STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155791	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLAIR RIDGE HEALTH CAMPUS	269 MEADOWVIEW DR PERU, IN 46970

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F000000	This survey was for the Investigation of Complaint IN00129650. Complaint IN00129650 - Substantiated. Federal/state deficiencies related to the allegation are cited at F157, F323 and F514. Survey dates: June 03-04, 2013 Facility number: 012565 Provider number: 155791 AIM number: 201021970 Survey Team: Honey Kuhn, RN Census bed type: SNF: 31 SNF/NF: 20 Total: 51 Census payor type: Medicare: 19 Medicaid: 12 Other: 20 Total: 51 Sample: 3 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.	F000000	The submission of this plan of correction does not indicate an admission by Blair Ridge Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and service provide to the residents of Blair Ridge. The campus maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities. This plan of correction shall serve as the credible allegations of compliance with all federal and state requirements governing the management of this campus.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	Quality Review completed on June 13, 2013 by Brenda Meredith, R.N.			

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F000157 SS=D	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). 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. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on record reviews and interviews, the facility failed to notify the family of a resident following 5 falls (Resident "D") and failed to notify a family in a timely manner following	F000157	F-157D **Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident D family were notified at	07/04/2013

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	a fall with injury (Resident "B") for 2 for of 3 residents reviewed for falls in a sample of 3. Findings include: 1. The record of Resident "D" was reviewed on 06/03/13 at 6:50 a.m. Resident "D" was admitted to the facility on 11/12/12, with diagnoses including, but not limited to, history of falls, dizziness/giddiness, hypertension, edema, and anxiety. Resident "D" had incurred 8 falls between 02/26/13 and 05/23/13. Review of the facility's forms, titled, "FALL CIRCUMSTANCE, ASSESSMENT AND INTERVENTION," indicated the family of Resident "D" was not notified of the falls which occurred on: 02/26/13 @ 2:30 a.m. 03/12/13 @ 11:45 a.m. 03/13/13 @ 11:50 p.m. 03/25/13 @ 11:10 p.m. 05/23/13 @ 2:45 a.m. The DNS (Director Nursing Services) was interviewed on 06/04/13 at 9:00 a.m. The DNS was unaware the forms indicated the family had not been notified of the resident's falls. 2. The record of Resident "B" was		0400 on 5/23/13 of the fall. Resident B family were notified 5/22/13 in regards to UA order and fall earlier that morning. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:** The DHS or designee will review the 24 hour report, circumstance forms and change in condition forms for the last 3 days to ensure that documentation is in place to support that the physician, residents responsible party were notified timely of a change in condition. In addition, will ensure a response for the MD has been documented. **Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur:** DHS or designee will re-educate the Licensed Nurses on the following campus guidelines: 1. Physician Notification 2. Change in Condition Form-including the name of the responsible party, date, and time notified. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** Per the campus guidelines, the Nursing Leadership Team will review the 24 hour report, circumstances	

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	reviewed on 06/03/13 at 5:30 a.m. Resident "B," who resided on the dementia unit, was admitted to the facility on 08/01/11, with diagnoses including, but not limited to, muscle weakness, fatigue, diabetes, osteoporosis,dementia, hypertension, abnormal gait and difficulty walking. The resident had incurred a fall on 11/28/12, with no injury. The next fall for Resident "B" occurred on 05/22/13, at 1:15 a.m., which resulted in a subdural hematoma. Review of "NURSE'S NOTES" indicated a note from 05/13/13. The next entries indicated: "05/22/13 1050 [10:50 a.m.] N.O. [New Order] rec'd [received] for: UA [urinalysis] C&S [Culture & Sensitivity]. "05/22/13 1435 [2:35 p.m.] N.O. rec'd for head CT [Computerized Tomography] s [without] contrast. [name of family member] notified." "05/22/13 1645 [4:45 p.m.] Resident admitted to [Acute Care Facility: hospital name] per MD orders [name of family member] notified." The DNS (Director Nursing Services) was interviewed on 06/04/13 at 9:00 a.m. The DNS was unaware the family was not notified until over 12		forms and change of condition forms in a daily clinical meeting 5 days a week, ongoing. This review is to ensure the Physicians, responsible party and acute care center, if applicable, has been notified timely of a change in condition and that a response from the physician has been documented. The Daily Clinical Meeting Report will be completed to document the review of the above stated reports/forms. The following audit and /or observations will be conducted by the DHS or designee 2 times per week times 4 weeks, then monthly times 5 months to ensure compliance. Daily Clinical Meeting Report review to ensure documentation review of change in condition for timely MD, responsible party and acute care center (if applicable) notification and for documented MD response. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendations. **Date of Compliance: July 4, 2013**	

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	hours after the fall with injury. The RNC (Regional Nurse Consultant) provided a Policy & Procedure, titled, "GUIDELINES FOR RESPONSIBLE PARTY NOTIFICATION" dated 11/2010, on 06/04/13 at 1:10 p.m. The Policy indicated: "Purpose: To ensure the resident's responsible party is aware of all diagnostic test results or change in condition in a timely manner. Procedure: 1. Resident assessments for change in condition, suspected injury, event of unknown origin or ordered lab and/or other diagnostic tests should be completed in a timely manner. 2. The responsible party should be notified of change in condition or diagnostic testing results in a timely manner... 5. Documentation of notification attempts should be recorded in the resident medical record." This Federal tag relates to Complaint IN00129650.			

