

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 12/17/2013
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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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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00136950.</p> <p>Complaint IN00136950-Substantiated. No deficiencies to the allegations were cited.</p> <p>Survey dates: December 10, 11, 12, 13, 16, and 17, 2013</p> <p>Facility number: 000078 Provider number: 155158 AIM number: 100289310</p> <p>Survey team: Regina Sanders, RN, TC Jennifer Redlin, RN Caitlyn Doyle, RN Heather Hite, RN (December 10, 13, 16, and 17, 2013)</p> <p>Census bed type: SNF/NF: 60 Total: 60</p> <p>Census by payor source: Medicare: 11 Medicaid: 42 Other: 7</p>	F000000	<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 mandate 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</p>	
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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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	<p>Total: 60</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2</p> <p>Quality review completed on December 22, 2013, by Janelyn Kulik, RN.</p>		<p>request consideration of paper compliance for the cited deficiencies</p>	

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F000157 SS=D	<p>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).</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 and interview, the facility failed to notify a resident's Physician timely, related to a fall, increased complaints of pain and bruising of a leg, related to the</p>	F000157	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident 64's physician remains apprised of the resident's current	01/16/2014			

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	<p>fall, for 1 of 4 residents reviewed for falls. (Resident #64).</p> <p>Findings include:</p> <p>Resident #64's record was reviewed on 12/16/13 at 1:55 p.m. The resident's diagnoses included, but were not limited to, dementia, diabetes mellitus, and fracture of the tibia/fibula. The resident was admitted into the facility on 07/31/13 from another nursing facility and readmitted to the facility from an acute care facility on 09/19/13.</p> <p>A Nurses' Note, dated 09/14/13 at 11:38 p.m., indicated, "09/14/13 3-11 (p.m.):...At approx (approximately) 4 p.m. CNA was toileting resident, and resident slid off toilet on to floor on buttocks. Resident with AROM (active range of motion) in all extremities, denied c/o (complaints) pain or discomfort at time. Resident c/o #9 (pain rating with #10 being the worse) pain to the left knee/hip at 5 p.m., adm. (administered) PRN (as needed) Norco (narcotic pain medication) as ordered, c/o #4 pain to hip/knee at 6 p.m., adm. tylenol (sic) as ordered with positive results. (Physician's Name) informed of incident, resident's c/o pain, ordered X-ray to left hip, femur, and knee.</p>		<p>condition. 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: A facility audit related to any resident changes in condition as per notation on the facility 24 hour report form was reviewed from the previous 30 days to ensure that physician notification was completed in a timely manner. No issues were identified via this audit. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Licensed Nursing staff will be inserviced by 01/12/2014 by the Staff Development Coordinator regarding the facility policy referencing physician notification. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: During the change of condition clinical meeting (held Monday through Friday) Nursing Administration will audit the documentation noted on the 24 hour report form related to any residents experiencing a change in condition and will ensure physician notification is completed in a timely manner. Audit results and system components will be reviewed by the QA Committee with subsequent plans of correction developed and implemented as deemed necessary. Date Certain: January 16, 2014.</p>				

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	<p>(X-ray company) called, they will be in first thing in a.m...." There was a lack of documentation to indicate what time the resident's Physician was notified.</p> <p>During an interview on 12/17/13 at 9:30 a.m., the East Wing Unit Manager indicated she could not find a written Physician's order for the x-ray nor any documentation to indicate what time the Nurse (no longer employed) notified the Physician. She indicated the X-ray company was notified of the order on 09/14/13 at 8:16 p.m. (which was 4 hours after the resident had fallen). The DoN (Director of Nursing) indicated the Nurse blocked charted so she was unsure when the resident's Physician was notified.</p> <p>A Nurses' Note, dated 09/15/13 at 6:48 a.m., indicated, "Resident c/o #8 pain to left knee at 12:40 a.m. Bruising noted to left knee/leg; no bruising noted at 6 p.m. when PRN tylenol (sic) given. Resident able to move left leg from side to side...Resident woke up and requested PRN pain med (medicine) again at 6:50 a.m., PRN Norco adm. Bruising noted to be more extensive than at 12:50 p.m., will inform 7-3 nurse bruising must be measured..."</p>				

