2) a significant change in the resident's physical, mental or psychosocial status, that is a deterioration in health, mental or psychosocial status in either life-threatening conditions or clinical complications, (3) a need to alter treatment significantly, that is a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment."</p> <p>This federal deficiency was cited on 08-19-11. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-5(a)(2)</p>				

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F0282 SS=D	<p>3.1-5(a)(3)</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 observation, record review and interview, the facility failed to ensure the residents' plans of care were followed in regard to interventions for the supervision of personal care, and prevention of falls and pressure ulcers, for 3 of 4 residents reviewed for care plans in a sample of 11. [Residents "C", "E" and "G"].</p> <p>Findings include:</p> <p>1. The record for resident "C" was reviewed on 09-29-11 at 2:40 p.m. Diagnoses included but were not limited to senile pre senile organic psychotic condition, neurotic disorder, anxiety and bipolar disorder. These diagnoses remained current at the time of the record review.</p> <p>Review of the Minimum Data Set assessment, dated 06-27-11, indicated the resident required supervision with hygiene and assistance with bathing.</p> <p>The resident's current plan of care, dated</p>	F0282	<p>Resident C has been provided with two electric razors. One is for shaving his face, the other for shaving his head. The facility's Occupational Therapist has worked with him to ensure that he is able to use the electric razors safely. Resident C's CNA Care Guide has been updated to include use of electric razors. All nursing staff will be inserviced by October 28, instructing them not to give razors to residents. Resident E has been provided padded side rails. His care plan and CNA Care Guide have been updated to include all fall prevention devices that are used with him. CNA #7 was counseled to review her CNA Care Guide daily and provide care to residents in accordance with the Guide. Nursing staff will be inserviced by October 28 reminding them of the importance of reviewing the CNA Care Guides and following the instructions on them. Nurses will also be inserviced on the importance of checking resident safety devices, bed and chair alarms, for placement and function each shift. This will be</p>	11/04/2011

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	<p>07-01-11, indicated, "needs supervision for dressing and bathing due to left hemiparesis, with interventions which included "assist resident with ADLs [activities of daily living] as needed, assist resident to shower twice weekly."</p> <p>During an interview on 09-30-11 at 12:30 p.m., a visitor indicated a need to "check" on this resident as resident had a "safety razor in possession and cut [resident] head numerous times." When interviewed how this visitor obtained this information, the visitor indicated "a resident told me about it. [Resident] said there was blood everywhere."</p> <p>Review of the nurses notes, dated 09-15-11 [no time documented] indicated, "Resident in room and shaving [resident] scalp without supervision. Has cut self in 5 places and bleeding."</p> <p>The nurses notes dated 09-26-11 at 3:00 p.m. indicated "has shaved head and cut self in numerous places with razor. Has 3 razors in trash along with bloody tissue and washcloth."</p> <p>During a discussion with the Administrator and Director of Nurses at the daily exit conference on 09-29-11 at 3:40 p.m., the administrative staff verified the resident "gave self a shower the other</p>		<p>monitored through the use of the medication administration record (MAR) and unit rounds three times a week for 12 weeks, and ongoing by the Director of Nursing. Resident G is very prone to pressure ulcers and has had skin issues since his admission in 2005. He uses a circulating air mattress to reduce pressure areas. A turn schedule has been implemented to ensure that resident is not on his back except during meal times. All nursing staff have been inserviced regarding Resident G's specific interventions to prevent further skin breakdown, how to properly float heels, and to promote wound healing. Charge nurses have been inserviced reminding them of the importance of observing Resident G frequently to make sure the designated turn schedule is followed. Resident G will continue to be followed by the Wound Care Center, as well as weekly wound rounds to monitor his skin. For continuum of care, the Director of Nursing and Wound Nurse met with the Wound Care Center and discussed what each entity might need for the resident's continued care, as one unit working together. A form was developed to ensure what the resident's status had been since the last visit, with a return of current measurements, treatments, and recommendations to the facility. This transition will begin on</p>		

