

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155158	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/08/2015
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NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF THE WILLOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 ELIZABETH DR VALPARAISO, IN 46383
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F 0000  Bldg. 00	<p>This visit was for a Post Survey Revisit (PSR) for the Recertification and State Licensure Survey completed on October 19, 2015.</p> <p>Survey dates: December 8, 2015</p> <p>Facility number: 000078 Provider number: 155158 AIM number: 100289310</p> <p>Census bed type: SNF/NF: 63 Total: 63</p> <p>Census payor type: Medicare: 7 Medicaid: 47 Other: 9 Total: 63</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 26143, on December 14, 2015.</p>	F 0000	<p>The facility requests that this plan of correction be considered its credible allegations of compliance. Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited and is also not to be construed as an admission of interest against the facility, the Administrator, or any employee, agents, or other individuals who draft or may be discussed in the response and Plan of Correction. In addition, preparation and submission of the Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the corrections of a conclusion set forth in this allegation by the survey agency. Accordingly, the facility has prepared and submitted this Plan of Correction prior to the resolution of Appeal of this matter solely because of the requirements under State and Federal law that mandates submission of the Plan of Corrections a condition to participate in the Title 18 and Title 19 programs. The submission of Plan of Correction within this timeframe should in no way be of non-compliance or admission by the facility. This facility respectfully requests</p>	

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

TITLE

(X6) DATE

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

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F 0323 SS=G Bldg. 00	<p>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, observation, and interview, the facility failed to provide adequate supervision while toileting a resident resulting in the resident falling and obtaining a hip fracture for 1 of 1 residents reviewed for falls. (Resident #31)</p> <p>Finding includes:</p> <p>Resident #31's record was reviewed on 12/8/15 at 1:30 PM. Diagnoses included, but were not limited to, hemiplegia and hemiparesis (partial paralysis) following cerebral infarction (stroke) affecting left side and hypertension.</p> <p>A quarterly Minimum Data Set (MDS) assessment dated 8/9/15 indicated Resident #31 was cognitively intact and required an extensive one person physical assist for transfers and toileting.</p> <p>Review of Progress Notes indicated the</p>	F 0323	<p>consideration of paper compliance for the cited deficiencies</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</b> Resident# 31 assessed, Physician notified, Resident is his own responsible party and had no immediate family that he wanted notified, resident sent to hospital. 10/31/2015 Staff member reeducated on proper transfer technique and educated on not leaving residents standing unattended during transfer or care. Training was also given on gait belt use and staff member was retrained on both mechanical lifts (Sabina and Hoyer). Orientation was extended</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</b> A full facility audit of care plans and care guides will be conducted by Nursing on current residents to identify residents that need assistance with transfers by</p>	01/04/2016

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	<p>following:</p> <ul style="list-style-type: none"> <li>- 10/31/15 11:40 AM: "Writer (LPN #2) was informed by nurse (LPN #1) while I was on break my resident had fallen ... 10:50 AM ambulance called for transfer for resident to emergency room to eval (evaluate) and treat ...."</li> <li>- 11/5/15 6:47 PM: "Resident arrived to east wing ... post left hip fx. (fracture) ... Left hip dressing dry and intact ... per Dr (Surgeon's name) resident is to follow up with him in his office in a week for dressing change and removal of staples. Do not remove dressing ...."</li> </ul> <p>Review of care plans indicated Resident #31 was at risk for injuries from falls related to CVA with hemiplegia, neuropathy (numbness and/or weakness of the extremities), diuretic use, and may try to transfer self and must have staff assist.</p> <p>A State reportable dated 11/1/15 and facility investigation for Resident #31 was reviewed on 12/8/15 at 12:00 p.m. The reportable indicated the following: "Incident date: 10/31/15; Incident time: 9:35 AM Diagnosis: CVA (stroke) with left hemiplegia (weakness), HTN (hypertension), CAD (coronary artery disease) Brief Description of Incident: (Resident</p>		<p>12/22/2015. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b> Nursing Staff will receive reeducation related to proper transfer technique on all transfer methods. Staff members will be educated on resident safety during transfers and care to be completed by 01/04/2015. New staff orientation will be revised and preceptors put in place to ensure staff are adequately trained to ensure resident safety and have a clear understanding of job duties and company expectations to be completed by 01/04/2016.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</b> The DON or designee will observe 5 random resident transfers weekly on varied shifts to validate proper transfer technique as indicated on resident care plans and care guides. The DON or designee will interview residents and /or family within 72 hours of hospital return from a reportable injury to ensure there are no concerns. Audit results and system components will be reviewed by the QA Committee with subsequent plans of correction developed and implemented as deemed necessary. QA committee will determine after 6 months if further auditing is</p>		