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	3.1-5(a)(1) 3.1-5(a)(2)			

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F000323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to ensure adequate supervision was provided and interventions were implemented to prevent falls for 2 of 3 residents reviewed for falls which resulted in a subdural hematoma injury for Resident B and a lower hip/buttock injury for Resident D. Findings include: 1. The record of Resident "B" was reviewed on 06/03/13 at 5:30 a.m. Resident "B", who resided on the dementia unit, was admitted to the facility on 08/01/11 with diagnoses including, but not limited to, muscle weakness, fatigue, diabetes, osteoporosis,dementia, hypertension, abnormal gait, and difficulty walking. Review of the most recent MDS Assessment (Minimum Data Set: a tool to provide guidance for planning resident care), dated 02/19/13, indicated the resident was cognitively impaired, required extensive assistance of 1 staff for transfers,	F000323	F323G **Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice:** Resident B: Interventions and care plans were revised on remission to campus on 5/25/13. To ensure their careplans interventions for falls were in place, including alarms which were in place and functioning. Resident D: Was reviewed at the time of survey to ensure their careplan interventions for falls were in place and functioning. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:** Current residents with alarms have been reviewed to ensure alarm is in place and functioning. Current residents that have fallen since May 1, 2013 have been reviewed to ensure their careplans has been updated with their interventions. **Measures put into place and systemic changes made to ensure that alleged deficient practice does not recur:**	07/04/2013

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	ambulation and toileting needs. The resident had incurred a fall on 11/28/12 with no injury. The next fall for Resident "B" occurred on 05/22/13, at 1:15 a.m., which resulted in a subdural hematoma. Review of a "FALL CIRCUMSTANCE, ASSESSMENT AND INTERVENTION" form indicated: "Date of fall: 05/22/13; Time of fall: 0115 [1:15 a.m.]; Location of fall: bathroom [room number]; witnessed: N [no];...Injury location: back of head; Hit head: [checked]... Neurochecks: WNL [Within Normal Limits]" The resident's vital signs were listed and the form indicated the resident did not complain of pain and was transferring self. The form indicated the physician and family were notified but did not include the date and time. The area for "Other Comments" was blank and did not include any further information. The fall investigation did not distinguish between interventions utilized prior to the fall or if interventions were added post fall. Review of "NURSE'S NOTES" indicated a note from 05/13/13. The next entries indicated: "05/22/13 1050 [10:50 a.m.] N.O. [New Order] rec'd [received] for: UA		All nursing staff has been in serviced on hourly rounding, documentation, fall prevention and safety with interventions. Nurses have been re-educated on completing the Circumstances and re-assessment forms with accuracy and completion. In addition: Recording intervention prior to fall and new interventions post fall. The care plans have been revised to reflect the individualized interventions at the morning CCM meetings and revised as deemed necessary for changes. Care plans and C.N.A. assignment sheets have been updated with current information to the care of the resident. **How the corrective measures will be monitored to ensure that the alleged deficient practice does not recur:** DHS/designee will review all Circumstance assessments, and re-assessment. IDT team will review each incident at the CCM meetings-reviewing for accuracy and looking at the Root cause analysis of each fall as well as ensuring that he interventions is tangible and root cause driven. The interventions will be closely monitored x 4 weeks in the CCM meets for appropriateness and effectiveness. In addition: Ensure residents identified as a fall risk have interventions in place and careplans, C.N.A. assignment sheets are updated with their interventions for care. DHS/designee will audit	

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	[urinalysis] C&S [Culture & Sensitivity]. "05/22/13 1435 [2:35 p.m.] N.O. rec'd for head CT [Computerized Tomography] s [without] contrast. [name of family member] notified." "05/22/13 1645 [4:45 p.m.] Resident admitted to [Acute Care Facility: hospital name] per MD orders [name of family member] notified." The DNS (Director Nursing Services) was interviewed on 06/04/13 at 9:00 a.m. The DNS provided an "ACCIDENT/INCIDENT REPORT," completed on 05/22/13. The DNS indicated the form is an internal investigation report for facility use that does not appear in residents records for physician or outside review. The report indicated: "Describe exactly what happened:....Res [resident] transferred herself to the toilet, bed alarm sounded, when CRCA [CNA] [name] entered the room, res was laying on the bathroom floor." The form indicated the physician was notified on 05/22/13 at 3:00 p.m. for the fall. The area regarding family notification was blank. The report did not indicate information to explain the resident's bed alarm going off and the CNA not responding to the alarm until the resident had ambulated into the		seven days per week x 4 weeks, regarding the following: hourly rounding completion, adaptive equipment in place and functioning. Then, three times per week for 30 days or until substantial compliance is achieved. Audits will be reviewed during the monthly Quality Assurance meetings for six months. **Date of compliance: July 4, 2013**	