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	<p>day and [resident] head was cut to high heaven. [Resident] does own shaving." During further discussion, the Administrator and Director of Nurses indicated they were unaware the resident had two episodes of cutting self.</p> <p>Interview on 10-04-11 at 12:00 p.m. the Director of nurses indicated "when we did a sweep of [resident] room we found 12 razors."</p> <p>2. The record for Resident "E" was reviewed on 09-29-11 at 12:10 p.m. Diagnoses included but were not limited to viral hepatitis, schizophrenic disorder and encephalopathy. These diagnoses remained current at the time of the record review.</p> <p>During the initial tour of the facility on 09-29-11 at 8:30 a.m., licensed practical nurse employee #3 indicated the resident was a "fall risk" and had recently fallen out of bed and sustained extensive bruising to face, arms and hands. The name plate outside of the resident's room had a "star" adjacent to the resident's name. The licensed practical nurse indicated the "star" was placed there to alert the staff the resident was a fall risk.</p> <p>Review of the Minimum Data Set assessment, dated 09-16-11, indicated the</p>		<p>November 1st, with each consecutive visit for treatment. The Licensed Nurses were inserviced, October 28, related to utilizing the C.N.A. shower sheets, a skin checklist, a tool to guide them in discerning different stages of wounds, the use of specific treatments for specific observations, and nutritional/supplemental interventions that might be used with residents noted to have skin issues, so as to act upon them timely. Wound rounds will continue to be conducted each Wednesday. All residents in the facility are identified as having potential to be affected. The Director of Nursing or designee will make rounds three times weekly to make sure that nursing staff is providing care to the residents as indicated on their CNA Care Guides. The DON will share her observations with the Quality Assurance Committee at least quarterly on an ongoing basis. The Administrator and Director of Nursing are responsible for compliance. Date of Completion November 4, 2011. Addendum: The Director of Nursing or designee will make rounds three times weekly to make sure that nursing staff is providing care to the residents as indicated on their CNA Care Guides. This will include placement of personal safety alarms, code alerts to prevent elopement, fall prevention</p>		

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	<p>resident required extensive assistance with bed mobility and was assessed as "total" care/assistance from the staff with transfer.</p> <p>Review of the current plan of care, dated 09-27-11, indicated the resident "gets bruises and skin tears easily due to anticoagulant use." The "goal" indicated "resident will be free of serious injuries through next review." Interventions to this plan of care included "Pad side rails on bed with pillows, pillow cases, bed pad alarm in bed, PSA [personal safety alarm] in wheelchair to alert staff if resident tries to transfer without assistance."</p> <p>A subsequent current plan of care dated 09-22-11, indicated the resident had the "Potential for injuries from falls due to recent history of falls." Interventions included "Monitor resident for steadiness and balance, personal safety alarm [PSA] when up in wheelchair, pressure pad alarm in bed."</p> <p>The certified nurses aide assignment sheet with resident specific information indicated the resident required a bed pad alarm and a PSA when up in the wheelchair.</p> <p>Review of the hospital patient information/discharge orders, dated</p>		<p>interventions, and hazards such as razors. The findings on these rounds will be shared with the interdisciplinary team at morning meeting on the business day after the rounds. The DON will also share her observations with the Quality Assurance Committee at least quarterly on an ongoing basis.</p>		

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	<p>09-09-11 indicated the resident required "bed rest - may sit on side of bed with assistance. The patient is currently A & O [alert and oriented] times 1 [self]."</p> <p>Review of the Nursing Admission Skin condition report, dated 09-09-11 indicated that at the time of admission to the facility the resident had "multiple bruises and scapping <sic> to bilateral upper extremities, scapping <sic> to right knee cap." "Initial care plan: problem fall risk. Approach: bed alarm, call light in reach. Goal: no falls."</p> <p>Review of the nurses notes indicated the following:</p> <p>"09-09-11 4:00 p.m. Alert to self, inappropriate speech noted. Resident on bedrest. Attempted to climb OOB [out of bed] times 3 times this shift bed alarm placed."</p> <p>"09-10-11 10:30 a.m. - Pt. [patient] has tried to climb out of bed times 2 this shift."</p> <p>"09-10-11 10:00 p.m. - Bed alarm in place alarms when res. [resident] moving about in bed."</p> <p>"09-14-11 6:00 a.m. - Sitting up on side of bed multiple times during this noc</p>						

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	<p>[night]."</p> <p>"09-18-11 8:00 p.m. - Alert to person Inappropriate speech at times. Resident attempt to get OOB times 2. Likes to side on edge of bed."</p> <p>"09-21-11 11:20 a.m. - Pt. found in room lying on floor on left side, alarm sounding, fall matt at bed side. pt alert verbal abrasion/laceration .5 in length area blue/purple with bright red drng [drainage], s/t skin tear noted to left elbow measures .6 by .5 cm [centimeters] flap intact."</p> <p>During an observation on 10-05-11 at 9:40 a.m., the resident was seated in a wheelchair in room. The resident, in a continuing motion, placed the palms of both hands on the armrests of the wheelchair and attempted a standing position.</p> <p>The resident was observed with white kerlix/gauze type dressings to bilateral arms from the wrists to the elbows. The siderails of the resident's bed were not padded to protect the resident from additional injury.</p> <p>During a subsequent observation on 10-05-11 at 9:50 a.m., the resident continued attempts at standing. Upon entering the resident's room, the resident</p>				

