

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/22/2013
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NAME OF PROVIDER OR SUPPLIER  AUTUMN HILLS HEALTH AND REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310
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F000000	<p>This visit was for the Investigation of Complaint IN00125676.</p> <p>Complaint IN00125676-Substantiated. Federal/state deficiencies related to the allegations are cited at F312, F314, F315, F323, and F505.</p> <p>Survey dates: March 21 &amp; 22, 2013</p> <p>Facility number: 000471 Provider number: 155572 AIM Number: 100290390</p> <p>Survey team: Janet Adams, RN, TC</p> <p>Census bed type: SNF/NF: 59 Residential: 10 Total: 69</p> <p>Census payor type: Medicare: 9 Medicaid: 43 Other: 17 Total: 69</p> <p>Sample: 7</p> <p>Theses deficiencies reflect state</p>	F000000		
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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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	findings cited in accordance with 410 IAC 16.2.  Quality review completed on March 28, 2013 by, Janelyn Kulik, RN.			

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F000312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, record review, and interview, the facility failed to ensure oral hygiene was provided for 2 of 3 dependents residents reviewed for activities of daily living in the sample of 7. (Residents #D and #F)</p> <p>Findings include:</p> <p>1. During orientation tour on 3/21/13 at 9:05 a.m., Resident #D was observed in bed. The resident was awake. The resident's lips were dry. There was an accumulation of light brownish colored substance on the residents upper teeth. LPN #1 was present during the Orientation tour and indicated the resident needed assistance of staff with all care.</p> <p>On 3/21/13 at 2:30p.m., the resident was observed in bed. The residents lips were dry. The light brown accumulation was still observed on the resident's upper teeth.</p>	F000312	<p><b>The facility requests paper compliance for this citation.</b> The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. <b>1) Immediate actions taken for those residents identified:</b> Immediate action for the residents was oral hygiene was provided immediately by staff members. <b>2) How the facility identified other residents:</b> No other residents were identified when oral assessments were done by facility staff. <b>3) Measures put into place/ System changes:</b> All staff inserviced on March 27 and 28 on ADL Care and Oral Hygiene reviewing procedure with emphasis on dependent residents and NPO residents with every shift oral care. Tasks have been assigned to every dependent resident to flag for oral care in electronic medical record. Resident care sheets were reviewed and updated if needed. <b>4) How the corrective actions</b></p>	04/21/2013	

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	<p>The record for Resident #D was reviewed on 3/22/13 at 12:30 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, depressive disorder, and glaucoma.</p> <p>Review of the 1/14/13 Minimum Data Set assessment indicated the resident's cognitive skills for decision making were severely impaired. The assessment also indicated the resident required extensive assist of staff (resident involved in activity with staff providing support) for personal hygiene and dressing. The assessment also indicated the resident was totally dependent on staff for bathing.</p> <p>The resident's current care plans were reviewed. A care plan initiated on 10/3/12 indicated the resident was dependent on staff for all ADL's (Activities of Daily Living). Care plan interventions included for staff to provide oral care daily.</p> <p>When interviewed on 3/21/13 at 2:35 p.m. the Nurse Consultant indicated oral care should have been provided for the resident during the day.</p> <p>2. During Orientation tour on 3/21/13 at 9:15 a.m., Resident #F was</p>		<p><b>will be monitored:</b> Hall Angels will observe dependent resident's oral hygiene on rounds and issues brought to morning meeting and reported to HFA/Designee. Concerns will be noted on HFA morning meeting sheet. Concerns noted on Morning Meeting Sheet will be brought to Monthly Quality Assurance meeting times 6 months. Once threshold of 100% is met further monitoring after 6 months will only be done as needed based on rounding concerns. <b>5) Date of compliance: 04/21/2013</b></p>		