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	bathroom and sustained a fall. Review of the ACF (Acute Care Facility: hospital) discharge summary indicated the resident was admitted on 05/22/13 with a diagnosis of subarachnoid hemorrhage, and discharged back to the ECF (Extended Care Facility) on 05/25/13. The report indicated: "PROCEDURES:...3. Head CT, May 22, 2013, showing acute parenchymal hemorrhage with a small portion of the right parietal lobe. There is a small amount of acute subarachnoid hemorrhage in this region...." Care Plans, including but not limited to, Cognition, ADL (Activities of Daily Living: transfers, hygiene, locomotion, toileting needs) Self-Care Deficit, and Restraint/Enabler (for 1/2 siderails) were reviewed. There was no Care Plan specific to falls in the resident's record. The Care Plans were last updated 03/2013. The Restraint/Enabler Care Plan indicated, and included but was not limited to: "Problems: weakness 2* (secondary to) osteoporosis; bed mobility, transfer's; Interventions:...Bed alarm, Mat...beside bed, Low bed, ...Encourage use of call light,			

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	Respond to call light promptly...Anticipate resident needs, Respond promptly to needs...." The DNS was interviewed on 06/04/13 at 1:00 p.m. The DNS indicated CNA's no longer had preprinted CNA worksheets (a paper with residents listed by room/unit which included quick reference information related specific to each resident). The DNS indicated the facility now utilized a kiosk for resident information where a CNA could visually reference information, if needed, in regards to a specific resident. The DNS provided a 1 page printout of the form for Resident "B," which was in narrative style, from 08/06/12 through 05/30/13, that included but was not limited to, and indicated: "09/12/12: Wanders." "0/12/12 Fall risk. Bed alarm. Self-releasing wheel chair seat belt. Bed in low position. Floor mat while in bed. Wears glasses. Assist of one for transfers....Observe for wandering...." Interview with the DNS, at the time, indicated the CNA referral information was updated as needed.			

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	2. The record of Resident "D" was reviewed on 06/03/13 at 6:50 a.m. Resident "D" was admitted to the facility on 11/12/12 with diagnoses including, but not limited to, history of falls, dizziness/giddiness, hypertension, edema, and anxiety. Review of the most recent MDS Assessment (Minimum Data Set: a tool to provide guidance for planning resident care), dated 05/07/13, indicated Resident "D", who resided on the dementia unit, was cognitively impaired, required extensive assist of 2 or more staff for transfers, ambulation, and toileting, and was frequently incontinent of bowel and bladder. Resident "D" had incurred 8 falls between 02/26/13 and 05/23/13. Review of the "FALL CIRCUMSTANCE, ASSESSMENT AND INTERVENTION" forms for the falls, which included but was not limited to, injuries and root causes, indicated: "02/26/13 0230 [2:30 a.m.] No injury... Root cause: Non-compliant c [with] safety measure]." "03/05/13 2:15 p.m. No injury...Root cause: Slipped out of w/c [wheelchair]." "03/12/13 1145 [11:45 a.m.] No injury...Root cause: Attempting to get out of recliner unassisted."			

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	"03/13/13 11:50 p.m. No injury. Rood cause: Non-compliant c transfers & need to toilet." "03/23/13 0050 [12:15 a.m.] No injury...Root cause: blank" "03/25/13 2310 [11:10 p.m.] Injury: (R) [right] lower hip/buttocks...Root cause: Non-compliant c safety measures." "04/19/13 1430 [2:30 p.m.] No injury...Root cause: self transferring." "05/23/13 0245 [2:45 a.m. Injury: Back of head & (L) [left] side of back. Hit head...Root cause: Balance. Non-compliant resident." Review of the information on the forms indicated numerous times the cognitively impaired resident removed or unplugged alarms located on the bed and or chair. The 8 of 8 forms reviewed for Resident "D" were not completely filled out. The fall investigations did not distinguish between interventions utilized prior to the falls and what interventions were added post fall. Review of "NURSE'S NOTES," for narrative documentation, from admission to survey, indicated: "05/23/13 0600 [6:00 a.m.] N.O. [New Order] received for: may send to ER to eval & treat...." "05/23/13 1000 [10:00 a.m.] N.O.			