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	<p>lacked a PSA alarm while seated in the wheelchair. During this observation, an alarm was observed on the resident's nightstand. CNA [Certified Nurses Aide] employee #7 entered the resident's room. When interviewed, the CNA indicated she was unaware the resident required a PSA. When requested, the CNA reviewed her assignment sheet which instructed staff of the need for the personal alarm. The CNA turned toward the nightstand and stated, "that probably needs to be on the wheelchair and attached to [resident]." The Director of Nurses was in attendance during this observation.</p> <p>3. The record for Resident "G" was reviewed on 10-05-11 at 11:20 a.m. Diagnoses for resident "G" included but were not limited to diabetes, schizophrenic, paraplegia and a history of pressure ulcers. The resident's record indicated an allergy to tape.</p> <p>Review of the Minimum Data Set assessment, dated 10-04-11, indicated the resident required extensive assistance with bed mobility, and total care for transfer, dressing and personal hygiene. In addition, the assessment indicated the resident was assessed at risk for developing pressure ulcers and currently had 3 stage two ulcers.</p>				

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	<p>Review of the current plan of care dated 07-22-11, indicated the resident was a "risk for skin breakdown due to total dependence on staff for bed mobility, total incontinence of bowel due to paraplegia, peripheral vascular disease and long term history of pressure ulcers." Interventions to this plan of care included "pressure reducing mattress, and reposition at least every two hours."</p> <p>A review of the CNA [certified nurse aide] assignment sheet instructed the staff to "turn side to side. Limit time in chair to meals only. Keep heels off bed. Blue multi-podus boots at night and up in chair."</p> <p>On 09-30-11 at 9:15 a.m. the resident was observed lying on back in bed. The CNA turned the resident to the left side for observation of the resident's skin.</p> <p>During this observation, a dressing was observed and dated 09-29-11. The skin adjacent to the dressing was bright red in color along the right side and bottom edge of the dressing. The resident's upper back, scapula area, had a small dime size reddened area observed. During this observation licensed practical nurse employee #3 was in attendance. The nurse indicated she was unaware why the</p>				

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	<p>resident's skin was bright red in color and further stated "I think it's from the tape. [Resident] is going to the Wound Clinic today. The area up here [pointing to the dime size reddened area] won't blanch. I don't know what it's from."</p> <p>During an observation on 10-05-11 at 9:40 a.m., the resident was positioned to the left side. At 12:00 p.m., the resident was positioned on back with a pillow beneath the resident's ankles. The resident's heels were on the bed.</p> <p>During interview at on 10-05-11 at 12:30 p.m., the Director of Nurses indicated the staff "cannot use a pillow to position the heels off the bed because the pillow will just sink down."</p> <p>This federal deficiency was cited on 08-19-11. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-35(g)(2)</p>				

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F0323 SS=G	<p>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.</p> <p>A. Based on record review and interview, the facility failed to ensure the safety and supervision of the residents in that a resident who required supervision with ADLs (activities of daily living) was allowed to shave independently, which resulted in bleeding and multiple cuts to the head. This deficient practice affected 1 of 3 residents who required supervision for activities of daily living in a sample of 11. [Resident "C"].</p> <p>B. Based on observation, record review and interview, the facility failed to ensure the safety of residents and provide the assistive devices needed to alert the staff of unassisted transfer/ambulation for 1 of 3 residents reviewed for falls in the sample of 11, resulting in injuries to the face which were deep purple in color with multiple bruises and abrasions around both eyes, cheeks, chin and forehead, and a large knot/hematoma on the left cheek bone adjacent to the left eye. [Resident "B"].</p> <p>C. Based on observation, record review and interview, the facility failed to ensure the whereabouts of residents in that the facility allowed residents the code to the</p>	F0323	<p>Resident C has been provided with two electric razors. One is for shaving his face, the other for shaving his head. The facility's Occupational Therapist has worked with him to ensure that he is able to use the electric razors safely. Resident C's CNA Care Guide has been updated to include use of electric razors. All nursing staff will be inserviced by October 28, instructing them not to give razors to residents. Resident E had falls resulting in multiple bruises. Resident E now has padded side rails. His care plan and CNA Care Guide have been updated to include all fall prevention devices that are used with him. CNA #7 was counseled to review her CNA Care Guide daily and provide care to residents in accordance with the Guide. Nursing staff will be inserviced by October 28 reminding them of the importance of reviewing the CNA Care Guides and following the instructions on them. Nurses will also be inserviced on the importance of checking resident safety devices such as personal safety alarms. Resident J has agreed to sign out prior to any outings from the facility. Residents H and K have agreed not to leave the facility unless</p>	11/04/2011

