

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/28/2016
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NAME OF PROVIDER OR SUPPLIER BENNETT PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 3928 HORNE AVE NEW ALBANY, IN 47150
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R 0000 Bldg. 00	<p>This visit was for the Investigation of Complaints IN00201601 and IN00201864.</p> <p>Complaint IN00201601 - Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00201864 - Substantiated. State residential deficiencies related to the allegations are cited at R36 and R214.</p> <p>Survey dates: June 27 and 28, 2016</p> <p>Facility number: 004442 Provider number: 004442 AIM number: N/A</p> <p>Residential Census: 38</p> <p>Residential sample: 4</p> <p>These State findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed by 34233 on June 29, 2016.</p>	R 0000		
R 0036 Bldg. 00	<p>410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the</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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	<p>resident ' s physician and the resident ' s legal representative when the facility has noticed:</p> <p>(1) a significant decline in the resident ' s physical, mental, or psychosocial status; or</p> <p>(2) 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>Based on interview and record review, the facility failed to notify the physician and family of a fall (Resident #C) in a timely manner for 1 of 4 residents reviewed for physician/family notification.</p> <p>Findings include:</p> <p>The clinical record for Resident #C was reviewed on 6/27/2016 at 10:45 a.m. Diagnoses included, but were not limited to, hypertension and syncope.</p> <p>On 6/27/16 at 11:00 a.m., the Administrator provided a copy of an incident report for Resident #C which indicated the resident fell on "...On 5/30/16 at 0715 [7:15 a.m.] resident was found on floor in apartment, at bedside. Resident stated she had fallen 5/29/16 at an unknown time, while getting ready for bed. Resident stated that she tripped on walker, and was unable to get to call light or pendant light that she had removed from her person prior to changing</p>	R 0036	<p><i>Resident C was discharged from the community on 5/30/2016. Current residents have the potential to be affected by the alleged deficient practice.</i></p> <p><i>The Care Services Manager re-educated current Licensed Nursing staff regarding timely notification to POA and MD on 7/6/2016 and will provide another in-service by 7/11/2016.</i></p> <p>The Care Services Manager is responsible for sustained compliance. The Care Services Manager will review incidents daily during normal business hours to ensure compliance for MD and family notification. Monitoring will be ongoing.</p>	07/27/2016

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	<p>clothes...Action Taken added -- 6/2/2016 Nursing evaluation; assisted to chair x [times] 2 staff; sent to ER [emergency room] and admitted to hospital after second fall at 0930 [9:30 a.m.]...."</p> <p>The Universal Incident Report, for Resident #C's first fall, was provided by the Administrator on 6/27/16 at 2:55 p.m. It included, but was not limited to, the following: "...Incident Date: 5/29/16...Incident Time: Bed time [PM box marked with an x]...Nature of Incident/Occurrence...Fall...Unwitnessed. ..Reported By: [CNA #4's first name] @ [sic] [at] 5/30/16 @ [at] 7:15 am...Type of Injury...Bruise...Part of Body Affected...R [right] Elbow...L [left] Elbow...Notification...Name of Family Member...[Resident #C's POA's [Power of Attorney] first name]...Date: 5/30...Time: 9:00 [AM marked with an x]...Name of Physician Notified: [name of Resident #C's physician]...Date: 5/30/16...Time: 9:45 [AM marked with an x]...MD [medical doctor] Instructions: (notified about both falls, sent to ER.)...."</p> <p>The Universal Incident Report, for Resident #C's second fall, was provided by the Administrator on 6/27/16 at 2:55 p.m. It included, but was not limited to, the following: "...Incident Date: 5/30/16...Incident Time: 9:30 [AM</p>			

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	<p>marked with an x]...Nature of Incident/Occurrence...Fall...Unwitnessed. ..Reported By: [CNA #4 and #5's first names]...Type of Injury...Skin Tear...Part of Body Affected... L [left] hand...Notification...Name of Family Member...[Resident #C's POA's first name]...Date: 5/30...Time: 10:00 [AM marked with an x]...Name of Physician Notified: [name of Resident #C's physician]...Date: 5/30/16...Time: 10:00 [AM marked with an x]...MD [medical doctor] Instructions: send to hospital...."</p> <p>During an interview on 6/27/16 at 2:45 p.m., the DON (Director of Nursing) indicated Resident #C's family was not notified because he/she was alert and oriented to person, place, and time.</p> <p>The clinical record indicated Resident #C had an active Power of Attorney.</p> <p>During an interview on 6/28/16 at 10:52 a.m., LPN (Licensed Practical Nurse) #3 indicated the physician and family should be notified immediately when a resident has a fall.</p> <p>The current policy titled "RESIDENT FALL RESPONSE", dated 7/1/2014, was provided by the Administrator and DON on 6/27/16 at 2:50 p.m. It included, but was not limited to, the following:</p>			

