

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155066	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/27/2014
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NAME OF PROVIDER OR SUPPLIER  EDGEWATER WOODS	STREET ADDRESS, CITY, STATE, ZIP CODE 1809 N MADISON AVE ANDERSON, IN 46011
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F000000	<p>This visit was for the Investigation of Complaint IN00158074.</p> <p>Complaint IN00158074 Substantiated. Federal/State deficiency related to the allegations are cited at F323.</p> <p>Survey date: October 27, 2014</p> <p>Facility number: 000026 Provider number: 155066 AIM number: 100274820</p> <p>Surveyor: Betty Retherford RN</p> <p>Census bed type: SNF/NF: 76 Total: 76</p> <p>Census payor type: Medicare: 10 Medicaid: 50 Other: 16 Total: 76</p> <p>Sample: 4</p> <p>This deficiency also reflects state findings cited in accordance with 410 IAC 16.2.-3.1.</p>	F000000	I would like to request paper compliance.	

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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F000323 SS=D	<p>Quality review completed by Debora Barth, RN.</p> <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 observation, record review, and interview, the facility failed to fully investigate an injury sustained by a resident in order to prevent a possible reoccurrence of the injury for 1 of 2 residents reviewed for injuries occurring during a staff assisted transfer in a sample of 4. (Resident #B)</p> <p>Findings include:</p> <p>The clinical record for Resident #B was reviewed on 10/27/14 at 10 a.m. Diagnoses for the resident included, but were not limited to, dementia with lewy bodies, congestive heart failure, restless leg syndrome, and hypertension.</p> <p>A quarterly Minimum Data Set assessment, dated 8/21/14, indicated Resident #B was severely cognitively impaired and required extensive</p>	F000323	<p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? The Resident affected had a bracket on her bed that was left attached after the removal of ¼ side rails. The bracket has been removed from her bed. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents have the potential to be affected. ED completed a bed side rail check for all beds in the facility and all brackets were removed. What measures will be put into place to place or what systemic changes will be made to ensure that the deficient practice does not recur? Maintenance Director will be in serviced on new procedure for removal of side rails by November 7, 2014. Going forward, orders will be to remove</p>	11/26/2014

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	<p>assistance from the staff for all activities of daily living. The assessment indicated the resident required the assistance of two staff members for transfers and toileting.</p> <p>A nursing note, dated 10/4/14 at 2:02 a.m., indicated "CNA called this nurse into Residents room where there was a puddle of blood on the floor. 'L' shaped laceration to left calf measuring roughly 5 cm [centimeters] by 2.5 cm. Wound cleaned, but was still bleeding, and was deeper than a superficial wound....." The note indicated the physician and family were contacted and the resident was sent to the emergency room for evaluation. The note indicated the resident could not verbalize how the laceration occurred.</p> <p>A nursing note, dated 10/4/14 at 6:46 a.m., indicated the resident had returned to the nursing home and new orders were received. A nursing note, dated 10/4/14 at 1:35 p.m. indicated the nursing staff had observed the wound and the resident had what appeared to be 7 sutures to the left calf.</p> <p>The nursing notes dated 10/4/14, 10/5/14, and 10/6/14 lacked any information related to the possible cause of the injury.</p> <p>A "Non-Pressure Wound Skin Evaluation Report, dated 10/6/14, documented</p>		<p>bed rails will include brackets. ED/ Designee will check beds when side rail is removed to ensure beds are safe and in good repair. How corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place, and by what date the systemic changes will be completed? To ensure compliance, the ED/Designee is responsible for the completion of the Environment/Safety CQI tool weekly times 4 weeks, monthly times 6 and then quarterly. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 100% is not achieved an action plan will be developed to ensure compliance. All staff to be in serviced on safety. POC will be completed by November 26, 2014.</p>				