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	<p>locked front door, which resulted in a resident missing from the facility for a period of time without staff being aware the resident had left the premises, for 3 of 3 residents reviewed who were allowed information related to the locked front door in which they were able to come and go from the facility premises without the staff knowing the residents' whereabouts, in a sample of 11. [Residents "J", "H", "K"].</p> <p>Findings include:</p> <p>A.) The record for resident "C" was reviewed on 09-29-11 at 2:40 p.m. Diagnoses included but were not limited to senile pre senile organic psychotic condition, neurotic disorder, anxiety and bipolar disorder. These diagnoses remained current at the time of the record review.</p> <p>Review of the Minimum Data Set assessment, dated 06-27-11, indicated the resident required supervision with hygiene and assistance with bathing.</p> <p>The resident's current plan of care, dated 07-01-11, indicated, "needs supervision for dressing and bathing due to left hemiparesis, with interventions which included "assist resident with ADLs [activities of daily living] as needed, assist</p>		<p>accompanied by a family member or staff member. All residents in the facility are identified as having potential to be affected. The exit codes have been changed and all staff has been instructed not to give the exit code to any residents. All staff has been inserviced to allow residents to sit outside in the enclosed patio area or allow them to sit on the front porch if accompanied by staff or a family member or other responsible person. The Administrator and Director of Nursing are responsible for compliance. Date of Completion November 4, 2011. Addendum: All staff was inserviced on 10/28/2011 instructing them not to allow residents to keep disposable razors. The Director of Nursing or designee will make rounds three times weekly to make sure that nursing staff is providing care to the residents as indicated on their CNA Care Guides. This will include placement of personal safety alarms, code alerts to prevent elopement, fall prevention interventions, and hazards such as disposable razors. The findings on these rounds will be shared with the interdisciplinary team at morning meeting on the business day after the rounds. The DON will also share her observations with the Quality Assurance Committee at least quarterly on an ongoing basis.</p>		

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	<p>resident to shower twice weekly."</p> <p>During an interview on 09-30-11 at 12:30 p.m., a visitor indicated a need to "check" on this resident as resident had a "safety razor in possession and cut [resident] head numerous times." When interviewed how this visitor obtained this information, the visitor indicated "a resident told me about it. [Resident] said there was blood everywhere."</p> <p>Review of the nurses notes, dated 09-15-11 [no time documented] indicated, "Resident in room and shaving [resident] scalp without supervision. Has cut self in 5 places and bleeding."</p> <p>The nurses notes dated 09-26-11 at 3:00 p.m. indicated "has shaved head and cut self in numerous places with razor. Has 3 razors in trash along with bloody tissue and washcloth."</p> <p>During a discussion with the Administrator and Director of Nurses at the daily exit conference on 09-29-11 at 4:00 p.m., the administrative staff verified the resident "gave self a shower and the other day and [resident] head was cut to high heaven. [Resident] does own shaving."</p> <p>During further discussion, the Administrator and Director of Nurses</p>				

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	<p>indicated they were unaware the resident had two episodes of cutting self.</p> <p>During an interview on 09-30-11 at 9:15 a.m. CNA [certified nurses aide] employee #9 indicated the residents "aren't supposed to have razors at all."</p> <p>During interview on 09-30-11 at 9:20 a.m. CNA #7 indicated "I think if they are independent then they can have razors."</p> <p>During interview on 09-30-11 at 9:45 a.m., licensed practical nurse employee #1 indicated "No resident if supposed to have a razor in their possession."</p> <p>During interview on 10-04-11 at 12:00 p.m., the Director of Nurses indicated "when we did a sweep of [resident] room we found 12 razors."</p> <p>B.) The record for Resident "E" was reviewed on 09-29-11 at 12:10 p.m. Diagnoses included but were not limited to viral hepatitis, schizophrenic disorder and encephalopathy. These diagnoses remained current at the time of the record review.</p> <p>Review of the hospital patient information/discharge orders, dated 09-09-11, indicated the resident required "bed rest - may sit on side of bed with</p>				

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	<p>assistance. The patient is currently A & O [alert and oriented] times 1 [self]."</p> <p>Review of the Nursing Admission Skin condition report, dated 09-09-11 indicated that at the time of admission to the facility the resident had "multiple bruises and scapping <sic> to bilateral upper extremities, scapping <sic> to right knee cap." "Initial care plan: problem fall risk. Approach: bed alarm, call light in reach. Goal: no falls."</p> <p>During the initial tour of the facility on 09-29-11 at 8:30 a.m., licensed practical nurse employee #3 indicated the resident was a "fall risk" and had recently fallen out of bed and sustained extensive bruising to face, arms and hands. The name plate outside of the resident's room had a "star" adjacent to the resident's name. The licensed practical nurse indicated the "star" was placed there to alert the staff the resident was a fall risk.</p> <p>Review of the Minimum Data Set assessment, dated 09-16-11, indicated the resident required extensive assistance with bed mobility and was assessed as "total" care/assistance from the staff with transfer.</p> <p>Review of the current plan of care, dated 09-27-11, indicated the resident "gets</p>				