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	<p>observed in bed. The resident's lower lip was crusty and dry on the right side. There was some debris on the residents upper teeth. LPN #2 was present during the Orientation tour and indicated the resident required total care from staff.</p> <p>On 3/21/13 at 2:35 p.m., the resident was observed in bed. There was no change in the resident's oral status.</p> <p>The record for Resident #F was reviewed on 3/21/13 at 12:50 p.m. The resident's diagnoses included, but were not limited to, dementia, osteoporosis, insomnia, and peripheral vascular disease.</p> <p>Review of the 3/11/13 Minimum Data Set (MDS) quarterly assessment indicated the resident's cognitive skills for decision skills were severely impaired. The assessment also indicated the resident required extensive assistance of staff (resident involved in activity with staff providing support) for dressing, and hygiene. The assessment indicated the resident was totally dependent on staff for bathing.</p> <p>When interviewed on 3/21/13 at 2:37 p.m., the Nurse Consultant indicated oral care should have been provided</p>				

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	<p>for the resident during the day.</p> <p>This federal tag relates to Complaint IN00125676.</p> <p>3.1-38(a)(3)(C)</p>			
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F000314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, record review, and interview the facility failed to ensure the necessary treatment and services were provided for a resident with pressure ulcers related to not addressing the Registered Dietitian's recommendation for protein supplements to aid in wound healing for 1 of 3 residents reviewed for pressure ulcers in the sample of 7. (Resident #C)</p> <p>Findings include:</p> <p>On 3/21/13 at 11:10 a.m., Resident #C was observed in bed. The Wound Nurse was present in the room to provide wound care. The resident had pressure ulcers to the coccyx area and the right gluteal fold area. The pressure ulcer to the coccyx was approximately 2.0 cm (centimeters) x 1.0 cm x .5 cm. There was no</p>	F000314	<p><b>The facility requests paper compliance for this citation.</b></p> <p>The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. <b>1) Immediate Actions taken for those residents identified:</b> Order for Promod was obtained and resident is receiving supplement. Follow-up lab to be done to monitor protein status. <b>2) How the facility identified other residents:</b> All Registered Dietician recommendations have been addressed and entered as resident orders. No other residents identified. <b>3) Measures put into place/System changes:</b> Staff has been assigned primary responsibility for Dietary Recommendations. RD gives recommendations to Dietary</p>	04/21/2013			

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	<p>drainage observed. A pressure ulcer was also observed the resident's right gluteal fold area. The ulcer appeared to extended from under the gluteal fold to the buttock area. The ulcer was irregularly shaped. The largest area of the ulcer was approximately 3 cm x 1.5 cm with a bright red center with a spots of yellowish tissue. There was no drainage or odor from the ulcer.</p> <p>The record for Resident #C was reviewed on 3/21/13 at 10:30 a.m. The resident's diagnoses included, but were not limited to, sepsis, muscle weakness, pressure ulcer, chronic bronchitis, high blood pressure, diabetes mellitus, dementia, osteoarthritis, and depressive disorder. The resident was admitted from the hospital on 2/7/13. The resident was admitted to the hospital on 3/6/13 and returned to the facility on 3/15/13.</p> <p>The 2/14/13 Minimum Data Set (MDS) admission assessment indicated the resident required extensive assistance of staff(resident involved in activity with staff providing support) for bed mobility, transfers, and dressing. A Braden Scale for predicting pressure ulcer risk was completed on 2/7/13. The</p>		<p>Manager, who gives to assigned staff to contact MD directly and order entered into electronic record. Once all recommendations are addressed the completed recommendations will be kept in a binder for a survey year by the Dietary Manager. <b>4) How the Corrective Actions will be monitored:</b> Dietary Manager will review completed recommendations for any areas not addressed and will follow up with assigned staff until all concerns addressed. Results of audits will be reviewed in the monthly Quality Assurance meeting x 6 months. Dietary Manager will monitor recommendations monthly for completed response following 6 months review in QA. If problem identified during monthly review will be brought forth to QA committee for action. <b>5) Date of compliance: April 6)</b> Responsible Person: DON/Designee</p>				

