

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E281	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/29/2012
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NAME OF PROVIDER OR SUPPLIER  GOSPORT NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 27 S SEVENTH ST GOSPORT, IN 47433
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F0000	<p>This visit was for the Investigation of Complaint IN00103990.</p> <p>Complaint IN00103990 substantiated, federal/state deficiencies related to the allegations are cited at F323.</p> <p>Survey date: February 29, 2012</p> <p>Facility number: 000409 Provider number: 15E281 AIM number: 100291270</p> <p>Survey team: Joyce Hofmann, RN</p> <p>Census bed type: NF: 42 Total: 42</p> <p>Census payor type: Medicaid: 39 Other: 3 Total: 42</p> <p>Sample: 3</p> <p>This deficiency also reflects state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on March 1, 2012 by Bev Faulkner, RN</p>	F0000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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

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F0323 SS=D	<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.</p> <p>Based on interview and record review, the facility failed to adequately supervise and place assistive devices for 1 of 3 residents reviewed for falls in a sample of 3. [Resident #B]</p> <p>Findings include:</p> <p>Resident #B's closed clinical record was reviewed on 02/29/12 at 10:20 a.m., and indicated the resident was admitted to the facility on 12/16/11. The resident had diagnoses which included, but were not limited to, falls, leukemia, coronary artery disease, degenerative joint disease, history of right shoulder fracture, and history of rib fractures.</p> <p>On 12/17/11 at 6 p.m., Nurse's Progress Notes indicated, "Res [Resident] found on floor by laundry room door. Alert but confused. Has lg [large] skin tear on (L) [left] elbow, laceration on (L) eyebrow from glasses, hematoma and 2 skin tears on back of head b/p [blood pressure] 120/60 p [pulse] - 60 r [respirations] - 20. Cold compresses applied to skin tears.</p>	F0323	<p>The corrective action accomplished for the resident found to have been affected by the deficient practice is that the resident is no longer with the facility. He did not return after the fall. Other residents having the potential to be affected by the same deficient practice will be identified by fall risk assessments. If they are determined to be a fall risk, a chair alarm will be initiated and resident will be monitored to determine if a physical restraint is necessary for safety. Fall risk assessments will be done upon admission, after falls, and quarterly. Measures put into place include inservicing staff on those residents who are fall risks and the need to monitor them by keeping them close to the nursing station and not leaving unattended in the activity/dining area. The corrective action will be monitored by the DON/designee with weekly checks in the dining/activity area to make sure no fall risk resident is left unattended. Checks will be done weekly times 4 weeks, monthly times 3 months, and then quarterly. Findings will be</p>	03/30/2012			

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	<p>EMS [Emergency Medical Service] called to transport res to [name of hospital] ER [emergency room]. [Name of POA (Power of Attorney)] notified and will meet res [at] ER. Hospice notified and nurse will notify [name of physician]."</p> <p>Review of the Admission Nursing Assessment, dated 12/16/11, indicated Resident #B's functional status as wheelchair only; needed assist of 1 person for transfers; and was full weight bearing.</p> <p>Review of facility records, dated 12/17/11, indicated Resident #B needed extensive assist of 2 persons for bed mobility, transfers, and toilet use.</p> <p>Review of a routine Hospice visit note, dated 12/13/11, indicated the resident had increased fatigue and weakness, needed assistance of others to transfer and ambulation support as gait was "unsteady/unsafe", unable to safely negotiate stairs, uses walls, etc. for support and requires the use of assistive device - "has quad canes in the home, will not use." "Pt. [Patient] states he almost fell in the bathroom this morning. Pt. was ambulating unassisted."</p> <p>Review of the Hospice Patient Information sheet dated as 12/15/11 indicated, "... Fall Risk High...."</p>		documented and discussed at the quarterly QA meetings.				