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R 0214 Bldg. 00	<p>"...When a resident falls, staff will respond to the emergency and provide assistance as indicated...Physician notification...Family/responsible party notification...."</p> <p>410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident.</p> <p>Based on interview and record review, the facility failed to ensure staff followed the fall response policy and procedure when a resident with an unwitnessed fall (Resident #C) indicated he/she hit his/her head at the time the fall occurred for 1 of 4 residents reviewed for accidents.</p> <p>Findings include:</p> <p>On 6/27/16 at 11:00 a.m., the Administrator provided a copy of an incident report for Resident #C which included, but was not limited to, the following: "...Incident Date: 5/30/2016...Incident Time: 7:15AM...Residents Involved...[Resident #C's name]...Brief Description of</p>	R 0214	<p><i>ResidentC was discharged from the community on 5/30/2016. Current residents have the potential to be affected by the alleged deficient practice. The Care Services Manager re-educated current Licensed nursing staff regarding appropriate policy for post fall procedures with an unwitnessed fall or if a resident reports he/she hit his/her head, on 7/6/2016 and will provide another in-service by 7/11/2016. The Care Services Manager is responsible for sustained compliance. The Care Services Manager will review falls with licensed staff to ensure appropriate procedure is followed related to unwitnessed falls and reports of resident hitting his/her head with a fall. Monitoring will be ongoing.</i></p>	07/27/2016

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	<p>Incident...Description added --6/2/2016 On 5/30/16 at 0715 [7:15 a.m.] resident was found on floor in apartment, at bedside. Resident stated she had fallen 5/29/16 at an unknown time, while getting ready for bed. Resident stated that she tripped on walker, and was unable to get to call light or pendant light that she had removed from her person prior to changing clothes...Type of injury added --6/2/2016 Bruises to head, neck and extremities. skin [sic] tear x [times] 2 to left hand each measuring 2 cm [centimeters]...Action Taken added --6/2/2016 Nursing evaluation; assisted to chair x [times] 2 staff; sent to ER [emergency room] and admitted to hospital after second fall at 0930 [9:30 a.m.]..."</p> <p>On 6/27/16 at 2:55 p.m., the Administrator provided a copy of the document titled, "Universal Incident Report", dated 5/30/16 at 7:15 a.m. It included, but was not limited to, the following: "1st fall [handwritten on the top right corner]...Incident Date: 5/29/16...Incident Time: Bed time [PM box marked with an x]...Nature of Incident/Occurrence...Fall...Unwitnessed. ..Reported By: [CNA #'s first name]...Type of Injury...Bruise...Part of Body Affected...R [right] Elbow...L [left] Elbow...Facts Observed at Scene...Res</p>			

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	<p>[resident] stated she fell while getting ready for bed, crawled to the side of the bed was [sic] unable to get up...remained on the floor. Found @ [at] 7:15 this AM..."</p> <p>On 6/27/16 at 2:55 p.m., the Administrator provided a copy of the document titled, "Universal Incident Report", dated 5/30/16 at 9:30 a.m. It included, but was not limited to, the following: "2nd fall [handwritten on the top right corner].....Incident Date: 5/30/16...Incident Time: 9:30 [AM marked with an x]...Nature of Incident/Occurrence...Fall...Unwitnessed. ..Reported By: [CNA #4 and #5's first names]...Type of Injury...Skin Tear...Part of Body Affected... L [left] hand...Facts Observed at Scene...Resident attempted to walk from her sitting chair to the rest room. Resident states she doesn't know what happened but she fell..."</p> <p>The nurses note, dated 5/30/16 at 9:00 a.m., included, but was not limited to the following: "CNA [Certified Nursing Assistant] reported to this nurse @ [at] 7:15 [sic] [7:15 a.m.]. CNA found resident on the floor, next to her bed...Resident has bruising to both elbows...Resident states she hit her head on the bathroom floor..."</p>			

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	<p>The written statement, dated 6/3/16 and untimed, included, but was not limited to, the following: "...I came into work at 6am [sic] [6:00 a.m.]...I received report from the off-going nurse....my aide [CNA #4's first name] reported to me around 7 am [sic] [7:00 a.m.], that a resident was on the floor in his/her room...the patient reported that she was getting ready for bed (the night before, between 8:30-9 pm [sic] [8:30 p.m. - 9:00 p.m.]...Resident stated that as she was coming out of the bathroom [sic] she hit the door frame with her walking [sic] [walker], causing her to stub [sic] her toe and lose her balance. Patient then stated she fell backwards into the bathroom, hitting her head on the bathroom floor...Please take this as a statement of the facts told to this nurse by the patient on the day of the incident..."</p> <p>During an interview on 6/28/16 at 10:52 a.m., LPN (Licensed Practical Nurse) #3 indicated, per facility policy, if a resident who had an unwitnessed fall or hits their head during a fall, we call 911.</p> <p>The current policy titled "RESIDENT FALL RESPONSE", dated 7/1/2014, was provided by the Administrator and DON on 6/27/16 at 2:50 p.m. It included, but was not limited to, the following: "...When a resident falls, staff will</p>			

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	respond to the emergency and provide assistance as indicated...If the resident is suspected to have struck their head or the resident was witnessed striking their head (even if no any [sic] injuries are noted), IMMEDIATELY CALL 9-1-1. Emergency personnel should be informed that the resident needs to be assessed for a possible closed head injury..."			