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	<p>assessment indicated the resident was at moderate risk for developing pressure ulcers.</p> <p>Review of the 2/12/13 Dietary Nutrition Risk Assessment indicated the resident was recently hospitalized and had a decubitis ulcer present. The assessment indicated the Registered Dietitian recommended the resident receive ProMod (a protein supplement) 30 ml (milliliters) two times a day.</p> <p>Review of the 2/20/2013 Nutrition Note indicated the Registered Dietitian noted the resident had open areas on the coccyx, right gluteal fold, and right buttock areas. The Registered Dietitian recommended the resident could benefit from receiving ProMod 30 ml's twice a day with medication pass.</p> <p>The 3/2013 Physician orders were reviewed. A Physician's order was written on 3/20/13 for the resident to receive 30 ml's of ProMod liquid three times a day for wound healing.</p> <p>The 2/2013 Physician orders were reviewed. There were no orders for the resident to receive ProMod ( a protein supplement) or any other protein supplements. Review of the</p>			
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	<p>3/1/13 through 3/6/13 Physician orders indicated there were no orders for the resident to receive ProMod supplement or any other protein supplements. Review of the current 3/2013 Physician orders indicated an order was written on 3/20/13 for the resident to ProMod 30 ml(milliliters) three times a day for wound healing.</p> <p>Review of the 2/7/13 Pressure Ulcer Report indicated the resident was admitted with a Stage II (a pressure ulcer with partial loss of the dermis with a red pink wound bed) pressure ulcer to the coccyx area. The pressure ulcer measured 4 cm x 0.6 cm.</p> <p>Review of a 2/19/13 Pressure Ulcer Report indicated the resident developed Stage II pressure ulcers to the right inner buttock and the right gluteal fold. The right gluteal fold ulcer measured 2 x 3 cm. The right inner buttock ulcer measured 1.2 cm x 0.5 cm. The 2/26/13 Pressure Ulcer Report indicated there were three Stage II ulcers to the right gluteal fold areas. The ulcers measured 2cm x 1cm, 1.5cm x 1cm, and 0.5cm x 0.1cm. The Stage II ulcer measured 1.8 cm x 0.9 cm.</p> <p>The 2/2013 Treatment Records were</p>				

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	<p>reviewed. A Physician's order was initiated on 2/2013 to apply a dermasyn and aquacell foam to the right gluteal fold areas every Monday, Wednesday, and Friday. The ordered treatment was signed out as completed 2/20/13 through 2/28/13.</p> <p>The 3/15/13 Admission Skin Assessment was reviewed. The assessment indicated the resident had areas on the coccyx and right gluteal folds. There was no documentation of the Stages of the areas on this assessment. The right gluteal fold area measured 6cm x 4cm. The 3/19/13 Pressure Ulcer report indicated the right gluteal fold area was a Stage III(an ulcer with full thickness tissue loss with no muscle, bone, tendon observed) ulcer and measured 3.5cm x 4 cm x 0.2 cm and a Stage III pressure ulcer was observed on the coccyx. The coccyx pressure ulcer measured 2cm x 0.6cm x0.2cm. The report indicated Dietary was not notified</p> <p>The facility policy titled "Weights" was reviewed on 3/21/13 at 2:30 p.m. The Nurse Consultant provided the policy. The policy was dated with a revised date of 3/2012. The Nurse Consultant indicated there was no policy available related to addressing</p>						

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	<p>the Dietitian's recommendations and the above policy was the only policy related to acting upon Dietary recommendations.</p> <p>The "Weights" policy indicated the purpose of the policy was to provide record of the resident's weight and the nutritional status. The policy indicated Dietary recommendations were to be acted upon in a timely manner.</p> <p>When interviewed on 3/22/13 at 10:30 a.m., the Nurse Consultant indicated the first order for the ProMod protein supplement was received on 3/20/13. The Nurse Consultant indicated the recommendations were not addressed in a timely manner.</p> <p>This federal tag related to Complaint IN00125676.</p> <p>3.1-40(a)(2)</p>			