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	<p>information related to the skin tear wound, but lacked any assessment or investigation related to the probable cause of the injury.</p> <p>The DON and Administrator were interviewed on 10/27/14 at 2:35 p.m. Additional information was requested related to an investigation having been completed to help determine the cause of the skin tear found on 10/4/14. The DON indicated only one staff member was needed for assistance with transfers at the time of the 10/4/14 laceration. They indicated the IDT (Interdisciplinary Team) had visited the resident's room after their morning meeting on 10/6/14. They indicated they observed the resident's bed and wheelchair and felt the injury may have been caused from possible leg contact with the leg rests on the wheelchair. The DON indicated she had talked with the staff working on the unit during the visit to the resident's room on morning of 10/6/14. This was a time period of two days after the injury was found and may not have directly involved all the staff who had contact with the resident.</p> <p>The DON indicated she had not taken any written statements from and/or individually interviewed the staff on duty who put the resident into bed on the</p>			

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	<p>evening of 10/3/14 or any who had contact with the resident after she was put to bed until the wound was found on 10/4/14 at 2:02 a.m.</p> <p>CNA #1 was interviewed on 10/27/14 at 3:35 p.m.. She indicated she was the CNA who put Resident #B to bed on 10/3/14. She indicated she completed the transfer with another CNA and a gait belt was used during the transfer. She indicated she could not remember who the second CNA was that helped her. She indicated she removed the resident's socks after she was put to bed and was unaware of any injury at that time. When asked if the facility staff had questioned her about the transfer that night and/or asked for a written statement related to the resident's skin tear injury prior to this inquiry, she indicated "No".</p> <p>A nursing note entry, dated 10/10/14 at 2:57 p.m., indicated Resident #B had been sent to the emergency room due to scraping her right lower leg on the bed during a transfer.</p> <p>Review of a "Facility reported incident", dated 10/10/14, indicated "Resident was being transferred by CNA with a gait belt from the wheelchair to the bed. Resident's leg got caught on bed rail support, causing a laceration to R [right]</p>			

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	<p>mid calf." A follow-up notation, dated 10/15/14, indicated the resident had been sent to the emergency room for treatment and then returned to the facility.</p> <p>An IDT Wound Review note, dated 10/13/14 at 3:31 p.m. indicated: "Laceration noted to R. calf. Root cause identified as res [resident] caught leg on side rail support during a transfer. Res was transferred to ER [emergency room] for treatment, and returned with 15 cm long closed laceration with 35 staples...."</p> <p>The Administrator and DON were interviewed on 10/27/14 at 10:30 a.m. Additional information was requested related to the "side rail support" referred to in the IDT note of 10/13/14. The Administrator indicated Resident #B did not have a side rail in place at the time of either injury previously noted. He indicated the half side rail had been removed from the resident's bed because it was not needed. The support bracket to which the siderail had been attached had not been removed from the bed. This support bracket was attached to the frame of the bed and would have extended out slightly from the resident's mattress area. He indicated this support bracket had been removed from the resident's bed after the injury occurred on 10/10/14 when the bracket was identified as the</p>			

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	<p>cause of the injury. He indicated he had not noted the bracket on the bed when the IDT team visited the resident's room on 10/6/14 and had looked for the possible cause of the laceration found on 10/4/14. He indicated he did not know if the support bracket was also the cause of the 10/4/14 injury.</p> <p>During an observation with the Administrator on 10/27/14 at 10:40 a.m., a bed which still had a side rail in place was observed. The administrator identified the support bracket on the bed which held the siderail onto the bed. He indicated the facility had changed it's previous practice and now all support brackets would be removed from a bed if the siderails were removed so no rough exposed edges would be present.</p> <p>Review of the current, but undated, facility policy, titled "Risk Management-Resident and Visitor Unusual Occurrences", provided by the Administrator on 10/27/14 at 4:25 p.m., included, but was not limited to, the following:</p> <p>"V. Definition of Unusual Occurrence/Event</p> <p>An unusual occurrence/event is defined as any happening not consistent with the</p>			

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	<p>routine operation of the nursing facility, which may have caused or may have the potential for causing injury to resident, visitors, or loss or damage of property.... All unusual occurrences are to be viewed as serious for purposes of investigation and follow-up.</p> <p>The individual facility must weigh all relevant facts when determining the severity of unusual occurrences/events. When a reasonable doubt exists regarding whether an event is serious or not, the event should be considered serious...."</p> <p>This federal tag relates to Complaint IN00158074.</p> <p>3.1-45(a)(2)</p>						