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	<p>There was a lack of documentation to indicate the Nurse notified the resident's Physician of the increased complaints of pain and the increased bruising.</p> <p>A Nurses' Note, dated 09/15/13 at 10:54 a.m. indicated, "...Bruise to left leg purple/blue in color. C/o pain to left leg given PRN pain medications. Awaiting x-ray to be done."</p> <p>A Nurses' Note, dated 09/15/13 at 2:30 p.m., indicated "Resident had x/ray done to right leg (should be left leg) results show acute proximal fracture to tibial (sic) and fibular. (Physician's Name) notified received orders to send to (Hospital Name)..."</p> <p>The Phycisian was not updated about the increased complaints of pain and bruising, until after the x-ray results at 2:30 p.m. were obtained.</p> <p>During an interview on 12/17/13 at 11:17 a.m., the East Wing Unit Manager indicated the nurse should have updated the Physician about the pain and the bruising.</p> <p>An undated facility policy, received by the DoN on 12/17/13 at 10:28 a.m. as current, titled, "Falls Management",</p>			

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	<p>indicated, "...The responsible party and physician are promptly notified of the occurrence and status of the resident...3. Follow-up for Falls:...The charge nurse or designee will update the physician and family as necessary of the resident's progress and response to the fall..."</p> <p>An undated facility policy, received by the East Wing Unit Manager on 12/17/13 at 11:12 a.m. as current, titled, "Changes in Resident's Condition or Status", indicated, "...Nursing services will be responsible for notifying the resident's attending physician when:...There is significant change in the resident's physical, mental, or emotional status...There is a need to alter the resident's treatment or medications significantly...Deemed necessary or appropriate in the best interest of the resident..."</p> <p>3.1-5(a)(2)</p>			

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F000226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to follow the facility's abuse policy and procedure, related to screening of potential employees for 3 of 5 employees reviewed, who were hired by the facility within the last 4 months. (CNA #3, LPN #5, and RN #6)</p> <p>Findings include:</p> <p>Employee records were reviewed on 12/17/13 at 1 p.m. The records indicated CNA #3 was hired on 10/8/13, LPN # 5 was hired on 10/8/13, and RN #6 was hired on 11/14/13.</p> <p>There was a lack of documentation to indicate past working/personal references were received for CNA #3, LPN #5, and RN #6.</p> <p>During an interview on 12/17/13 at 1:24 p.m., the Staff Development Coordinator indicated she was responsible for getting references for the Nursing Department and to</p>	F000226	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Written request for completion of employee references for C.N.A #3; LPN #5 and RN #6 has been forwarded to designated individuals. 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: An audit of all current facility employees will be conducted by administration to ensure that reference checks were completed prior to start of employment. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Staff Development Coordinator was inserviced by 12/31/2013 by the Executive Director regarding the facility policy on completing reference checks as part of pre-employment process for all new employees. Documentation of completion will be reflected on a new hire checklist form. How the corrective action(s) will be monitored to ensure the deficient practice will not</p>	01/16/2014	

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	<p>ensure employee records were up to date. She indicated references were not obtained for CNA #3, LPN #5, and RN #6. She indicated she did not know what happened. She indicated the facility's abuse policy was not followed.</p> <p>A facility policy, dated 02/2009, titled "Protection of Residents: Reducing the Threat of Abuse & Neglect", received from the Administrator as current, indicated, "...Screening Potential Employee...This facility will conduct reference checks and criminal conviction investigation checks on all employees who apply for employment..."</p> <p>3.1-28(a)</p>		<p>recur: Administration will validate reference check completion on new employee candidates prior to initiation of employment. Audit results and system components will be reviewed monthly by the QA Committee for 6 months with subsequent plans of correction developed and implemented as deemed necessary. Date Certain: January 16, 2014.</p>		

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F000250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>Based on record review and interview, the facility failed to provide medically related social services, related to a Psychological/Mental Health evaluation not completed as ordered for 1 of 6 residents reviewed for unnecessary medications. (Resident #72)</p> <p>Findings include:</p> <p>Resident #72's record was reviewed on 12/12/13 at 1:48 p.m. The resident's diagnoses included, but were not related to depression and dementia with behaviors.</p> <p>The Physician's Recapitulation Orders, dated 12/13, indicated the resident received Seroquel (anti-psychotic) 75 mg (milligrams) at bedtime and 12.5 mg twice a day and Buspar (anti-depressant) 10 mg twice a day.</p> <p>The Behavior Monitoring forms, dated 09/13 through 12/13 indicated the facility was monitoring the resident for the behavior of yelling at her peers.</p>	F000250	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #72: Referral for Psychological/Mental Health evaluation has been discontinued per physician order as resident is no longer exhibiting behavioral concerns of yelling at her peers. 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: An audit of all physician orders related to Psychological/Mental Health evaluations will be conducted to ensure completion of request. This audit will review orders from previous 6 months for all current residents. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Social Services Director will be inserviced on 1/09/14 per facility Social Services Consultant regarding the process for notifying outside psychological agency in a timely manner of all physician orders for mental health evaluations. The Social Services Director will track completion via use of an audit</p>	01/16/2014			