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F000315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on record review and interview, the facility failed to ensure the necessary treatment and services were provided to treat a urinary tract infection related to failure to obtain the final culture sensitivity results to ensure the correct antibiotic was provided for 1 of 3 residents reviewed for urinary tract infections in the sample of 7. (Resident #C)</p> <p>Findings include:</p> <p>The record for Resident #C was reviewed on 3/21/13 at 10:30 a.m. The resident's diagnoses included, but were not limited to, sepsis, muscle weakness, pressure ulcer, chronic bronchitis, high blood pressure, diabetes mellitus, dementia, osteoarthritis, and depressive disorder. The resident was admitted</p>	F000315	<p><b>The facility requests paper compliance for this citation.</b></p> <p>The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. <b>1) Immediate Actions taken for those residents identified:</b> Resident #C had repeat urine culture and placed on antibiotic that was sensitive to identified pathogen. <b>2) How the facility identified other residents:</b> No other residents were identified as being treated with inappropriate antibiotic for pathogen or disease process. <b>3) Measures put into place/System changes:</b> All licensed nursing staff has been reeducated on reviewing the laboratory reports for appropriate treatment once MD order received and 2 licensed nurses</p>	04/21/2013			

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	<p>from the hospital on 2/7/13.</p> <p>The 2/7/13 Physician order were reviewed. An order was written for the resident receive Cipro (Cirprofloxacin) (an antibiotic) 400 milligrams IV(intravenously) every 12 hours for a urinary tract infection.</p> <p>The results of a urine analysis test obtained in the hospital on 2/4/13 indicated the urine analysis test was positive for 4+bacteria (normal is negative for bacteria) and high for protein (normal is negative). The 2/6/13 final culture and sensitivity results indicated the culture was positive for growth of Escherichia coli(a bacteria) greater then 100,000. The sensitivity results indicated the Escherichia coli were resistant to Cirprofloxacin.</p> <p>An "Individual Infection Report" was initiated on 2/7/13. The report indicated the resident was admitted on 2/7/13 with Physician orders for Ciproflaxacin 400 milligrams IV every 12 hours to treat a urinary tract infection. There were sections on the report to document if a culture was done and to identify organisms isolated. These sections were not completed on the report.</p>		<p>must sign off on lab report indicating sensitivity reviewed. <b>4) How the Corrective Actions will be monitored:</b> Antibiotic orders are reviewed in Morning Meeting by Nurse Management team and lab will be reviewed at that time for appropriate antibiotic treatment. Results of audits will be reviewed in the monthly Quality Assurance meeting x 6 months. A lab tracking tool will be reviewed daily in morning meeting by Nurse Management. Results of lab tracking tool will be part of Monthly Quality Indicator Laboratory Review with 100% threshold. This is a recommended ongoing monthly QA monitoring tool. Results of audits will be reviewed in the Monthly Quality Assurance meeting. <b>5) Date of Compliance:</b> April 21, 2013<b>6) Responsible Person:</b> DON/Designee <b>LAB AUDIT TOOL:CLINICAL RECORDS: LABORATORY TESTING RESULTS AVAILABLE DATE(S) REVIEWED:</b> _____</p> <p>DATE LAB DRAWN RESIDENT NAME INDICATE LAB(S) DRAWN LIST RESULTS RECEIVED DATE RESULTS RECEIVED DATE/TIME OF MD NOTIFICATION SCANNED TO CHART <b>F315 REVIEW ALL LABORATORY DRAWS AND RESULTS -- DAILY IN</b></p>				

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	<p>Review of the 2/2013 Nursing Progress Notes indicated there was no documentation the Physician was notified that the antibiotic the resident returned from the hospital with to treat an urinary tract infection was resistant to the Escherichia Coli noted on the culture report.</p> <p>An "Individual Infection Report" was initiated on 2/7/13. The report indicated the resident was admitted on 2/7/13 with Physician orders for Ciproflaxacin 400 milligrams IV every 12 hours to treat a urinary tract infection. There were sections on the report to document if a culture was done and to identify organisms isolated. These sections were not completed on the report.</p> <p>When interviewed on 3/21/13 at 4:15 p.m., the Director of Nursing indicated she had been monitoring the Infection Control program. The Director of Nursing indicated she did not contact the hospital or review the results of the urine culture to ensure the antibiotic the resident was to receive upon admission to the facility was sensitive to the organism identified in the hospital culture report.</p> <p>This federal tag relates to Complaint</p>		<b>MORNING MEETING</b>		

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	IN00125676.  3.1-41(a)(2)				