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	<p>bruises and skin tears easily due to anticoagulant use."</p> <p>The "goal" indicated "resident will be free of serious injuries through next review."</p> <p>Interventions to this plan of care included "Pad side rails on bed with pillows, pillow cases, bed pad alarm in bed, PSA [personal safety alarm] in wheelchair to alert staff if resident tries to transfer without assistance.</p> <p>A subsequent current plan of care dated 09-22-11, indicated the resident had the "Potential for injuries from falls due to recent history of falls." Interventions included "Monitor resident for steadiness and balance, personal safety alarm [PSA] when up in wheelchair, pressure pad alarm in bed."</p> <p>The certified nurses aide assignment sheet with resident specific information indicated the resident required a bed pad alarm and a PSA when up in the wheelchair.</p> <p>Review of the nurses notes indicated the following:</p> <p>"09-09-11 4:00 p.m. Alert to self, inappropriate\ speech noted. Resident on bedrest. Attempted to climb OOB [out of bed] times 3 times this shift bed alarm placed."</p>						

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	<p>"09-10-11 10:30 a.m. - Pt. [patient] has tried to climb out of bed times 2 this shift."</p> <p>"09-10-11 10:00 p.m. - Bed alarm in place alarms when res. [resident] moving about in bed."</p> <p>"09-14-11 6:00 a.m. - Sitting up on side of bed multiple times during this noc [night]."</p> <p>"09-18-11 8:00 p.m. - Alert to person inappropriate speech at times. Resident attempt to get OOB times 2. Likes to sit on edge of bed."</p> <p>"09-21-11 11:20 a.m. - Pt. found in room lying on floor on left side, alarm sounding, fall matt at bed side. pt alert verbal abrasion/laceration 5 in length area blue/purple with bright red drng [drainage], s/t skin tear noted to left elbow measures .6 by .5 cm [centimeters] flap intact."</p> <p>During the initial tour of the facility on 09-29-11 at 8:30 a.m., the resident was observed seated in a wheelchair. The resident's face was deep purple in color with multiple bruises and abrasions around both eyes, cheeks, chin and forehead. The resident had a large knot</p>			

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	<p>on the left cheek bone adjacent to the left eye.</p> <p>During an observation on 10-05-11 at 9:40 a.m., the resident was seated in a wheelchair in room. The resident, in a continuing motion, placed the palms of both hands on the armrests of the wheelchair and attempted a standing position.</p> <p>During a subsequent observation on 10-05-11 at 9:50 a.m., the resident continued attempts at standing. Upon entering the resident's room, the resident lacked a PSA alarm while seated in the wheelchair. During this observation an alarm was observed on the resident's nightstand. CNA [Certified Nurses Aide] employee #7 entered the resident's room. When interviewed the CNA indicated she was unaware the resident required a PSA. When requested the CNA reviewed her assignment sheet which instructed staff of the need for the personal alarm. The CNA turned toward the nightstand and stated, "that probably needs to be on the wheelchair and attached to [resident]." The Director of Nurses was in attendance during this observation.</p> <p>The resident was observed with white kerlix/gauze type dressings to bilateral arms from the wrists to the elbows. The siderails of the resident's bed were not</p>				

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	<p>padded to protect the resident from additional injury.</p> <p>C 1.) The record for resident "J" was reviewed on 09-30-11 at 9:30 a.m. Diagnoses included but were not limited to paranoid schizophrenia, restless legs paraplegia and diabetes mellitus. These diagnoses remained current at the time of the record review.</p> <p>Review of the Minimum Data Set assessment dated 05-05-11, indicated the resident had no cognitive impairment; however, the resident' plan of care indicated the resident was at risk for confusion and disorganized thought due to the diagnosis of schizophrenia. The resident also had a history of noncompliance with medications. The resident used a wheelchair for mobility.</p> <p>Review of an incident reported to ISDH, dated 09-17-11 at approximately 5:00 a.m., indicated the following:</p> <p>"[Resident] states that [resident] left the facility at about 5:00 a.m. and wheeled self to [name of local area restaurant] approximately seven blocks from the facility. After arriving at [name of local area restaurant], [resident] telephoned a friend to meet [resident] and [other family member] as well. [Family member]</p>				