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	<p>A Physician's Telephone Order, dated 09/13/13, indicated an order for a Psychological/Mental Health evaluation and treatment.</p> <p>There was a lack of documentation to indicate the resident had received the Psychological/Mental Health evaluation as ordered by the Physician.</p> <p>During an interview on 12/12/13 at 3 p.m., the DoN (Director of Nursing) indicated the Psychological evaluation was not completed. She indicated it was missed. She indicated the Social Service Director (SSD) would have set up the Psychological evaluation.</p> <p>During an interview on 12/12/13 at 3:11 p.m., the SSD indicated Nursing did notify Social Service, and the request was found in the binder for referrals that had been made. She indicated she notified the company who would perform the Psychological evaluation and they indicated they had not been notified of the referral.</p> <p>During an interview on 12/12/13 at 3:21 p.m., the East Wing Unit Manager indicated the evaluation was ordered due to the resident's</p>		<p>form. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Nursing Administration will audit completion of Psychological/Mental Health Evaluations on a weekly basis for 6 months to ensure completion. Audit results and system components will be reviewed monthly by the QA Committee with subsequent plans of correction developed and implemented as deemed necessary. Date Certain: January 16, 2014.</p>		

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	depression. She indicated the SSD had asked nursing to get the order. 3.1-34(a)			

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</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 record review and interview, the facility failed to follow residents' care plans and Physician's Orders, related to a resident transfer and psychological support for 2 of 31 residents reviewed for Physician's Orders and care plans. (Residents #64 and #72)</p> <p>Findings include:</p> <p>1 .Resident #64's record was reviewed on 12/16/13 at 1:55 p.m. The resident's diagnoses included, but were not limited to, dementia, diabetes mellitus, and fracture of the tibia/fibula (leg).</p> <p>The Admission Minimum Data Set Assessment, dated 8/7/13, indicated the resident required extensive assistance of 2 or more staff for transfers and toilet use, was not steady and was only stable with human assistance when moving from seated to standing and moving on and off toilet.</p> <p>Fall Risk Assessments, dated</p>	F000282	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #64's care plan and physician orders have been amended to reflect current transfer instructions. Resident #72's referral for Psychological/Mental Health evaluation has been discontinued per physician order as resident is no longer exhibiting behavioral concerns of yelling at her peers. 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: A full facility audit of care plans and physician orders will be conducted by Nursing Administration by 01/12/2014 current residents to validate appropriate transfer orders. Amendments made when necessary. An audit of all physician orders related to Psychological/Mental Health evaluations will be conducted by 01/12/2014 to ensure completion of request. This audit to review orders from previous 6 months for all current residents. What measures will be put into place or what systemic changes will be</p>	01/16/2014

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	<p>07/31/13 and 09/14/13, indicated the resident was a high risk for falls with scores of 21 (10 or higher is at risk). The interventions indicated the resident had a low bed and alarms on her wheelchair and bed.</p> <p>A care plan, dated 08/08/13, indicated the resident was at risk for injuries from falls. The interventions included, alarm to w/c and bed.</p> <p>A care plan, dated 08/08/13, indicated the resident needed staff assistance with activities of daily living. The interventions included, 08/29/13 transfer with Sabina (stand up lift) lift.</p> <p>The Care Directive (care card for CNA's), dated 08/19/13 and received from the Director of Nursing (DoN), indicated the resident required assistance of two and the Sabina lift for transfers.</p> <p>A Nurses' Note, dated 09/14/13 at 11:38 p.m., indicated, "09/14/13 3-11 (p.m.):...At approx (approximately) 4 p.m. CNA was toileting resident, and resident slid off toilet on to floor on buttocks...(Physician's Name) informed of incident, resident's c/o pain, ordered X-ray to left hip, femur, and knee. (X-ray company) called, they will be in first thing in a.m...."</p>		<p>made to ensure that the deficient practice does not recur: Nursing Staff will receive education related to adherence to current physician orders/care plans related to resident transfer instructions. This education will be provided by the Staff Development Coordinator and completed by 01/12/2014. The Social Services Director was inserviced on 1/09/14 per facility Social Services Consultant regarding the process for notifying outside psychological agency in a timely manner of all physician orders for mental health evaluations. The Social Services Director will track completion via use of an audit form. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: The MDS Coordinator or designee will audit 5 care plans and physician orders weekly for 6 months to ensure adherence to current resident transfer instructions. Nursing Administration will audit completion of Psychological/Mental Health Evaluations on a weekly basis for 6 months to ensure completion. Audit results and system components will be reviewed monthly by the QA Committee with subsequent plans of correction developed and implemented as deemed necessary.</p>				