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F000323 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. Based on observation, record review and interview, the facility failed to provide adequate supervision to prevent accidents related to the use of the incorrect lift device used to transfer a resident for 1 of 4 residents reviewed for assistive lift devices for transfers in the sample of 7. The facility also failed to address the use of the incorrect device in a timely manner. (Resident #C)</p> <p>Findings include:</p> <p>During Orientation Tour on 3/21/13 at 9:15 a.m., Resident #C was observed in bed. When interviewed at this time, LPN #5 indicated the resident was to be transferred using a Hoyer lift (a mechanical lift).</p> <p>The record for Resident #C was reviewed on 3/21/13 at 10:30 a.m. The resident's diagnoses included, but were not limited to, sepsis, muscle weakness, pressure ulcer, chronic bronchitis, high blood</p>	F000323	<p><b>The facility requests paper compliance for this citation.</b> The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. <b>1) Immediate Actions taken for those residents identified:</b> a) Inserviced facility staff on proper use of hoyer lift. Reviewed resident CNA care sheet and care plan. b) Incident report was completed on transfer. <b>2) How the facility identified other residents:</b> a) All residents being transferred with a lift had their transfer assessment reviewed for appropriate lift and no other residents were identified as having incorrect lift transfer utilization. b) No other residents were identified as having transferring incident. <b>3) Measures put into place/System changes:</b> a) All staff training on lift use done by restorative CNA. Facility reference material packet was distributed at the all staff</p>	04/21/2013			

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	<p>pressure, diabetes mellitus, dementia, osteoarthritis, and depressive disorder. The resident was admitted from the hospital on 2/7/13. The resident was sent to the hospital on 3/6/13 and was readmitted to the facility from the hospital on 3/15/13.</p> <p>Review of the 2/14/13 Minimum Data Set (MDS) admission assessment indicated the resident's cognitive skills for decision making were severely impaired. The assessment also indicated the resident required extensive assistance of two or more staff for transfers. A "Transfer Assessment" was completed on 2/7/13. The assessment was completed by Nursing staff. The assessment indicated the resident was not able to bear weight on at least one leg and was not able to safely perform greater than or equal to 50% of lift/transfer. The assessment also indicated a "Total Lift" was required to transfer the resident.</p> <p>Review of the 2/2013 Physical Therapy Plan of Care notes indicated the resident started receiving therapy on 2/8/13. The notes indicated the resident level of transfer from bed/chair was "total assist (100% assist).</p>		<p>in-service. All new nursing employees will be trained on proper lifts upon hire, annually and as needed and checked off. Restorative Nurse Aides will be responsible for training for continuity. Resident Transfer Assessments are completed by licensed nursing staff to determine what type of lift and procedures will be used to transfer each individual resident safely. Appropriate transferring technique was added to CNA care sheets. b) Licensed nursing staff was inserviced on completing incident reports per facility protocol which is: When an incident is in regard to the improper following of facility protocol, practice or care inconsistent with residents care plan, reeducation and training of staff will occur on the correct procedure. <b>4) How the Corrective Actions will be monitored:</b> a) Transfer assessments will be reviewed during care plan reviews and CNA care sheet updates for proper use. Staff will be checked off on transfer training and will be kept in employee file. b) Progress note entries are reviewed Monday through Friday (on business days) of preceding progress note entries to review for any potential incorrect device usage and/or safety concerns. Staff will be retrained and repeat offenders will be given progressive discipline up to and</p>		