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	decrease Lasix to 40 mg 1 daily, decrease Potassium to 10 mEq (milliequivalent) 1 daily." The narrative did not include any information in regards to the head injury described in the "FALL CIRCUMSTANCE REPORT". There was no documentation in the NURSE's NOTES in reference to the 03/25/13 fall with (R) lower hip/buttock injury or in regard to any of the falls incurred since admission. The DNS (Director Nursing Services) was interviewed on 06/04/13 at 9:00 a.m. The DNS provided an "ACCIDENT/INCIDENT REPORT," for each fall. The DNS indicated the forms are internal investigation reports for facility use that do not appear in resident records for physician or outside review. The reports referred to the cognitively impaired resident being educated on using the call light and instructions to not unplug/disable the alarms. The investigations did not address interventions other than reminding the cognitively impaired resident to use her call light or to monitor alarms. Review of Care Plans for Resident "D," included but were not limited to, COGNITIVE FUNCTION, ADL: SELF-CARE DEFICIT,			

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	INCONTINENCE and FALLS. Review of the FALLS Care Plan, initiated on 11/21/12 and updated on 02/19/13, included but were not limited to: "Problems: History of falls, dementia, and unsteady gait. Goals: Resident will have reduced risk of fall related injury by utilizing fall precautions. Interventions:...Call light within reach...Remind resident and reinforce safety awareness: Lock breaks on bed, chair, etc before transferring; When rising from a lying position, sit on side of bed for a few minutes before transferring/stand...." The DNS was interviewed on 06/04/13 at 1:00 p.m. The DNS indicated CNA's no longer had preprinted CNA worksheets (a paper with residents listed by room/unit which included quick reference information related specific to each resident). The DNS indicated the facility now utilized a kiosk for resident information where a CNA could visually reference information, if needed, in regards to a specific resident. The DNS provided a 1 page printout, dated 05/20/13, of the form for Resident "D," which included 2 entries: "05/20/13 bed and chair alarms,			

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	dycem to chair, self releasing seatbelt alarm, bed in low position. I require the assistance of one for transferring. I also have a tendency to shut off my alarms so please listen closely for them." "05/20/13 I have a diagnosis of dementia and I look for my husband, who has passed. Please remind me that he is ok. Activities that I have stated that I enjoy include cards, crafts, exercise, talking, cooking and watching TV. I enjoy having things available to read. Visitors are welcomed. I enjoy taking care of my personal items. My family come to visit me. I prefer for them to be involved in my care. My goal for activities will be to remain engaged in activities that bring me pleasure. Please reevaluate my interest by 08/17/13." Confidential interviews were conducted with staff members on all three shifts throughout the survey, which included, but were not limited to, RN's, LPN's, and CNA's. LPN #3 indicated the CNA's no longer utilized CNA worksheets and could only access resident care direction by prior knowledge, inquiring of a nurse or another CNA, or accessing the kiosk which provided care information for			

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	each resident. LPN #3 indicated the kiosks were located in the hallways and could only be accessed by one CNA at a time. CNA #4 was interviewed and indicated resident care needs were accessed through the kiosk. The CNA indicated if unfamiliar with care needs and a call light went off, the kiosk was the only access point for information beyond prior knowledge or asking a co-worker. A Policy and Procedure, titles, "FALLS MANAGEMENT PROGRAM GUIDELINES: 03/2008" was provided by the DNS on 06/04/13 at 8:45 a.m. Review of the Policy and Procedure indicated: "PROCEDURE: 1....b. Care plan interventions should be implemented that address the resident's risk factors... 3. Should the resident experience a fall, the attending nurse shall complete the "Fall circumstance and Reassessment Form". The form includes an investigation of the circumstances surrounding the fall to determine the cause of the episode, a reassessment to identify possible contributing factors, interventions to			

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	reduce risk of repeat episode and a review by the IDT [Intra Disciplinary Team] to evaluate thoroughness of the investigation and appropriateness of the interventions. 4. An "Accident and Incident Report" should be completed at the time of the incident. 5. The staff member attending to the resident at the time of the incident should notify the attending physician or medical director in the absence of the attending physician and the responsible party... 7. The nursing assistant assignment sheet and resident care plan should be updated to reflect any new or change in interventions. 8. Nursing staff will monitor and document continued resident response and effectiveness of interventions for 72 hours...." This Federal tag relates to Complaint IN00129650. 3.1-45(a)(2)			

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F000514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interviews, the facility failed to ascertain resident records were documented in a complete, consistent and accurate manner in regards to falls for 3 of 3 residents in a sample of 3 residents reviewed for falls. Resident B, Resident C and Resident D Findings include: The records of 3 residents were reviewed during the survey. The resident record review areas included, but were not limited to, assessments and fall information. Resident "B" was reviewed for 2 falls, Resident "C" was reviewed for 9 falls and Resident "D" was reviewed for 8 falls.	F000514	F-514D **Corrective actions accomplished for those residents found to have been affected by the alleged deficient practice:** Residents: B,C,D are confidential as apart of the compliant survey. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:** DHS or designee will review the fall circumstance forms for the past 30 days to ensure the forms are complete and accurate. **Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur:** DHS or designee will re-educate nurses on accurate completion of the fall circumstances assessment	07/04/2013