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	<p>A Fall Investigation, received from the DoN, dated 09/17/13 at 5:25 p.m., indicated, CNA #7 was interviewed and during the interview, CNA #7 indicated she transferred Resident #64 with one assistance to the toilet. CNA #7 then indicated she had left the room to answer a call light for another resident (leaving the resident alone in the bathroom) and when she returned, Resident #64 was sliding off the toilet. CNA #7 indicated she slid Resident #64 to the floor.</p> <p>During an interview on 12/16/13 at 4:35 p.m., the DoN indicated the resident was fall risk, had alarms, and should not have been left alone in the bathroom. She indicated there should have been two staff assisting with the transfer when the Sabina lift was used. She indicated the CNA had transferred the resident to the toilet by herself and without using the Sabina lift .</p> <p>2. Resident #72's record was reviewed on 12/12/13 at 1:48 p.m. The resident's diagnoses included, but were not related to depression and dementia with behaviors.</p> <p>A care plan, dated 05/15/13, indicated the resident had verbal outbursts,</p>			

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	<p>related to frustration and agitation. On 10/23/13, the resident will isolate herself to her room when frustrated or agitated was added to the care plan. The interventions included, "...Investigate/observe need for psychological/psychiatric support. Provide services...as ordered by the physician..."</p> <p>A Physician's Telephone Order, dated 09/13/13, indicated an order for Psychological/Mental Health evaluation and treatment.</p> <p>There was a lack of documentation to indicate the resident had received the Psychological/Mental Health evaluation as ordered by the Physician.</p> <p>During an interview on 12/12/13 at 3 p.m., the DoN (Director of Nursing) indicated the Psychological evaluation was not completed. She indicated it was missed. She indicated the Social Service Director (SSD) would have set up the Psychological evaluation.</p> <p>During an interview on 12/12/13 at 3:11 p.m., the SSD indicated nursing did notify Social Service, and the request was found in the binder for referrals that had been made. She</p>			

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	<p>indicated she notified the company who would perform the Psychological evaluation and they indicated they had not been notified of the referral.</p> <p>3.1-35(g)(2)</p>			

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F000323 SS=G	<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 and interview, the facility failed to ensure a resident received supervision and assistance to prevent accidents, related to not transferring an extensive care resident correctly, leaving the resident, who was a fall risk, unattended in the bathroom, and transferring a resident off the floor after a fall without a nurse assessing the resident for 1 of 4 residents reviewed for falls. (Resident #64). The resident had increased complaints of pain and bruising of the left leg and was diagnosed with a fracture of the proximal tibia and fibula (lower leg) after the fall, and was admitted for in-patient care at an acute care hospital.</p> <p>Findings include:</p> <p>Resident #64's record was reviewed on 12/16/13 at 1:55 p.m. The resident's diagnoses included, but were not limited to, dementia, diabetes mellitus, and fracture of the tibia/fibula. The resident was admitted</p>	F000323	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The care plan and physician orders have been updated to reflect current transfer instructions for Resident #64. 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: A full facility audit of care plans and physician orders will be conducted by Nursing Administration on current residents to validate appropriate transfer orders by 01/12/2014. Amendments made when necessary. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Nursing Staff will receive education related to adherence to current physician orders/care plans related to resident transfer instructions, fall management and assessment following a resident fall. This education will be provided by the Staff Development Coordinator and completed by 01/12/2014. How the corrective</p>	01/16/2014			

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	<p>into the facility on 07/31/13 from another nursing facility and readmitted to the facility from an acute care facility on 09/19/13.</p> <p>The Admission Minimum Data Set Assessment, dated 8/7/13, indicated the resident required extensive assistance of 2 or more staff for transfers and toilet use, was not steady and was only stable with human assistance when moving from seated to standing and moving on and off toilet, and had no pain.</p> <p>Fall Risk Assessments, dated 07/31/13 and 09/14/13, indicated the resident was a high risk for falls with scores of 21 (10 or higher is at risk). The interventions indicated the resident had a low bed and alarms on her wheelchair and bed.</p> <p>A care plan, dated 08/08/13, indicated the resident was at risk for injuries from falls. The interventions included, alarm to w/c and bed.</p> <p>A care plan, dated 08/08/13, indicated the resident needed staff assistance with activities of daily living. The interventions included, 08/29/13 transfer with Sabina (stand up lift) lift.</p> <p>The Care Directive (care card for</p>		<p>action(s) will be monitored to ensure the deficient practice will not recur: The MDS Coordinator or designee will audit 5 care plans and physician orders weekly for 6 months to ensure adherence to current resident transfer instructions. Nursing Administration will observe 5 random resident transfers weekly on varied shifts to validate proper transfer technique as indicated on resident care plan. Audit results and system components will be reviewed monthly by the QA Committee with subsequent plans of correction developed and implemented as deemed necessary. Date Certain: January 16, 2014.</p>	