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	<p>The 3/2013 Nursing Progress Notes were reviewed. An entry made on 3/1/13 at 11:53 p.m. indicated the resident needed a mechanical lift for transfers. An entry made on 3/3/13 at 9:36 p.m. indicated a mechanical lift was needed for transfers. There were no entries in the 3/3/13 Nursing Progress Notes related to any actual transfers of the resident on this day.</p> <p>An entry made in the Nursing Progress Notes on 3/5/13 at 4:03 a.m., indicated bruises to the resident's left breast and left arm were present and the resident denied pain or discomfort. An entry made on 3/6/13 at 1:10 a.m., indicated the bruising continued to the left breast and arm areas at this time.</p> <p>An entry made in the 3/2013 Nursing Progress Notes on 3/6/13 at 1:39 p.m. as a "late entry" indicated it was brought to the Nurses attention by the aides that bruising was present on the bilateral breast areas and bruising on the left shoulder and arm. The Physician and family were notified.</p> <p>An "Initial Non Pressure Skin Report" indicated bruises were first observed to the left side of the resident's breast and left inner arm above the elbow on</p>		<p>including termination. A Quality Indicator tool named Injury of Unknown Origin Investigation will be completed weekly x4 then monthly x 5 with a 95% threshold. Indicators addressed with audit tool:1) Was an Occurrence Report completed per facility protocol?2) Was the Occurrence Report complete and accurate?3) Was the physician and family notified of the incident?4) Were local agencies notified in accordance with ISDH "Unusual Occurrence" guidelines?5) Did the investigation include contact with staff members caring for the resident in the previous 24 hours?6) Based on the facts of the investigation, was the conclusion reasonable and appropriate?7) The resident Plan of Care was updated to reflect necessary changes?Results of audits will be reviewed in the monthly Quality Assurance meeting x 6 months. Once threshold achieved, will revisit as needed.5) <b>Date of compliance: April 21, 2013</b> 6) <b>Responsible Person: DON/Designee</b></p>		

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	<p>3/4/13. The report indicated the Physician was notified on 3/4/13. The report also indicated the CNA informed the writer the resident had bruising to the left breast and left upper arm. The areas were assessed and were dark purple in color and the resident denied pain. The report indicated the CNA informed the Nurse the resident did slip in the sling of the lift when transferring two days ago and the Nurse did assess the resident at the time and no apparent injuries were noted. The section on the bottom of the second page of the report indicated next to "signed by" and "signed date" section were an LPN's name and the date of 3/12/13.</p> <p>When interviewed on 3/22/13 at 9:00 a.m., the Assistant Director of Nursing indicated the 2/2013 and 3/2013 CNA assignment sheets indicated staff were to use a Hoyer lift when transferring Resident #C. The Assistant Director of Nursing indicated the 2/7/13 Transfer Assessment indicated the resident was a total lift. The Assistant Director of Nursing indicated a Hoyer lift was to be utilized for residents assessed as a total lift.</p> <p>When interviewed on 3/22/13 at 9:33 a.m. the DON indicated the date she</p>						

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	<p>was first notified of the bruises and the 3/3/13 transfer incident was on 3/6/13. The DON indicated the previous DON would have been on call the weekend of 3/3/13. The DON indicated she worked 3/4/13 and 3/5/13 and nothing was communicated to her related to the incident. The DON indicated she was told about the resident's bruises on 3/6/13 and thought it was the Admission Nurse who informed her. The DON indicated she observed the bruising on 3/6/13. The DON indicated the resident had bruising across the upper abdomen under the breast areas from one breast to the other. The DON also indicated the bruising extended from under the left breast to the left armpit area. The DON indicated the areas were dark purple and the bruised line area under the breasts was approximately 3- 4 inches wide and looked like "something had crossed over there and made the bruises." The DON indicated she recalled this was the same day the resident had a critical level abnormal lab result and was sent out to the hospital. The DON indicated she spoke to LPN #3(who worked the evening shift on 3/3/13) related to the bruising on 3/6/13 and he indicated the resident did not fall to the floor and had no injuries on 3/3/13</p>						

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	<p>and he did not make out an incident report. The DON indicated she obtained the LPN's statement and instructed him to make out the incident report. The DON indicated she was not aware the resident had been transferred with a Sit to Stand lift on 3/3/13 at the time she was first notified of the bruising and the occurrence on 3/6/13. The DON indicated she spoke with the LPN on 3/6/13 but did not ask the LPN the type of lift device that was supposed to be used at that time.</p> <p>Continued interview with the DON indicated she first attempted to contact the two CNA's who had transferred the resident (on 3/3/13) on 3/7/13. The DON indicated CNA #1 was off on Sick Leave starting that day and she did not receive her statement until she faxed it on 3/13/13. The DON indicated the second CNA involved in the resident's transfer on 3/3/13 was CNA #2 and CNA#2 came to the facility on 3/12/13 and wrote her statement.</p> <p>A copy of CNA #1's statement was reviewed on 3/21/13. The statement written by the CNA on 3/13/13. The statement indicated on 3/3/13 the CNA and CNA #2 were getting ready to put Resident #C to bed. The CNA's</p>			