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	<p>telephoned the facility at about 8:30 a.m. indicated [resident] was at [name of local area restaurant]. CNA [name documented of employee #9] went to the restaurant to bring [resident] back but [resident] refused to come back with her at that time. [Name of CNA] then left [resident] at [name of local area restaurant] with [family member] and friend. [Resident] had his friend bring [resident] back to the facility later that morning."</p> <p>Further review of the report indicated the Assistant Administrator spoke with the resident and reminded the resident of the need to "sign in and out of the facility." The resident indicated [resident] "made a mistake today and in the future will sign out prior to leaving the facility."</p> <p>Statements, handwritten, by facility staff member indicated she "thought" she saw the resident around 6:00 a.m., however, the facility staff was unaware of the resident's whereabouts for approximately 2 - 2 1/2 hours.</p> <p>During observation on 10-04-11 at 11:25 a.m., the local area restaurant was approximately 1/2 mile from the facility. Getting to the restaurant necessitated crossing four lanes of moving traffic from north to the south lanes, and two lanes of traffic for the east west lanes of traffic.</p>				

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	<p>Review of the Social Service Review and Resident Interview, dated 08-08-11 indicated "Outside Supervision Needs - "understands the facility LOA policy (Signing in/out), and may sit out on front porch unsupervised."</p> <p>Although the incident occurred on 09-17-11, the facility failed to do a post elopement assessment until 10-05-11.</p> <p>C 2.) The record for Resident "H" was reviewed on 10-05-11 at 11:00 a.m. Diagnoses included but were not limited to anoxic brain damage, blindness - low vision and hypotension. These diagnoses remained current at the time of the record review.</p> <p>Review of the resident's Minimum Data Set, dated 07-22-11, indicated the resident had no cognitive impairment but did display short term memory loss. During observation on 10-04-11 at 1:10 p.m., the resident was observed with a stumbling gait.</p> <p>During an observation on 10-04-11 at 1:10 p.m., this resident was observed walking toward the front door of the facility with another resident's family member. The resident accessed the key pad, entered the code and exited the</p>				

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	<p>building with this visitor.</p> <p>During interview, on 10-04-11 at 1:45 p.m., the resident indicated [resident] did not get the code from a staff member. The resident was reminded the code had been changed the previous Friday, 09-30-11, and again asked to think about where [resident] obtained the code. The resident stated "I have short term memory problems I don't remember." The resident became confrontational and asked "Do you mean I have to ask someone to let me out to go to church ?" The Director of Nurses who was in attendance stated, "Yes." The resident then stated [resident] let self out of the facility on Sunday to attend church without anyone letting her out.</p> <p>The elopement risk assessment was not conducted until 10-05-11.</p> <p>C 3.) The record for Resident "K" was reviewed on 10-04-11 at 2:00 p.m. Diagnoses included but were not limited to cerebral vascular accident, neuropathy, vision abnormalities, left sided paresis, right sided craniotomy and hypertension. These diagnoses remained current at the time of the record review.</p> <p>A review of the resident's Minimum Data Set assessment, dated 08-31-11, indicated the resident had no cognitive impairment</p>				

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	<p>or memory loss. The resident used a motorized wheelchair for mobility.</p> <p>A physician order dated 08-26-11 indicated the resident's physician allowed the resident to go LOA by self.</p> <p>During an observation on 10-04-11 at 11:30 a.m., the resident was observed in a motorized wheelchair approximately 6 blocks from the facility on Keystone Avenue, a four lane divided street that runs north and south.</p> <p>Review of the "Sign In/Out" sheet, dated 10-04-11, indicated the staff member "signed" the resident as returned to the facility at 11:00 a.m.</p> <p>Further review of the "Sign In/Out sheet, indicated the resident left the facility on 09-16-11 at 12:30 p.m., but lacked a staff member's signature of the resident's return to the facility. There was no indication the staff were aware of the resident's whereabouts.</p> <p>During an interview on 10-04-11 at 1:00 p.m. the Director of Nurses indicated the resident liked to cross the street and watch the golfers [at the local area golf course].</p> <p>During interview on 10-04-11 at 2:30 p.m., the Assistant Administrator</p>			

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	<p>indicated he telephoned the staff member who verified she had not actually looked at the exact time the resident returned, but rather knew it was around the time she "ate" and then "took her smoke break."</p> <p>C 4.) During observation on 10-05-11 at 10:30 a.m., a group of nursing students were observed in the facility. One nursing student approached the front door and verbally stated the code to exit the facility. During interview on 10-05-11 at 10:40 a.m., the Director of Nurses was alerted who then indicated the students were given the code but must not be aware of the importance not to verbally state the code in the event there are residents in the area.</p> <p>Review of Friendship Healthcare Center "Rules for Residents, on 09-30-11 at 11:00 a.m., and dated as "revised" January 2009 indicated the following:</p> <p>"It is the policy of Friendship Healthcare to expect resident to behave in such a manner that the safety, well being and right of others are respected."</p> <p>"4. Residents are not to cause injury to themselves or others."</p> <p>"6. Residents are not to leave the facility without signing out. They must sign back</p>				