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	<p>#31) who is alert x 3 and an assist of 1 was being assisted in his bathroom by CNA. (Resident #31) was standing and holding onto the grab bar and states his knees gave out and he fell. The CNA was right there and witnessed the event. The facility was notified by ER that x-ray revealed a fractured left hip and resident was being admitted for treatment.</p> <p>Type of Injury: left hip fracture Immediate Action Taken: The attending CNA immediately got assistance from the nurse. The first responder nurse assessed (Resident #31) in the bathroom and then with the help of other CNAs assisted (Resident #31) into bed for further assessment. (Resident #31) had no immediate complaints. When the regular hall nurse returned from break she too assessed (Resident #31) and he complained of left hip pain. Dr was notified and order to send to ER for evaluation was received. (Resident #31) is his own responsible party and has no immediately family to notify.</p> <p>Preventative Measures Taken: Will evaluate upon (Resident #31's) return from hospital. CNA who was with (Resident #31) at the time of fall was educated to use a gait belt and due to being a new CNA was also educated on transfers by the ADON and the restorative CNA.</p> <p>Follow up: 11/4/15 Resident still remains</p>		necessary. <b>By what date will the Systemic changes will be completed.</b> To be completed by 01/04/2016	

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	<p>in the hospital"</p> <p>The facility investigation completed by the former Director of Nursing (DON) included statements from CNA #1, LPN #1 who originally assessed the resident, and LPN #2 who was the regular hall nurse.</p> <p>The written statement dated 10/31/15 from CNA #1 regarding Resident #31's fall indicated, "I, a new CNA, was instructed to get the resident for a shower. Upon entering the resident's room, the resident informed me that he had to use the restroom very badly. Because he stated that he had to go right away, I helped him myself instead of calling for help. Everything went fine until the resident had to be wiped. The resident had taken a large BM (bowel movement) which required extensive wiping to clean so that he would not get a rash. The brief he was wearing had gotten soiled in the process; so I turned to get another brief. The resident fell in this moment, I immediately ran to get help to lift him back up. He fell on his elbow and left hip."</p> <p>The written statement regarding Resident #31's fall from LPN #2 indicated, "Writer asked (Resident #31) what had happened. Resident that's alert &amp; oriented x 3 with</p>			

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	<p>clear speech stated 'I was on the toilet, had bowel movement, stood up with assist of CNA, holding bar in bathroom being cleaned when my knees got weak. Next thing I know I'm falling. I landed on my left side. That hurts ..."</p> <p>The typed root cause analysis of Resident #31's fall completed by the former DON indicated the following: "Problem: (Resident #31) fell in bathroom while being toileted and fractured left hip. (Resident #31) has DX (diagnoses) of CVA with left hemiplegia. Why: He had an extra-large bowel movement that needed more time to be cleaned up by CNA. Why: new CNA was slower than normal CNA's in cleaning him up and got BM on his new brief and had to get another one from the room. Why: Extra briefs are kept in the closet in the rooms due to no cabinet space in bathroom Why: He was standing holding onto the grab bar to {sic} long while she cleaned him up and got a new brief Why: (Resident #31) states his knees gave out and he fell. CNA went to the resident room to assist him to the shower room and (Resident #31) stated he had to use the bathroom immediately. She did not want him to have an accident and therefore assisted</p>			