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	<p>got the Sit to Stand lift ready and strapped Resident #C's legs and criss crossed the straps. The statement also indicated straps under the resident's armpits were latched also. The statement also indicated the resident went "limp" and the Nurse entered the room during the transfer and it took three staff members to put the resident into the bed.</p> <p>A copy of CNA #2's statement was also reviewed. The statement was signed by the CNA on 3/12/13. The statement indicated this CNA and CNA #1 were using the Sit to Stand lift to transfer the resident into bed on 3/3/13 and the resident was standing and then moved and started to slip out of the harness and let go of the lift. The statement indicated the staff yelled for the Nurse and the resident was placed into bed.</p> <p>When interviewed on 3/22/13 at 10:05 a.m., LPN #4 indicated she was the Nurse assigned to care for Resident #C for the day shift on 3/6/13. LPN #4 indicated the CNA called her into the residents room related to observing bruises on the resident. The LPN indicated she observed dark bruises across the area under both breasts and the left shoulder and armpit areas. The LPN</p>						

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	<p>indicated she reviewed the Nurses Notes in the resident's record and noted there was documentation of the resident having bruises. The LPN indicated she did not recall being told in the change of shift report about the bruises that morning. The LPN indicated she paged and called the Physician and then did send him a text message and he responded. The LPN indicated she informed him of the bruises and that the resident also appeared lethargic. The LPN indicated the resident was sent out to the Emergency Room. LPN #4 indicated she found out from other staff members something occurred with the resident's lift transfer a few days before. The LPN indicated she felt the bruises she observed on 3/6/13 could have been caused from the use of a lift. LPN #4 indicated she was working on 3/8/13 also and received a phone call from a Nurse taking care of Resident #C at the hospital. The LPN indicated the nurse questioned the bruises the resident had been admitted with and did not think the proper lift was used. The LPN indicated the hospital Nurse asked to talk to someone in charge and she gave her the names and numbers for the ADON and DON at that time. LPN #4 indicated she informed the Admission Nurse as she</p>			

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	<p>was the manager on at the time.</p> <p>When interviewed on 3/22/13 at 8:45 a.m.,the Nurse Consultant indicated the staff should have followed the 2/7/13 Transfer Assessment to use Hoyer lift when she was transferred on 3/3/13.</p> <p>When interviewed on 3/22/13 at 8:50 a.m., the Therapy Manager indicated Resident #C was on therapy case load from 2/8/13 until the time of her discharge to the hospital on 3/6/13. The Therapy Manager indicated the resident was be a total lift and was to be transferred with a Hoyer left during the above time.</p> <p>When interviewed on 3/22/13 at 10:30 a.m., the facility Administrator indicated he recalled a bruise being reviewed in a morning meeting but did not recall the date. The Administrator indicated he believed staff were watching the bruise. The Administrator indicated he was aware the resident was admitted to the hospital. The Administrator indicated the resident's injury was of a known origin and it was his understanding they felt the bruises could have occurred using the Hoyer lift. The Administrator indicated he was not</p>				

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	<p>aware until this time that the resident was transferred with a Sit to Stand lift on 3/3/13 instead of the Hoyer lift as per her assessment. The Administrator also indicated he had not seen the 3/8/13 written statement of LPN #4's phone conversation with the hospital staff nurse indicating the hospital nurse had questioned about the resident's bruising, wound, and concerns regarding the "mis use of the lifts."</p> <p>When interviewed on 3/22/13 at 9:00 a.m., the current Assistant Director of Nursing indicated she was unaware of the 3/8/13 call from the hospital Nurse related to the use of the lift device and to her knowledge there was no further follow up.</p> <p>When interviewed on 3/22/13 at 12:00 p.m., the Nurse Consultant indicated they had started reviewing the resident's with lifts and inservicing staff on the use of the correct lifts.</p> <p>This federal tag relates to Complaint IN00125676.</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p>			