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	<p>CNA's), dated 08/19/13 and received from the Director of Nursing (DoN), indicated the resident required assistance of two and the Sabina lift for transfers.</p> <p>A Nurses' Note, dated 09/14/13 at 11:38 p.m., indicated, "09/14/13 3-11 (p.m.):...At approx (approximately) 4 p.m. CNA was toileting resident, and resident slid off toilet on to floor on buttocks. Resident with AROM (active range of motion) in all extremities, denied c/o (complaints) pain or discomfort at time. Resident c/o #9 (pain rating with #10 being the worse) pain to the left knee/hip at 5 p.m., adm. (administered) PRN (as needed) Norco (narcotic pain medication) as ordered, c/o #4 pain to hip/knee at 6 p.m., adm. tylenol (sic) as ordered with positive results. (Physician's Name) informed of incident, resident's c/o pain, ordered X-ray to left hip, femur, and knee. (X-ray company) called, they will be in first thing in a.m...." There was a lack of documentation to indicate what time the resident's Physician was notified. On 12/17/13 at 9:30 a.m., the East Unit Manager indicated the x-ray company was notified of the need for an x-ray on 09/14/13 at 8:16 p.m.</p> <p>A Nurses' Note, dated 09/15/13 at</p>				

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	<p>6:48 a.m., indicated, "Resident c/o #8 pain to left knee at 12:40 a.m. Bruising noted to left knee/leg; no bruising noted at 6 p.m. when PRN tylenol (sic) given. Resident able to move left leg from side to side...Resident woke up and requested PRN pain med (medicine) again at 6:50 a.m., PRN Norco adm. Bruising noted to be more extensive than at 12:50 p.m., will inform 7-3 nurse bruising must be measured..."</p> <p>A Nurses' Note, dated 09/15/13 at 10:54 a.m. indicated, "...Bruise to left leg purple/blue in color. C/o pain to left leg given PRN pain medications. Awaiting x-ray to be done."</p> <p>A Nurses' Note, dated 09/15/13 at 2:30 p.m., indicated "Resident had x/ray done to right leg (should be left leg) results show acute proximal fracture to tibial (sic) and fibular. (Physician's Name) notified received orders to send to (Hospital Name)..."</p> <p>The Pain Flow Sheet, dated 09/13, indicated the resident received Norco 5-325 mg (milligrams) on 09/14/13 at 5 p.m. for pain rated at #9 (on a scale of 1-10 with 10 being the worse), 09/15/13 at 4:30 a.m. for pain rated at #8, and 09/15/13 at 1 p.m. for pain rated at #8.</p>			

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	<p>The Medication Adminsitration Record, dated 09/13, indicated the resident received acetaminophen (Tylenol) 325 mg, two tablets on 09/14/13 at 6 p.m.</p> <p>A Radiology Report, dated 09/15/13, indicated the resident had an acute fracture of the left proximal tibia and fibular (left lower leg) metaphyses.</p> <p>A Consultation Report from the hospital, dated 09/15/13, indicated, "...the patient has a history of being unsteady and is at risk for multiple falls. The nursing home did not seem to take too much concern with her fall yesterday;although, she was having difficulty bearing weight due to the pain and she was brought to the emergency department today for further evaluation, and x-rays were taken and she had a left proximal tibia and fibular fracture, and we were then consulted on further management of this patient..."</p> <p>A Fall investigation written by the East Wing Unit Manager, received from the DoN, dated 09/16/13, indicated she had received a phone call on 09/15/13 at approximately 3 p.m. to inform her the resident had fallen on 09/14/13 and the resident had</p>						

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	<p>received a x-ray and was sent to the hospital with a fracture of the tibia and fibula. The note indicated CNA #7 had informed her the resident was sliding off the toilet and she and CNA #8 lowered the resident to the floor. She indicated CNA #7 had said she and CNA #8 had transferred the resident to the toilet and they had not used the Sabina lift.</p> <p>A Fall Investigation, received from the DoN, dated 09/16/13, indicated LPN #9 was interviewed by telephone, and during the interview, LPN #9 (no longer employed at facility) indicated: CNA #8 came and told her Resident #64 was on the floor. LPN #9 arrived at Resident #64's room and observed her sitting on her buttocks with her legs stretched out in front of the toilet. She stated she asked the resident if she had any pain and the resident denied pain, she checked the resident's range of motion, and assessed for bruising and there was none noted. She indicated CNA #7 and CNA #8 then transferred the resident into the wheelchair, she finished her assessment and left the resident's room. Continued investigation in person on 09/17/13 with LPN #9 indicated LPN #9 had asked the resident if she was in any pain and the resident had stated she</p>						