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	<p>him into his bathroom to use the toilet. (Resident #31) is a one assist and she transferred him onto the toilet. When he was finished she assisted him to a standing position to clean him up after his extra-large bowel movement. (Resident #31) was standing and holding onto the grab bar directly in front of him with his right hand. She was taking her time and cleaning him thoroughly when BM got on his new brief. She stepped out of the bathroom to obtain a new brief from his closet and it was during that time that (Resident #31's) knees gave out and he fell. CNA was educated by ADON who set up an in-service with the Restorative Aide and she was trained on use of gait belt, transfers 1 assist - where to stand, how to lift, how to work with people with hemiplegia and then also re-trained on lifts both Sabina and hoyer. She had previously been through lift training during orientation. CNA stated that this training help {sic} her immensely and she now feels more comfortable."</p> <p>A termination form for CNA #1 provided by the Administrator by her own request on 12/8/15 at 2:45 PM, indicated CNA #1 was terminated by the facility on 11/18/15. The form indicated, "Employee still in her 90 day probation period. Employee has been educated and</p>			

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	<p>orientation has been extended. Employee still unable to keep up with the work load as a CNA. Her performance at this time is not what the Willows feels is safe for the residents or the employee at this time. Consequence to the facility: Potential safety issues and state tags, resident care issues, employee safety. Reason for termination: Unable to perform CNA duties in a skilled facility at this time safely for the residents or the employee...."</p> <p>On 12/8/15 at 2:18 PM, the DON provided a copy of "Life Care Centers of America, Restorative Nursing Guidelines Manual, Chapter Two, Body Mechanics and Transfers" as the facility's guidelines for proper resident transfers by staff and deemed the document as current. The document stated, "F. Sit to Stand to Chair ... 2. Place the gait belt around the resident ...."</p> <p>Resident #31 was observed on 12/8/15 at 12:40 PM wheeling himself down the hallway in his wheelchair. His left hand was secured on a platform and his left foot had on a padded boot. He was interviewed at that time regarding his fall on 10/31/15. He indicated he had been standing in the bathroom holding onto the grab bar across from the toilet with his right hand while the CNA helped</p>			

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	<p>clean him up when she said she'd be right back and left him standing there for "awhile." He further indicated his knees got weak from standing so long, he called out for help, and then he fell, breaking his left hip. Resident #31 also indicated no one else had ever left him alone in the bathroom before and he had not been wearing a gait belt at the time. He indicated no one from the facility had come to talk to him specifically about what had happened during his fall since he returned from the hospital.</p> <p>Interview with the current DON on 12/8/15 at 12:51 PM, indicated she was the Assistant DON (ADON) at the time of the fall and CNA #1 no longer worked at the facility. She further indicated CNA #1 was partway through her first week of orientation on the floor and had received transfer training prior to being out on the floor. She further indicated CNA #1 had not used a gait belt for Resident #31 during the transfer, would have been given a gait belt to use during orientation, and should have used a gait belt for transferring a resident. CNA #1 was given an extended orientation after the incident and ended up leaving the facility before her probation period was completed.</p> <p>Interview with LPN #2 on 12/8/15 at</p>			

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	<p>1:21 PM, indicated she was at lunch when Resident #31 fell on 10/31/15 and she came into the resident's room shortly after he had been placed back in bed. At the time, he complained about pain to his affected L (left) leg when he normally can't feel anything there. Resident #31 indicated to her he had just had a BM, CNA #1 was helping him while he was hanging on to the bar across from the toilet when his knees just gave out and he fell . He didn't say anything to her about CNA #1 leaving him alone in the bathroom at that time. She immediately called the Physician and sent the resident to the ER for evaluation. After he was taken to the hospital, she asked CNA #1 and nurse responder LPN #1, to write up statements. She further indicated briefs for him were usually kept right on the sink since he uses them frequently and resident supplies were restocked in the rooms at the beginning of every shift.</p> <p>Phone interview with the former DON on 12/8/15 at 1:47 PM, indicated she conducted the investigation for Resident #31's fall on 10/31/15. She indicated after his return from the hospital, she welcomed him back, asked if he had any concerns, and the resident said no. She indicated she did not specifically ask what happened to cause his fall, since it was on the written statement of LPN #2.</p>			

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	<p>She further indicated she had talked directly to CNA #1, who reported that she had only gone to the closet area in his room to get another brief and that's when the resident fell. CNA #1 indicated she had a gait belt with her at the time but did not use it.</p> <p>3.1-45(a)(2)</p>			