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F000505 SS=D	<p>483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS The facility must promptly notify the attending physician of the findings. Based on record review and interview, the facility failed to notify the Physician of Critical laboratory results in a timely manner for 1 of 3 residents reviewed for change in condition in the sample of 7. (Resident #C).</p> <p>Findings include:</p> <p>The record for Resident #C was reviewed on 3/21/13 at 10:30 a.m. The resident's diagnoses included, but were not limited to, sepsis, muscle weakness, pressure ulcer, chronic bronchitis, high blood pressure, diabetes mellitus, congestive heart failure, dementia, osteoarthritis, and depressive disorder. The resident was admitted from the hospital on 2/7/13. The resident was sent to the hospital on 3/6/13 and was readmitted to the facility on 3/15/13.</p> <p>The 3/2013 laboratory test results were reviewed. A laboratory test result report dated 3/6/13 indicated electrolytes were completed. The results indicated the resident's sodium level was at a critical level of</p>	F000505	<p><b>The facility requests paper compliance for this citation.</b> The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. <b>1) Immediate Actions taken for those residents identified:</b> MD notified and order for repeat testing obtained with appropriate treatment for identified pathogen. Resident was sent to ER and was treated for sodium level on same day of lab draw. <b>2) How the facility identified other residents:</b> No other residents were identified as being treated with inappropriate antibiotic for pathogen or disease process requiring MD notification. No other critical labs received at facility. <b>3) Measures put into place/System changes:</b> All licensed nursing staff has been reeducated on reviewing the laboratory reports for appropriate treatment once MD order received and 2 licensed nurses must sign off on lab report indicating sensitivity reviewed and on any critical labs received that MD notification occurred timely. <b>4) How the Corrective</b></p>	04/21/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/22/2013
NAME OF PROVIDER OR SUPPLIER  AUTUMN HILLS HEALTH AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310		
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	<p>161. The report indicated a normal sodium level was 135-145. The report indicated the results were called to the facility at 12:51 p.m. on 3/6/13.</p> <p>The 3/6/13 Nursing Progress Notes were reviewed. The first entry was made at 4:26 p.m. as a "late entry." This note was entered as a "change in condition" note. The entry indicated the resident's temperature was 100.9 degrees and her heart rate was 115. The note indicated the resident opened her eyes upon verbal cues but did not respond to questions and drifted back to sleep. The Physician and family were notified and Tylenol was given to reduce the fever.</p> <p>An entry was made at 5:41 p.m. as a late entry. This entry indicated the resident was sent to the hospital Emergency Room per the Physician's order due to a change in condition. An entry made at 5:53 p.m. indicated the Physician was notified of the abnormal lab results.</p> <p>The facility policy titled "Physician Notification for Change in Condition" was reviewed on 3/21/13 at 2:30 p.m. There was a revised date of 1/2012 on the policy. The policy was identified as the current policy when</p>		<p><b>Actions will be monitored:</b> Antibiotic orders are reviewed in Morning Meeting by Nurse Management team and all labs will be reviewed at that time for MD notification and order for appropriate antibiotic treatment. A lab tracking tool will be reviewed daily in morning meeting by Nurse Management. Results of lab tracking tool will be part of Monthly QA Quality Indicator Laboratory Review threshold of 100%. This is a recommended ongoing monthly QA monitoring tool. Results of audits will be reviewed in the monthly Quality Assurance meeting. 5) <b>Individual Responsible:</b> <b>DON/Designee6)</b> <b>Date of compliance: April 21, 2013</b> <b>TOOLS: CLINICAL RECORDS: LABORATORY TESTING RESULTS AVAILABLE DATE(S) REVIEWED: _____</b></p> <p><b>DATE LAB DRAWN RESIDENT NAME INDICATE LAB(S) DRAWN LIST RESULTS RECEIVED DATE RESULTS RECEIVED DATE/TIME OF MD NOTIFICATION SCANNED TO CHART</b></p>		

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	<p>received from the Nurse Consultant at the above time. The policy indicated the purpose of the policy was to ensure medical problems were communicated to the Physician in a timely manner. The policy also indicated Physician notification included reporting of abnormal lab and diagnostic findings.</p> <p>This federal tag relates to Complaint IN00125676.</p> <p>3.1-49(f)(2)</p>			