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	The facility utilized "SKILLED NURSING ASSESSMENT AND DATA COLLECTION" forms which list "Skilled: Reason," "Acute Change" and "Other" to clarify why the form was being used, and included, "Date," "Time" and "Nurse signature /title." The forms were specific to assessment issues, which included but were not limited to, Cognitive Patterns, Communication/Hearing, Pain, Elimination, Pulmonary, Cardiac and included an additional area for narrative charting to be documented. An interview with RN #3, on 05/03/13 at 7:30 a.m., indicated the forms were not required daily for documentation unless the resident required daily Medicare documentation. The facility had a traditional, two sided, "NURSE'S NOTE" for additional narrative documentation. The facility had available circumstance specific forms, as exampled by, "FALL CIRCUMSTANCE, ASSESSMENT AND INTERVENTION", for focused documentation. The Fall Circumstance form addressed areas of Investigation, Fall Risk Re-Assessment, Prevention Update, and IDT (Intra-Disciplinary Team) Review. The back side of the form included 9 areas for 72 hour follow-up		form. DHS or designee will re-train nursing staff on the Falls Management Program Guidelines. **How the corrective measure will be monitored to ensure the alleged deficient practice does not recur:** DHS or designee will review fall circumstance forms after they are initiated to ensure they are complete and accurate times 60 days. The results of the audits will be presented to the Quality Assurance Committee on a monthly bases until consistent applications of guidelines are noted. Periodic evaluation will be conducted for applicable guidelines **Date of compliance: July 4, 2013**	

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	documentation. 1. The record of Resident "B" was reviewed on 06/03/13 at 5:30 a.m. Resident "B", who resided on the dementia unit, was admitted to the facility on 08/01/11 with diagnoses including, but not limited to, muscle weakness, fatigue, diabetes, osteoporosis,dementia, hypertension, abnormal gait, and difficulty walking. Review of the most recent MDS Assessment (Minimum Data Set: a tool to provide guidance for planning resident care), dated 02/19/13, indicated the resident was cognitively impaired, required extensive assistance of 1 staff for transfers, ambulation and toileting needs. A fall for Resident "B" occurred on 05/22/13, at 1:15 a.m., which resulted in a subdural hematoma. Review of a "FALL CIRCUMSTANCE, ASSESSMENT AND INTERVENTION" form indicated: "Date of fall: 05/22/13; Time of fall: 0115 [1:15 a.m.]; Location of fall: bathroom [room number]; witnessed: N [no];...Injury location: back of head; Hit head: [checked]... Neurochecks: WNL [Within Normal Limits]" The resident's vital signs were listed and the form indicated the resident did not			

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	complain of pain and was transferring self. The form indicated the physician and family were notified but did not include the date and time. The area for "Other Comments" was blank and did not include any further information. The fall investigation did not distinguish between interventions utilized prior to the fall or if interventions were added post fall. Review of "NURSE'S NOTES" indicated a note from 05/13/13. The next entries indicated: "05/22/13 1050 [10:50 a.m.] N.O. [New Order] rec'd [received] for: UA [urinalysis] C&S [Culture & Sensitivity]." "05/22/13 1435 [2:35 p.m.] N.O. rec'd for head CT [Computerized Tomography] s [without] contrast. [name of family member] notified." "05/22/13 1645 [4:45 p.m.] Resident admitted to [Acute Care Facility: hospital name] per MD orders [name of family member] notified." The DNS (Director Nursing Services) was interviewed on 06/04/13 at 9:00 a.m. The DNS provided an "ACCIDENT/INCIDENT REPORT," completed on 05/22/13. The DNS indicated the form is an internal investigation report for facility use that does not appear in residents records			

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	for physician or outside review. The report indicated: "Describe exactly what happened:....Res [resident] transferred herself to the toilet, bed alarm sounded, when CRCA [CNA] [name] entered the room, res was laying on the bathroom floor." The form indicated the physician was notified on 05/22/13 at 3:00 p.m. for the fall. The area regarding family notification was blank. The report did not indicate information to explain the resident's bed alarm going off and the CNA not responding to the alarm until the resident had ambulated into the bathroom and sustained a fall. The DNS was interviewed on 06/04/13 at 1:00 p.m. The DNS indicated CNA's no longer had preprinted CNA worksheets (a paper with residents listed by room/unit which included quick reference information related specific to each resident). The DNS indicated the facility now utilized a kiosk for resident information where a CNA could visually reference information, if needed, in regards to a specific resident. The DNS provided a 1 page printout of the form for Resident "B," which was in narrative style from 08/06/12 through 05/30/13, included but was not limited to, and indicated:			

