

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155678	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/01/2013
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NAME OF PROVIDER OR SUPPLIER WATERFORD PLACE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 800 ST JOSEPH DR KOKOMO, IN 46901
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F000000	<p>This visit was for the Investigation of Complaint IN00124813.</p> <p>Complaint IN00124813 - Substantiated. Federal/state deficiencies related to the allegations are cited at F323.</p> <p>Survey dates: February 28, & March 1, 2013.</p> <p>Facility number: 002667 Provider number: 155678 AIM number: 200300090</p> <p>Survey team: Christi Davidson, RN</p> <p>Census bed type: SNF: 55 SNF/NF: 46 Residential: 37 Total: 138</p> <p>Census payor type: Medicare: 50 Medicaid: 30 Other: 58 Total: 138</p> <p>Sample: 5</p> <p>These deficiencies reflect state</p>	F000000	<p>Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the Provider of the accuracy or validity of the findings as alleged or conclusion set forth in the statement of deficiencies. This Plan of Correction is prepared and/or executed solely because it is required by the provision of federal and state law. Please accept this Plan of Correction as Waterford Place Health Campus' Credible Allegation of Compliance. The facility respectfully requests desk review of this Plan of Correction submitted as Waterford Place Health Campus' Credible Allegation of Compliance in response to the deficiencies cited.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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	findings cited in accordance with 410 IAC 16.2. Quality Review completed by Tammy Alley RN on March 6, 2013.				

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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 observation, interview and record review the facility failed to ensure the safety of 1 resident during a transfer using a lift device. The resident sustained a compound fracture to the left ankle. The facility failed to ensure the safety of 1 resident with unsafe gaps inside the bed rail and an unsafe gap between the mattress and headboard. This affected 2 of 5 residents reviewed for accidents. (Resident #B, #D)</p> <p>Findings include:</p> <p>1. The record for Resident #B was reviewed on 2/28/13 at 11:20 a.m.</p> <p>Diagnoses included, but were not limited to, diabetes and dementia.</p> <p>The most recent quarterly Minimum Data Set (MDS) Assessment dated 12/21/2012 indicated Resident #B could not report the correct year and could not recall 2 of 3 words given at the beginning of the Brief Interview for Mental Status (BIMS) assessment.</p>	F000323	<p>1. Resident B was sent to the hospital and was treated for the injury. She has since returned to the facility. Resident D was assessed and no findings were noted related to the measurement of the side rail. 2. All other residents who utilize the transfer lift were assessed for any injuries. No injuries were noted. All side rails in the facility were measured to ensure compliance with the measurements per facility policy. 3. All staff were re-educated on the proper use of the transfer lift. This education will occur upon hire, at least annually, and as needed. The Director of Health Services (DHS) and/or designee will observe at least 5 transfers weekly on various residents and various staff to ensure proper techniques are being followed. Any identified concerns will be immediately addressed. The Director of Plant Operations or designee will measure all side rails in the facility at least annually. Any beds being brought into the facility by another individual or agency will be inspected by the Director of Plant Operations or designee prior to being put into</p>	03/21/2013			

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	<p>The resident's BIMS assessment was a 7 out of a possible 15. The MDS assessed Resident #B an extensive assist of one person physical assist for transfers and toilet use. The MDS assessed Resident #B to have impairment on both sides regarding the lower extremities.</p> <p>A care plan titled, "ADL [activities of daily living] Self-Care Deficit, dated 9/21/12, indicated, "...Needs assistance or is dependent in...Transfer...Weight bearing...Mechanical lift...."</p> <p>A Rehabilitation Screening dated 9/13/12 for Resident #B indicated, "...Resident was a mechanical lift transfers. Resident had a change...Resident could benefit from skilled PT [physical therapy] to [sign for decrease] assistance needed in long term care...."</p> <p>A physical therapy discharge summary dated 10/18/12 indicated, "...Staff to continue to use a stand up lift to transfer patient for safety...."</p> <p>A Rehabilitation Screening dated 12/17/12 for Resident #B indicated, "...do not show any change in functional mobility [sign for at] this time...."</p>		<p>use. The Maintenance Director will measure at least 5 bed rails weekly to ensure ongoing compliance.4. The Director of Health Services and the Director of Plant Operations will report their results of these observations and or audits to the QA committee for review monthly for three months and then quarterly.5. 3/21/13</p>				