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	<p>was ok. LPN #9 indicated she had came to the room approximately five minutes after notification and she had told the CNA's to transfer the resident into the wheelchair and bring her to the Nurses' Station. She indicated an assessment had been completed while the resident was still on the floor.</p> <p>A Fall Investigation, received from the DoN, dated 09/16/13, indicated CNA #8 was interviewed, and during the interview, CNA #8 indicated: CNA #7 came up to the Nurses' Station and asked her for help. CNA #8 went to the resident's room and CNA #7 asked her to help transfer Resident #64 off the floor and back into the wheelchair. CNA #8 told CNA #7 they had to get a nurse then she went to tell LPN #9 and LPN #9 said she would be right there. After a few minutes LPN #9 had not come to the room so CNA #7 went to get LPN #9. CNA #7 returned and said LPN #9 said to just go ahead and get her up. CNA #7 and CNA #8 then lifted the resident off the floor using the under the arm and under the thigh technique and transferred the resident into the wheelchair and then to bed. A continued investigation with CNA #8 on 09/17/13, indicated LPN</p>						

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	<p>#9 had not come into the room to assess the resident until after the resident had been transferred into her bed and the Sabina lift was not in the Bathroom</p> <p>A Fall Investigation, received from the DoN, dated 09/17/13 at 5:25 p.m., indicated, CNA #7 was interviewed and during the interview, CNA #7 indicated she transferred Resident #64 with one assistance to the toilet. CNA #7 then indicated she had left the room to answer a call light for another resident (leaving the resident alone in the bathroom) and when she returned, Resident #64 was sliding off the toilet. CNA #7 indicated she slid Resident #64 to the floor. CNA #7 indicated the resident was screaming. CNA #7 indicated she called for CNA #8 to assist her. CNA #7 told CNA #8 to go and get the Nurse (LPN #9). She indicated CNA #8 asked the resident what she did and the resident just kept yelling. CNA #8 went to get LPN #9 then came back to the room and they waited 10 minutes and LPN #9 did not come to the room. Then CNA #7 went to get LPN #9. CNA #7 indicated LPN #9 asked her if the resident had hit her head and CNA #7 told her no. CNA #7 indicated LPN #9 asked her if she had any bruises and CNA #7 told her</p>						

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	<p>no. CNA #7 indicated LPN #9 told her to get the resident off the floor. CNA #7 and CNA #8 then lifted the resident to the wheelchair and then to bed. CNA #7 indicated LPN #9 arrived at the room approximately five minutes after the resident was in bed.</p> <p>During an interview with the DoN on 12/16/13 at 4:35 p.m., the DoN indicated the resident was a fall risk, used wheelchair and bed alarms, and should not have been left by herself in the bathroom. She indicated the Sabina lift should have been used for the transfer and there should have been two staff helping with the transfer. She indicated CNA #7 transferred the resident by her self and without the Sabina lift. She indicated CNA #7's conflicting information on how the resident was transferred was because the CNA was scared. She indicated LPN #9 had said she went into the room to assess the resident while she was still on the floor, but both CNA's had said she did not go into the room until after the resident was back into bed. She indicated LPN #9 had not returned to the facility to work after the investigation on 09/17/13. She indicated LPN #9 should have assessed the resident before she was moved off the floor and the CNA's</p>			

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	<p>knew not to move the resident.</p> <p>An undated facility policy, received by the DoN on 12/17/13 at 10:28 a.m. as current, titled, "Falls Management", indicated, "...Residents who experience a fall will receive prompt medical attention. Immediate needs will be quickly assessed and responded to...When a resident has a fall, the charge nurse will be notified immediately. b. The charge nurse will provide prompt medical attention as needed...The charge nurse will assess for injuries prior to moving the resident...The responsible party and physician are promptly notified of the occurrence and status of the resident...3. Follow-up for Falls:...The charge nurse or designee will update the physician and family as necessary of the resident's progress and response to the fall..."</p> <p>The Indiana State Department of Health, Core Curriculum for Nurse Aide Training Program, dated July 1998, Topic 22: Transferring, indicated, "...Have at least one co-worker assist when using a mechanical lift..."</p> <p>3.1-45(a)(2)</p>						

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F000329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure a resident's medication was adequately monitored for effectiveness, related to obtaining thyroid levels for 1 of 6 residents reviewed for unnecessary medications. (Resident #73)</p> <p>Findings include:</p> <p>Resident #73's record was reviewed on 12/11/13 at 1:02 p.m. The</p>	F000329	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #73 had a Thyroid level drawn on 12/13/13 and results communicated to physician. Labwork to be repeated in 4 months. 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: An audit of all residents receiving Thyroid medications will be completed to ensure lab monitoring is in place	01/16/2014