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	<p>Review of the facility's records of documentation sent to ISDH [Indiana State Department of Health], dated 12/26/11, indicated the resident was admitted to the facility for respite care and a stay of 5 days. The facility put Resident #B in a low bed with a bed alarm. When the resident was admitted, the son was shown by the Social Service Director the facility's lap buddy and the son agreed it would be okay to use it on his father when needed. The next evening, around 6 p.m., Resident #B had a fall by the laundry room door. The resident suffered a laceration on his left eyebrow from his glasses, a hematoma and 2 skin tears on the back of his head and a skin tear on his left elbow. Later in the evening, the charge nurse placed a call to the emergency room and was told the resident had suffered no fractures and was being admitted for observation. "In investigating the incident, the nursing assistant who had worked with him during the day stated that it took two people to toilet him during the day. Stated that he was unable to ambulate without two assist. He had sat in the dining room during most of the afternoon and evening. She stated he had a lap buddy on him in the early afternoon, but he had removed it. After dinner, we were busy taking resident's up to the West</p>				

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	<p>wing. We didn't think he could get out of the wheelchair by himself because he had not done it all day. ... During the time [name of Resident #B] fell (approximately 6pm), there were 44 residents in the facility with 3 CNA's, 1 LPN, and 1 RN in the facility. Two night shift CNA's had also reported for duty just before 6p...."</p> <p>Interview with the Social Service Director [SSD] on 02/29/12 at 1:50 p.m., indicated she was at the facility when Resident #B was admitted and she had put him in a low bed because he had fallen so much at home. The SSD indicated she suggested a lap buddy for the resident and the son was okay with that. The SSD indicated Resident #B never removed the lap buddy when she was at the facility, but lap buddies are removed when the residents eat.</p> <p>Interview with RN #1 on 02/29/12 at 2:21 p.m., indicated the facility had just finished with supper meal and staff had come up to the nurse's station to start passing 6 p.m. pills and a resident came up and said Resident #B was down. RN #1 indicated the resident had been in the dining room and had gotten up and walked to the laundry room hallway. RN #1 indicated the resident was assessed, was laying on his side, had a laceration on</p>						

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	<p>his head and arms and staff did immediate care. RN #1 indicated she called EMS, called the family, and called Hospice and Hospice said she would notify the doctor. RN #1 indicated the resident was in a wheelchair, had a lap buddy on and evidently took it off and got up. RN #1 indicated there was no alarm on the wheelchair and she did not remember what kind of footwear the resident had on. RN #1 indicated there were 2 nurses on duty and they usually have 3 or 4 aides. RN #1 indicated it was right after supper and the girls were bringing the residents up from supper and getting them ready for bed. RN #1 indicated it was explained to her he had a lap buddy and had been fine all day, napped in the afternoon, and the girls had gotten him up for supper.</p> <p>Interview with the Director of Nursing [DON] on 02/29/12 at 4 p.m. and 4:20 p.m., indicated CNA #1 had told her Resident #B had been very lethargic all day and it took 2 persons to take him to the bathroom. The DON indicated the lap buddy was by the wheelchair.</p> <p>Interview with LPN #1 on 02/29/12 at 4:36 p.m., indicated she admitted the resident and indicated he did have a lap buddy with him. LPN #1 indicated she did not recall a wheelchair alarm.</p>						

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	<p>Interview with CNA #1 on 02/29/12 at 4:44 p.m., indicated they had been feeding the residents and were pushing residents up from the dining room. CNA #1 indicated Resident #B had his lap buddy off and they thought since he had difficulty walking with 2 persons assist he would not try to get up on his own. Later, the kitchen staff told her the nurse needed help down by the laundry room and she went down and got cold compresses to hold pressure on the open areas. CNA #1 indicated the resident had been down in the dining room next to the radio; they tried to toilet him and had a hard time having him to stand and walk to the toilet. CNA #1 indicated the resident had a bed alarm, but did not have a chair alarm and she didn't know he needed a chair alarm as he was a new admit and they did not know much about him.</p> <p>Interview with LPN #2 on 02/29/12 at 4:49 p.m., indicated a resident had said Resident #B had fallen and she went down and saw him laying on the floor in the laundry hallway. Resident #B had a cut on his head, a hematoma on the back of his head and a cut over his left eyebrow. LPN #2 indicated they put cold compresses on the areas and called the ambulance. LPN #2 indicated she did not know if he had a lap buddy, didn't recall hearing an alarm, and didn't remember</p>			

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	<p>anything but the resident saying he was on the floor.</p> <p>This federal tag is related to Complaint IN00103990.</p> <p>3.1-45(a)(2)</p>				