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	<p>A nurse's note for Resident #B dated 2/13/13 at 1510 (3:10 p.m.) indicated, "Called to Rsd [resident] room per CNA's [Certified Nursing Assistant], noted Rsd kneeling in BR [bathroom]...CNA's reported Rsd did not fall, while attempting to roll Rsd onto her side noted Fx [fracture] to [sign for left] [sign for lower] extremity...911 called."</p> <p>A Fall Circumstance Assessment and Intervention form dated 2/13/13 indicated Resident #B was assisted to the floor with injury to the left lower extremity. The form indicated the resident was transferring from the toilet to a wheel chair with a stand-up lift. The form indicated the root cause was the resident was transferred improperly with a lift device.</p> <p>A physician's order dated 2/13/13 indicated, "Send to...ER [emergency room] per ambulance."</p> <p>A hospital record with an admission date of 2/13/13 for Resident #B indicated, "...Diagnosis: Grade 2 open distal tibia/fibula fractures...a large transverse open wound involving the distal tibial fracture...which is about 10 x 5 cm</p>						

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	<p>[centimeters]. There is exposed bone...Assessment: This is an open fracture...we will place an external fixator...The risks include loss of extremity....may consider below knee amputation if the family is willing to proceed...."</p> <p>A nurse's note dated 2/22/13 at 1515 "(3:15 p.m.) indicated Resident #B has a left below the knee amputation.</p> <p>During an interview on 2/28/13 at 11:00 a.m., regarding the transfer incident with Resident #B, the Director of Nursing (DoN) indicated 3 CNA's and 2 LPN's were suspended immediately pending an investigation of the incident.</p> <p>A Job Specific Orientation checklist dated 1/3/13 indicated, "...New employee to initial & date each line when completed...." CNA #1's initials were marked on the line for stand-up lifts.</p> <p>A Personnel Action Form dated 2/21/13 for CNA #1 and signed by CNA #1 indicated, "...Termination...Involuntary - Reason: Improper use of equipment [sign for with] serious consequence...."</p> <p>A Job Specific Orientation checklist</p>						

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	<p>dated 9/18/12 indicated, "...New employee to initial & date each line when completed...." CNA #2's initials were marked on the line for stand up lifts.</p> <p>An Employee Counseling Record Form dated 2/14/13 for CNA #2 and signed by CNA #2 on 2/25/13 indicated, "...was present during care of a RSD [resident] when all safety measures were not in place and RSD was injured...[name of CNA #2] stated she was present...but engaged in conversation...and unaware sling was not applied correctly...."</p> <p>An Employee Counseling Record Form dated 2/14/13 for CNA #3 and signed by CNA #3 on 2/25/13 indicated, "...was aware coworker did not utilize all safety precautions during a RSD transfer and did not intervene. RSD was seriously injured...."</p> <p>During an interview on 3/1/13 at 1:50 p.m., CNA #2 indicated on 2/13/13 the resident "needed to go to the bathroom." CNA #2 indicated the resident used the Sara 3000 mechanical lift. CNA #2 indicated CNA #1 and CNA #3 were passing ice water and came into the room to assist. CNA #2 indicated CNA #1</p>						

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	<p>applied the sling to Resident #B and attached the sling to the stand-up lift device. CNA #2 indicated the resident was moved to the bathroom by CNA #1. CNA #2 indicated CNA #1 and CNA #3 returned to passing ice water. CNA #2 indicated peri care and incontinence care was provided to Resident #B. CNA #2 indicated Resident #B's "feet slipped off the platform." CNA #2 indicated the device was lowered, and Resident #B's knees were on the ground. CNA #2 indicated, "yelled for help." CNA #2 indicated CNA #1 and CNA #3 returned to help, and LPN #4 and LPN #5 also entered to assess the resident and assist. CNA #2 indicated when Resident #B was repositioned on the ground there was a "snap" and "it was broke." CNA #2 indicated Resident #B went to the hospital.</p> <p>During an interview on 3/1/13 at 2:26 p.m., LPN #5 indicated CNA #2 "came and got me." LPN #5 indicated when she entered Resident #B's room, Resident #B was on the lift "chicken winging." LPN #5 indicated the sling was under Resident #B's armpits and the resident's hands were in the down position. LPN #5 indicated Resident #B's knees were on the ground with the resident's</p>						