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	<p>in upon return. LOA [leave of absence] resident need to be accompanied by a staff member, family member, or responsible party. Residents should remain within fenced areas when outside, unless accompanied by a suitable attendant."</p> <p>"12. Upon admission, no resident will be allowed outside unsupervised until having been assessed for elopement potential."</p> <p>Review of Inservice education on 09-30-11 at 1:30 p.m., instructed the nursing staff as follows:</p> <p>"For our residents' safety, please be sure to not [underscored] give out the door code to our resident's. The door code may be given to family members. however, please politely ask them to respect the rules of out facility and not give the code out to their loved one or any other resident. Please be advised, any employee caught giving the code out to a resident will be immediately terminated."</p> <p>This federal deficiency was cited on 08-19-11. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-45(a)(2)</p>				

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F0431 SS=E	<p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on record review, the facility failed to ensure the reconciliation of controlled drugs in that when the nursing staff completed their assigned shift, they failed to ensure another nurse counted and reconciled the count for the controlled drugs, on 1 of 2 units, potentially</p>	F0431	<p>No residents were adversely affected by the absence of signatures on the shift change narcotic count sheets, as the actual narcotic counts have been conducted and observed on different shifts.</p> <p>All residents are identified as having potential to be affected.</p>	11/04/2011

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	<p>affecting 25 of 25 residents who resided on the south unit.</p> <p>Findings include:</p> <p>Review of the "Controlled Drug Audit," sheet for the North Unit lacked signatures of the nursing staff to verify the actual count of the controlled drugs from shift to shift by the licensed nursing staff as follows:</p> <p>"September 15, 2011 evening shift signature." "September 19, 2011 day and evening shift signature." "September 24, 2011 night shift signature." "September 28, 2011 day shift signature." "September 29, 2011 day shift signature."</p> <p>The notation/instructions to the licensed nursing staff indicated the following:</p> <p>"IMPORTANT [bold type and underscored]: Controlled drugs are counted at each shift by two members of the nursing staff, the nurse/medication aide coming on duty and the nurse/medication aide going off duty. Signatures by the nurse/medication aides verify that an actual count has been made and the count is the same as that indicated on the individual control drug record</p>		<p>All nurses were inserviced immediately, upon the Surveyor's exit conference on 10/07/2011 and continued until each nurse had been notified of the lack of documentation and required signatures. Additionally, nurses were instructed, as they sign the count at change of shift, to observe the paper for any previous shift changes which are missing a signature and bring this to the attention of the Director of Nursing promptly. The Director of Nursing or Designee will conduct audits of the actual narcotic count sheets and the sign in sheets, which require 2 nursing signatures, will be conducted 3 times a week for 12 weeks, with issues addressed as soon as they are found. The frequency of these audits will not decrease until 100% compliance is achieved. Disciplinary actions will be given for lack of professional standards. The results of the audits will be discussed at the monthly Quality Assurance meetings X 3 months, and then quarterly thereafter on an ongoing basis. The Administrator and Director of Nursing are responsible for compliance. Date of Completion November 4, 2011.</p>		

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	<p>(32002). Note any discrepancy in the comment section and report discrepancy to the Director of Nurses."</p> <p>Review of facility policy on 10-07-11 at 10:00 a.m., titled "Medication Storage in the Facility," and dated as "effective" January 2007, indicated the following:</p> <p>"CONTROLLED MEDICATION STORAGE"</p> <p>"Policy - Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal and recordkeeping in the facility in accordance with federal, state and other applicable laws and regulations."</p> <p>"D. At each shift change, a physical inventory of all controlled medications, including the emergency supply, is conducted by two licensed nurses and is documented on the controlled medication accountability record."</p> <p>This federal deficiency was cited on 08-19-11. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-25(e)(2) 3.1-25(e)(3)</p>				

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F9999	<p>State finding:</p> <p>Administration and Management</p> <p>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: Immediately informing the division by telephone, followed by written notice within twenty-hour hours, of unusual occurrences that directly threaten the welfare, safety, or health of the resident or residents....</p> <p>This rule was not met as evidenced by:</p> <p>Based on record review, observation and interview, the facility failed to ensure the implementation of their policy in regard to notification of the State Agency of an incident which involved dependent resident, in that when a cognitively impaired resident fell and sustained significant facial injuries, the facility</p>	F9999	<p>Resident E was provided with prompt and appropriate medical and nursing care following his fall. He experienced no adverse outcomes caused by the facility not reporting the fall and injury to ISDH. It is our intention to report all reportable unusual occurrences, as per regulation and facility policy. We apologize that the report was not done in this case.</p> <p>All residents in the facility are identified as having potential to be affected.</p> <p>To ensure that we report all required events, we have added to our Morning Meeting Minutes a "Reportables" item following falls. Each morning after discussing resident change in condition, falls and behaviors, we will determine if any events occurred that require a report to ISDH. At that time it will be decided who will report this (usually will be either Administrator or the Director of Nursing). Each day at morning meeting, a review of the previous meeting's notes will be conducted for any reportable events identified the previous day, and to double-check to ensure compliance with reporting the event has been delivered to ISDH, as required by regulation.</p>	11/04/2011