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	"09/12/12: Wanders." "0/12/12 Fall risk. Bed alarm. Self-releasing wheel chair seat belt. Bed in low position. Floor mat while in bed. Wears glasses. Assist of one for transfers....Observe for wandering...." Interview with the DNS, at the time, indicated the CNA referral information was updated as needed. 2. The record of Resident "C" was reviewed on 06/13/13 at 7:30 a.m. Resident "C's" most recent admission to the facility was on 12/04/12, with diagnoses which included, but were not limited to, muscle weakness, difficult ambulation, abnormal gait, urinary incontinence, Parkinson's, anxiety, anorexia and anemia. The resident had incurred 9 falls between 01/13/13 and 05/31/13. Review of a MDS (Minimum Data Set: a tool to provide guidance for planning resident care), dated 01/13/13, indicated the resident was cognitively intact, required extensive assistance of 1 staff for transfers and toileting, limited assistance for ambulation, and was always continent of bowel and bladder. Review of a MDS dated 04/18/13, indicated Resident "C" had incurred a significant change in			

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	status. The MDS indicated the resident was cognitively impaired, required extensive assistance of 2 or more staff for bed mobility, transfers, ambulation, and toileting and was frequently incontinent of bowel and occasionally incontinent of bladder. The resident had sustained 6 falls between the 2 MDS for Resident "C." Review of the "FALL CIRCUMSTANCE, ASSESSMENT AND INTERVENTION" forms for the falls did not include information for a fall which on 03/30/13, which resulted in a pelvic fracture. Review of the information for the other falls, included but was not limited to injury assessment and root causes, indicated: "01/13/13:... no injury....Root cause: balance issues r/t (related to) Parkinson's Dx (diagnosis)...." "02/27/13: low back...Root cause: balance issues recent med ^ [change]...." "03/01/13: no injury...Root cause: recent med change...." "03/13/13: left lower back...Root cause: recent med changes et [and] c/o [complaint/of] weakness et lightheadedness...." "04/18/13: none...Root cause: blank...."			

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	Additionally, the resident had falls on: "05/10/13: hit head: (R) (right) occipital...Root cause: balance/non-compliant resident...." "05/31/13 @ 8:30 a.m.: no injury...Root cause: balance/weakness...." "5/31/13 @ 10:30 a.m.: no injury...." (1 form was used for both 05/31/13 falls.) Review of 8 of 8 forms indicated the information was incomplete or inconsistent. The documentation did not indicate the date and time the physician and the family were notified. Review of NURSE'S NOTES, from admission through 05/31/13, indicated entries for 3 of the resident's falls: "03/30/13 1350 [1:50 p.m.] Resident had a fall in her room d/t [due/to] getting up unassisted to look for addresses. She had been sitting in her recliner c [with] call light attached to her chair arm within reach...Another resident came to writer to say resident had fallen in her room. When entering room still another resident on her scooter was in the room & stated she saw her fall...lost her balance falling on her right hip beside her bed....Hip not			

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	rotated out but when gotten up & applying pressure, resident grimaces & states it hurts really bad on the right side. When writer palpated area to right hip she also grimaced & stated it hurts...." "03/30/13 1800 96:00 p.m. Rec'd [received] updated from [ACF: Acute Care Facility: hospital name]. Resident has fx [fractured] pelvis et [and] will be admitted." "04/18/13 1540 [3:40 p.m.] Res [resident] stood up from bed unassisted, call light et safety alarm in place. 0 injury, CNA was present et coming around side of bed to res to assist her...." "05/31/13 1250 [12:50 p.m.] Res had 2 falls today attempting to transfer self....Add alarming seat belt to w/c [wheelchair]...." The DNS (Director Nursing Services) was interviewed on 06/04/13 at 9:00 a.m. The DNS provided an "ACCIDENT/INCIDENT REPORT" for each fall. The DNS indicated the forms are internal investigation reports for facility use that do not appear in resident records for physician or outside review. A report for the 03/3013 fall was provided and indicated:			

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	"Date of Occurrence: 03/30/13; Time of Occurrence: 1310 [1:10 p.m.]; Location: Residents room...; Describe exactly what happened...She was sitting in recliner c [with] call light clipped to chair arm & had been reminded to ask for help but she felt good she said & got up to look for addresses & fell..." "TYPE OF ACCIDENT/INCIDENT...2. Unassisted fall...DESCRIBE INJURY...(R) hip pains...ADDITIONAL INFORMATION: Res [resident] recent med changes felt better attempted to get address book et lost balance. fracture of pubic ramous." The DNS indicated there was no staff direction in regards to the identified Root Cause of balance issues and medication changes following the falls of Resident "C." Review of the ACF (Acute Care Facility: hospital) Discharge Summary indicated the resident was admitted to the ACF on 03/30/13, and discharged back to the ECF (Extended Care Facility: Nursing Home) on 04/11/13. The report indicated: "ADMISSION DIAGNOSES: 1. Pubic rami fracture. 2 Parkinson disease. 3. Confusion....ADMISSION HISTORY AND PHYSICAL EXAM:...presented			