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	<p>resident's diagnoses included, but were not limited to, hypothyroidism and dementia with associated behaviors. The resident was admitted into the facility from an acute care facility on 11/16/12.</p> <p>The Physician's Recapitulation Orders, dated 11/13, indicated levothyroxine (thyroid replacement medication) 75 micrograms daily, originally ordered on 11/16/12.</p> <p>There was a lack of documentation to indicate the resident's thyroid levels had been monitored within the past year.</p> <p>During an interview on 12/12/13 at 11:26 a.m., the West Wing Unit Manager indicated the resident had not had thyroid levels obtained.</p> <p>A Professional Resource, titled "2010 Nursing Spectrum Drug Handbook", page 662, levothyroxine, indicated, "...Monitor thyroid and liver function tests...Monitor closely for drug efficacy..."</p> <p>3.1-48(a)(3)</p>		<p>per physician order by 01/12/2014. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Licensed Nursing Staff will receive inservice education related to lab monitoring for Thyroid Medications. This Staff development Coordinator will provide the education by 01/12/2014. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Nursing Administration will audit new admission physician orders for those residents receiving Thyroid Medications to ensure that corresponding lab monitoring has been discussed with the physician. A monthly lab audit will also be conducted to ensure completion of ordered thyroid function lab tests. Audit results and system components will be reviewed monthly by the QA Committee for 6 months with subsequent plans of correction developed and implemented as deemed necessary. Date Certain: January 16, 2014.</p>		

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F000371 SS=E	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the facility failed to distribute food under sanitary conditions, related to fluids uncovered during meal pass for 2 of 2 meals observed on the West Unit. This had the potential to affect 12 of 20 residents who resided on West Unit and received their meals on West Unit. (West Unit).</p> <p>Findings include:</p> <p>1. During an observation of the noon meal on the West Unit on 12/10/13 at 12:13 p.m., the following was observed: CNA #3 carried a tray down the hallway to room #18, the glass of juice on the tray was uncovered. The Caraft of cranberry juice was left uncovered on top of the food cart in the hallway. CNA #2 pushed the food cart down the hall to room #7. The cranberry juice on top of the cart was uncovered. CNA #2 carried a glass of hot</p>	F000371	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No residents were adversely effected by the deficient practices. 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: The facility will distribute and serve fluids under sanitary conditions glasses, cups and carafes will be covered during meal service. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Dietary and Nursing staff will be educated regarding distribution and serving of fluids under sanitary conditions by 01/12/2014. This education will be provided by both the Dietary Manager and the Staff Development Coordinator. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Management staff will audit 5 meals at various meal times for 6 months to ensure proper distribution of fluids. Audit</p>	01/16/2014	

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	<p>chocolate down the hallway uncovered. LPN#1 pushed the food cart from room #6 to room #11. The carafes of cranberry juice and apple juice on top of the cart were uncovered.</p> <p>2. During an observation of the noon meal on the West Unit on 12/12/13 at 12:11 p.m., the following was observed: CNA #4 poured coffee into a cup and carried the cup uncovered from the cart to room #3 across the hall. CNA #3 and CNA #4 carried trays down the hallway to room #15, room #18, and room #22, the fluids on the trays were uncovered.</p> <p>Interview with the Dietary Manager on 12/12/13 at 12:24 p.m., indicated all drinks were to be covered when being passed.</p> <p>3.1-21(i)(3)</p>		<p>results and system components will be reviewed monthly by the QA Committee for 6 months with subsequent plans of correction developed and implemented as deemed necessary. Date Certain: January 16, 2014.</p>		

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F000428 SS=D	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on record review and interview, the facility failed to ensure pharmacy recommendations were acted upon timely for 2 of 6 residents reviewed for unnecessary medications. (Residents #72 and #73)</p> <p>Findings include:</p> <ol style="list-style-type: none"> Resident #73's record was reviewed on 12/11/13 at 1:02 p.m. The resident's diagnoses included, but were not limited to, hypothyroidism, depression, and dementia with associated behaviors. The resident was admitted into the facility from an acute care facility on 11/16/12. <p>The Physician's Recapitulation Orders, dated 11/13, indicated orders for paroxetine (anti-depressant) 20 mg (milligrams) daily for depression (11/16/12) and risperidone (anti-psychotic) 0.5 mg, twice a day (06/20/13)</p>	F000428	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #73 had a gradual dose reduction of her antidepressant on 11/14/13. Resident #72 had an increase in her Aricept on 3/04/13. 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: Full facility audit of pharmacy recommendations from the previous 6 months will be completed by 01/12/2014 by Nursing Administration to ensure timely completion of all noted requests. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Nursing Administration will be inserviced on the importance of ensuring timely completion of pharmacy recommendations by Nurse Consultant by 01/12/2014. How the corrective action(s) will be monitored to ensure the deficient</p>	01/16/2014