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	<p>failed to notify the State Agency of the incident as required, for 1 of 3 residents reviewed for falls in a sampled of 11. [Resident "E"].</p> <p>Findings include:</p> <p>The record for Resident "E" was reviewed on 09-29-11 at 12:10 p.m. Diagnoses included but were not limited to viral hepatitis, schizophrenic disorder and encephalopathy. These diagnoses remained current at the time of the record review.</p> <p>Review of the hospital patient information/discharge orders, dated 09-09-11, indicated the resident required "bed rest - may sit on side of bed with assistance. The patient is currently A & O [alert and oriented] times 1 [self]."</p> <p>Review of the Nursing Admission Skin condition report, dated 09-09-11 indicated that at the time of admission to the facility the resident had "multiple bruises and scapping <sic> to bilateral upper extremities, scapping <sic> to right knee cap." "Initial care plan: problem fall risk. Approach: bed alarm, call light in reach. Goal: no falls."</p> <p>During the initial tour of the facility on 09-29-11 at 8:30 a.m., licensed practical</p>		<p>At the QA meeting, we will discuss timeliness of reporting reportable events to ISDH quarterly on an ongoing basis. The Administrator and Director of Nursing are responsible for compliance. Date of Completion November 4, 2011.</p>		

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	<p>nurse employee #3 indicated the resident was a "fall risk" and had recently fallen out of bed and sustained extensive bruising to face, arms and hands. The name plate outside of the resident's room had a "star" adjacent to the resident's name. The licensed practical nurse indicated the "star" was placed there to alert the staff the resident was a fall risk.</p> <p>Review of the Minimum Data Set assessment, dated 09-16-11, indicated the resident required extensive assistance with bed mobility and was assessed as "total" care/assistance from the staff with transfer.</p> <p>Review of the current plan of care, dated 09-27-11, indicated the resident "gets bruises and skin tears easily due to anticoagulant use."</p> <p>The "goal" indicated "resident will be free of serious injuries through next review."</p> <p>Interventions to this plan of care included "Pad side rails on bed with pillows, pillow cases, bed pad alarm in bed, PSA [personal safety alarm] in wheelchair to alert staff if resident tries to transfer without assistance.</p> <p>Review of the nurses notes indicated the following:</p> <p>"09-09-11 4:00 p.m. Alert to self,</p>			

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	<p>inappropriate\ speech noted. Resident on bedrest. Attempted to climb OOB [out of bed] times 3 times this shift bed alarm placed."</p> <p>"09-10-11 10:30 a.m. - Pt. [patient] has tried to climb out of bed times 2 this shift."</p> <p>"09-10-11 10:00 p.m. - Bed alarm in place alarms when res. [resident] moving about in bed."</p> <p>"09-14-11 6:00 a.m. - Sitting up on side of bed multiple times during this noc [night]."</p> <p>"09-18-11 8:00 p.m. - Alert to person inappropriate speech at times. Resident attempt to get OOB times 2. Likes to sit on edge of bed."</p> <p>"09-21-11 11:20 a.m. - Pt. found in room lying on floor on left side, alarm sounding, fall matt at bed side. pt alert verbal abrasion/laceration 5 in length area blue/purple with bright red drng [drainage], s/t skin tear noted to left elbow measures .6 by .5 cm [centimeters] flap intact."</p> <p>During the initial tour of the facility on 09-29-11 at 8:30 a.m., the resident was observed seated in a wheelchair. The</p>			

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	<p>resident's face was deep purple in color with multiple bruises and abrasions around both eyes, cheeks, chin and forehead. The resident had a large knot on the left cheek bone adjacent to the left eye.</p> <p>Review of facility policy on 10-07-11 at 10:00 a.m., titled "Reportable Unusual Occurrences - Policy/Procedure," and dated as "revised 05-23-02" indicated the following:</p> <p>"Purpose [bold type and underscored] - to insure <sic> that reportable occurrences are recorded and monitored to facilitate compliance with state and federal laws."</p> <p>"Policy [bold type and underscored] - All unusual occurrences reported to the Indiana State Department of Health will be recorded and tracked or monitored to insure <sic> resident are receiving appropriate care and services."</p> <p>"Procedure [bold type and underscored] - Facilities are required by law to report unusual occurrences within 24 hours of occurrence to the Long Term Care Division. CFR 483.13(c)(2) states that "the facility must ensure that all alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident</p>				

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	<p>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>This State deficiency was cited on 08-19-11. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-13(g)(1)</p>				