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	to the ER from Blair Ridge ECF after falling. She complained of right-sided pain. She went to the ER and had x-rays which showed no evidence of fracture, but she had a CT scan showing the right superior pubic rami fracture. She was admitted to the hospital for pain management and treatment...." Review of a Care Plan for Falls for the cognitively impaired resident, included but was not limited to: "Problems: 02/25/13 05/25/13: history of falls; potential for falls. Goals:...Resident will have reduced risk of fall related injury by utilizing fall precautions. Interventions:...Provide environmental adaptations: ...half rails as enabler...Call light within reach...Remind resident and reinforce safety awareness: Lock breaks on bed, chair etc before transferring; When rising from a lying position, sit on side of bed for a few minutes before transferring/stand...." The DNS was interviewed on 06/04/13 at 1:00 p.m. The DNS indicated CNA's no longer had preprinted CNA worksheets (a paper with residents listed by room/unit which included quick reference information related specific to each resident). The DNS indicated the			

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	facility now utilized a kiosk for resident information where a CNA could visually reference information, if needed, in regards to a specific resident. The DNS provided a 2 page printout, from 10/09/12 through 05/28/13, of the form for Resident "C," which included but was not limited to the indicated entries: "10/09/12 Occasionally incontinent of bowels. Wears pull-ups." "04/25/13 I have a dx of muscle weakness and anxiety. My dx make it hard for me to move about easily. I enjoy being around others. At times I like to be taken back to my room if I am not feeling well. I enjoy getting my hair done in the beauty shop. My family visits often and the time I spend with them is important. When I participate in a group activity I enjoy cards, crafts, talking and cooking. I was a volunteer for years and I like to help others when I am able. Having music playing in my room is relaxing, if my player is not on please ask me if you can turn it on. I would like to have you come and provide 1 to 1 activities with me once a week. Please reevaluate my interests by 08/25/13." "05/28/13 I have a dx of Parkinson's which at times can make it difficult for			

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	me to care for myself. During my down times I require an assist of 1 for ADL's. I also use a w/ch daily, but when my symptoms subside I can use a walker but make sure I am safe because I have a history of falls. Due to my weakened state and fall history I have alarms on both my bed and chair. Make sure my call light is always in reach as I have poor impulse control and will attempt to walk without assistance. I also wear glasses and denture that I need to make sure I wear....Per [physician's name] I am to continue my OT [Occupational Therapy] therapy, 5 times a week for 30 days to improve on my functional abilities, and self care (ADL) abilities, w/c [wheelchair] management and cognitive training. Please do all you can to assist the OT in any way." "05/28/13 While I am here I receive both PT [Physical Therapy] and OT and require the use of lateral support in my w/c to help me maintain positioning." Review of the care information did not correspond with the most recent MDS, dated 04/18/13. Interview with the DNS, at the time, indicated the information was updated as needed.			

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	3. The record of Resident "D" was reviewed on 06/03/13 at 6:50 a.m. Resident "D" was admitted to the facility on 11/12/12, with diagnoses including, but not limited to, history of falls, dizziness/giddiness, hypertension, edema, and anxiety. Review of the most recent MDS (Minimum Data Set: a tool to provide guidance for planning resident care), dated 05/07/13, indicated Resident "D", who resided on the dementia unit, was cognitively impaired, required extensive assist of 2 or more staff for transfers, ambulation, and toileting, and was frequently incontinent of bowel and bladder. Resident "D" had incurred 8 falls between 02/26/13 and 05/23/13. Review of the "FALL CIRCUMSTANCE, ASSESSMENT AND INTERVENTION" forms for the falls, which included but was not limited to, injuries and root causes, indicated: "02/26/13 0230 [2:30 a.m.] No injury... Root cause: Non-compliant c [with] safety measure]." "03/05/13 2:15 p.m. No injury...Root cause: Slipped out of w/c [wheelchair]." "03/12/13 1145 [11:45 a.m.] No injury...Root cause: Attempting to get out of recliner unassisted."			