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	<p>weight down on the resident's ankles. LPN #5 indicated the resident was lowered to the ground and assessed. LPN #5 indicated during the attempt to reposition the resident by a "log roll" someone asked, "Oh did her foot hit the lift?" LPN #5 saw the injury to the left ankle and indicated to "get help."</p> <p>During an interview on 3/1/13 at 2:44 p.m., CNA #3 indicated on 2/13/13, while passing ice water with CNA #1, both CNA's entered Resident #B's room to assist CNA #2 with a transfer of Resident #B to the bathroom. CNA #3 indicated CNA #1 retrieved the stand-up lift from the hall. CNA #3 indicated CNA #1 applied the sling to Resident #B and attached the sling to the lift device. CNA #3 indicated, "it looked like the buckles were dangling." CNA #3 indicated CNA #1 operated the device and wheeled Resident #B into the bathroom. CNA #3 indicated CNA #1 indicated, "...all yours," and they returned to finish passing ice water and left Resident #B in the care of CNA #2.</p> <p>During an interview on 3/1/13 at 3:25 p.m., the DoN indicated she had concerns at the scene of the incident on 2/13/13. The DoN indicated the resident was wearing socks that were</p>			

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	<p>not skid-proof. The DoN indicated she would not expect that with any transfer. The DoN indicated the CNA's reported the resident "slid out." The DoN indicated, "cannot slide out if in it properly."</p> <p>During a phone interview on 3/1/13 at 3:45 p.m., CNA #1 indicated she and CNA #3 were passing ice water. CNA #1 indicated they entered Resident #B's room to assist CNA #2. CNA #1 indicated she applied the sling to Resident #B and did not buckle the belts around the resident's waist. CNA #1 indicated she did not buckle the leg straps. CNA #1 indicated she transferred the resident into the bathroom on the stand-up lift and placed the resident on the toilet. CNA #1 indicated she and CNA #3 returned to passing ice water and left Resident #B in CNA #2's care.</p> <p>A facility policy provided by the DoN on 2/28/13 at 11:00 a.m., titled, "Guidelines for Resident Transfers," indicated, "...All devices are safe to be used by one staff member per manufactures guidelines...."</p> <p>The Sara 3000 Operating and Product Care Instructions, Issue 4, September 2010, provided by the DoN on 2/28/13 at 12:10 p.m.,</p>						

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	<p>indicated, "...Lower Leg Straps: Accessory used to ensure that the lower parts of the resident's legs stay close to the knee support...Ensure that the straps are firm but comfortable for the resident...Warning: The sling chest support strap must always be applied and fastened when using the sling...."</p> <p>2. The record for Resident #D was reviewed on 3/1/13 at 10:40 a.m.</p> <p>Diagnoses included, but were not limited to hypertension, osteoporosis and insomnia.</p> <p>A care plan titled, "ADL Self-Care Deficit" dated 2/4/13 indicated, "...Prefers to sleep in r/c [recliner]... 1/2 side rails as an enabler...."</p> <p>A Restraint/Enabler Circumstance Assessment and Intervention dated 1/9/13 for Resident #D indicated side rails for positioning and to assist with mobility. The form indicated Resident #D had dementia and decreased mobility.</p> <p>An Assessment Review and Considerations dated 1/10/13 indicated Resident #D was a fall risk due to cognitive impairment and</p>						

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	<p>mobility impairment.</p> <p>A physician's order dated 1/10/13 indicated 1/2 siderails as an enabler.</p> <p>During an observation in the presence of the DoN on 2/28/13 at 2:40 p.m., Resident #D had 1/2 siderails bilaterally to the head of the bed. The bed was against the wall. The 3 gaps inside each of the side rails measured respectively 8 inches x 8.5 inches, 8 inches x 17 inches and 8 inches x 8.5 inches. The gap between the headboard and the mattress measured 4.5 inches wide. Resident #D was up in a wheel chair at the time of the observation.</p> <p>During an interview on 2/28/13 at 2:45 p.m., the DoN indicated the maintenance staff would remove the bed from the room.</p> <p>A facility policy provided by the Nurse Consultant on 2/28/13 at 4:05 p.m., titled, "Guidelines for Bed Frame Fitting," indicated, "...Bed frames, mattresses and side rails shall be monitored to ensure proper fit...There should be no more than 2.5 inches between the head board and the mattress...There should be no more than 4.5 inches between the side rail bars...."</p>			

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	<p>This Federal Tag relates to Complaint IN00124813.</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p>			