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	<p>Pharmacy Recommendations, dated 09/23/13, indicated, "...Please re-evaluate the need for the continued use of risperidone, perhaps considering a gradual dosage reduction to 0.25 mg BID (twice a day), with the end goal of discontinuation of therapy..." and "paroxetine 20 mg...Please consider documenting that gradual dose reduction (GDR) is clinically contraindicated in this individual with major depressive disorder..."</p> <p>A Physician's telephone order, dated 11/14/13, indicated to decrease the paroxetine to 10 mg daily.</p> <p>The risperidone recommendation had written on the bottom of the page, "...11/14/13 on GDR of Paxil (paroxetine) decline until outcome evident..."</p> <p>There was a lack of documentation the Pharmacy Recommendations had been acted upon prior to 11/14/13, which was 53 days after the Pharmacy had made the recommendations.</p> <p>During an interview on 12/12/13 at 11:26 a.m., the West Wing Unit Manager indicated she could not</p>		<p>practice will not recur: Pharmacy recommendations will be audited on a monthly basis by the Director of Nursing to ensure ongoing timely and appropriate completion. Audit results and system components will be reviewed monthly by the QA Committee for 6 months with subsequent plans of correction developed and implemented as deemed necessary. Date Certain: January 16, 2014.</p>		

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	<p>locate documentation to indicate the Physician had been notified of the Pharmacy Recommendations until 11/14/13.</p> <p>2. Resident #72's record was reviewed on 12/12/13 at 1:48 p.m. The resident's diagnoses included, but were not related to depression and dementia with behaviors.</p> <p>The Physician's Orders, dated 12/12/12, indicated donepezil (Alzheimer's medication) 5 mg daily.</p> <p>A Pharmacy Consultation Report, dated 01/23/13, indicated a recommendation to increase the donepezil to 10 mg daily in the evening.</p> <p>The Pharmacy Consultation Report, indicated the Physician declined the recommendation, and was signed by the physician on 03/04/13, which was 40 days after the recommendation was made.</p> <p>During an interview on 12/12/13 at 3 p.m., the Director of Nursing indicated she was informed by the Pharmacist at the end of February the recommendation was still out standing. She indicated she put it in the Physician's mail box and it did</p>			

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	<p>not get done until March. She indicated she did not know why it was not completed sooner.</p> <p>3.1-25(j)</p>			

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F000496 SS=B	<p>483.75(e)(5)-(7) NURSE AIDE REGISTRY VERIFICATION, RETRAINING</p> <p>Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or the individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered.</p> <p>Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual.</p> <p>If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program.</p> <p>Based on record review and interview the facility failed to ensure a CNA's certification was not expired. This had the potential to affect 42 of 60 residents who reside in the facility.</p>	F000496	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: C.N.A #1 had certification renewed effective 12/17/13. How other	01/16/2014			

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	<p>Findings include:</p> <p>Employee files were reviewed on 12/17/13, at 1:30 p.m. CNA #1 certificate expired on 10/18/13.</p> <p>CNA #1 was a Shower Aid for 42 residents at the facility. A review of CNA #1 time card read as followed:</p> <p>10/18/13 through 10/31/13= worked 8 shifts 11/1/13 through 11/30/13= worked 20 shifts 12/2/13 through 12/17/13= worked 12 shifts</p> <p>Interview with the Director of Nursing on 12/17/13, at 1:50 p.m., indicated CNA #1's certificate was expired and CNA #1 had worked in the facility as a Shower Aid after her certificate had expired. She further indicated the CNA renewed her certificate online 12/17/13, after this was brought to their attention.</p> <p>3.1-14(f)</p>		<p>residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: Full facility audit of C.N.A certifications was completed by Administration on 12/17/13 to ensure all certifications were current for all C.N.A staff. No issues were identified via this audit. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Staff Development Coordinator was inserviced on the importance of verifying renewal of all C.N.A staff certifications by the Executive Director on 12/31/2014. Staff Development Coordinator to develop a tracking tool to ensure timely renewal. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: The Executive Director or designee will audit C.N.A certifications due for renewal in the next 30 days as well as validate renewal prior to expiration date. Audit results and system components will be reviewed monthly by the QA Committee for 6 months with subsequent plans of correction developed and implemented as deemed necessary. Date Certain: January 16, 2014.</p>		