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	"03/13/13 11:50 p.m. No injury. Rood cause: Non-compliant c transfers & need to toilet." "03/23/13 0050 [12:15 a.m.] No injury...Root cause: blank" "03/25/13 2310 [11:10 p.m.] Injury: (R) [right] lower hip/buttocks...Root cause: Non-compliant c safety measures." "04/19/13 1430 [2:30 p.m.] No injury...Root cause: self transferring." "05/23/13 0245 [2:45 a.m. Injury: Back of head & (L) [left] side of back. Hit head...Root cause: Balance. Non-compliant resident." Review of the information on the forms indicated numerous times the cognitively impaired resident removed or unplugged alarms located on the bed and or chair. The 8 of 8 forms reviewed for Resident "D" were not completely filled out and 5 of 8 indicated the family was not notified of the fall. The forms did not indicate a date and time for physician or family notification. The fall investigations did not distinguish what interventions were being utilized prior to the falls or what interventions were added post fall. Review of "NURSE'S NOTES", for narrative documentation, from admission to survey, indicated:			

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	"05/23/13 0600 [6:00 a.m.] N.O. [New Order] received for: may send to ER to eval & treat...." "05/23/13 1000 [10:00 a.m.] N.O. decrease Lasix to 40 mg 1 daily, decrease Potassium to 10 mEq (milliequivalents) 1 daily." The narrative did not include any information in regards to the head injury described in the "FALL CIRCUMSTANCE REPORT." There was no documentation in the NURSE's NOTES in reference to the 03/25/13 fall with (R) lower hip/buttock injury or in regard to any of the falls incurred since admission. The DNS (Director Nursing Services) was interviewed on 06/04/13 at 9:00 a.m. The DNS provided an "ACCIDENT/INCIDENT REPORT," for each fall. The DNS indicated the forms are internal investigation reports for facility use that do not appear in resident records for physician or outside review. The reports referred to the cognitively impaired resident being educated on using the call light and instructions to not unplug/disable the alarms. Review of Care Plans for Resident "D", included but were not limited to, COGNITIVE FUNCTION, ADL: SELF-CARE DEFICIT,			

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	INCONTINENCE and FALLS. Review of the FALLS Care Plan, initiated on 11/21/12 and updated on 02/19/13, included but were not limited to: "Problems: History of falls, dementia, and unsteady gait. Goals: Resident will have reduced risk of fall related injury by utilizing fall precautions. Interventions:...Call light within reach...Remind resident and reinforce safety awareness: Lock breaks on bed, chair, etc before transferring; When rising from a lying position, sit on side of bed for a few minutes before transferring/stand...." The DNS was interviewed on 06/04/13 at 1:00 p.m. The DNS indicated CNA's no longer had preprinted CNA worksheets (a paper with residents listed by room/unit which included quick reference information related specific to each resident). The DNS indicated the facility now utilized a kiosk for resident information where a CNA could visually reference information, if needed, in regards to a specific resident. The DNS provided a 1 page printout, dated 05/20/13, of the form for Resident "D," which included 2 entries: "05/20/13 bed and chair alarms,			

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	dycem to chair, self releasing seatbelt alarm, bed in low position. I require the assistance of one for transferring. I also have a tendency to shut off my alarms so please listen closely for them." "05/20/13 I have a diagnosis of dementia and I look for my husband, who has passed. Please remind me that he is ok. Activities that I have stated that I enjoy include cards, crafts, exercise, talking, cooking and watching TV. I enjoy having things available to read. Visitors are welcomed. I enjoy taking care of my personal items. My family come to visit me. I prefer for them to be involved in my care. My goal for activities will be to remain engaged in activities that bring me pleasure. Please reevaluate my interest by 08/17/13." Confidential interviews were conducted with staff members on all three shifts throughout the survey, which included, but were not limited to, RN's, LPN's, and CNA's. LPN #3 indicated the CNA's no longer utilized CNA worksheets and could only access resident care direction by prior knowledge, inquiring of a nurse or another CNA, or accessing the kiosk which provided care information for			

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	each resident. LPN #3 indicated the kiosks were located in the hallways and could only be accessed by one CNA at a time. CNA #4 was interviewed and indicated resident care needs were accessed through the kiosk. The CNA indicated if unfamiliar with care needs and a call light went off, the kiosk was the only access point for information beyond prior knowledge or asking a co-worker. A Policy and Procedure, titles, "FALLS MANAGEMENT PROGRAM GUIDELINES: 03/2008" was provided by the DNS on 06/04/13 at 8:45 a.m. Review of the Policy and Procedure indicated: "PROCEDURE: 1....b. Care plan interventions should be implemented that address the resident's risk factors... 3. Should the resident experience a fall, the attending nurse shall complete the "Fall circumstance and Reassessment Form". The form includes an investigation of the circumstances surrounding the fall to determine the cause of the episode, a reassessment to identify possible contributing factors, interventions to			

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	reduce risk of repeat episode and a review by the IDT [Intra Disciplinary Team] to evaluate thoroughness of the investigation and appropriateness of the interventions. 4. An "Accident and Incident Report" should be completed at the time of the incident... 7. The nursing assistant assignment sheet and resident care plan should be updated to reflect any new or change in interventions. 8. Nursing staff will monitor and document continued resident response and effectiveness of interventions for 72 hours...." This Federal tag relates to Complaint IN00129650. 3.1-50(a)(1) 3.1-50(a)(2)			