

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155100	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/07/2011
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NAME OF PROVIDER OR SUPPLIER GARDEN VILLA	STREET ADDRESS, CITY, STATE, ZIP CODE 2111 NORTON LN BEDFORD, IN47421
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F0000	<p>This visit was for the Recertification and State Licensure Survey.</p> <p>Survey dates: December 5, 6 and 7, 2011</p> <p>Facility number: 000040 Provider number: 155100 AIM number: 100274460</p> <p>Survey team: Melinda Lewis, RN,TC Marla Potts, RN Sharon Whiteman, RN</p> <p>Census bed type: SNF: 13 SNF/NF: 136 Total: 149</p> <p>Census payor type: Medicaid: 17 Medicare: 123 Other: 9 Total: 149</p> <p>Sample: 24 Supplemental Sample: 5</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p>	F0000		

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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F0241 SS=E	<p>Quality review completed 12/14/11 Cathy Emswiler RN</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation and interview the facility failed to ensure residents environment maintained their dignity in that signs were posted to cue staff concerning the care required for residents, for 2 of 24 sampled residents reviewed for dignity, Resident #134 and 63, and five random residents reviewed for dignity from the facility census of 149, Resident #28, 37, 124, 35 and 67.</p> <p>Finding include:</p> <p>1. Resident #28's room, on the locked dementia unit, was observed on 12/6/11 at 2:00 P.M. to contain a sign hanging above her bed which indicated "Do Not Unplug bed Please" and "Night shift please be aware (Name of Resident 28) has dentures that must be come out every night. Please put them in denture cup and soak them every night. They keep being</p>	F0241	<p>What corrective actions will be accomplished for those found to have been affected by the deficient practice?All signs posted in rooms were immediately removed.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?All residents rooms were immediately checked and all signs were removed.What measures will be put in place or what systemic changes will you make to ensure that deficient practice does not recur?A dignity inservice was completed by all staff.How will the corrective changes monitored to ensure the deficient practice does not recur? Who will monitor?Resident rroms will be checked weekly for 4 weeks. If no infractions they will be checked monthly for 2 months. If no further problems rooms will be check quarterly. All results will be reported to the</p>	12/23/2011

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	<p>misplaced..."</p> <p>2. Resident #37's room, on the locked dementia unit, was observed on 12/6/11 at 2:00 P.M. to have a sign hanging above his bed which indicated "(Resident 37's name) is totally deaf."</p> <p>3. Resident # 124's room, located on the pediatric wing of the facility, was observed on 12/6/11 at 2:30 p.m. to have a sign hanging over her bed which indicated " Please put underwear over (residents name) briefs to hold them in place to prevent leaking. Remember to toilet every 1 to 2 hours. Double knot a bandana around her neck to keep tops dry. thank you nursing. use slipper socks...'</p> <p>4. Resident 134's room, located on the pediatric wing of the facility was observed on 12/6/11 at 2:30 p.m. to have a sign hanging above his bed, which indicated "Do not fasten (residents name) brief until the head of his bed is up..."</p> <p>5. Resident # 63's room, was observed on 12/6/11 at 2:30 P.m. The resident was observed sitting in a recliner in her room, next to the recliner was a white plastic trash can, with many breaks. The residents Foley catheter bag was observed located inside the trash can. Written on the trash can visible from the hallway was</p>		<p>QA&A Committee. The social Service Director or designees will be responsible to monitor.</p>		

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	<p>"residents name and for catheter bag to sit in."</p> <p>6. On 12/6/11 at 3:30 P.M., during observation of Resident # 35's room a hand written note was observed to taped to the wall. The note indicated "Please make sure to do good mouth care every morning and every night and eyes. Thanks (Unit Manager # 1 name)."</p> <p>7. On 12/6/11 at 3:45 P.M., during observation of Resident # 67's room a hand written note was observed to be taped above the bed. The note indicated "Keep HOB [head of bed] at 30 degrees. Please do not put mattresses next to bed."</p> <p>During interview with the Director of Nursing on 12/6/11 at 1:30 P.M. indicated she would remove the signs concerning personal care, and was not aware staff was hanging signs.</p> <p>3.1-3(t)</p>				

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/03/2012

FORM APPROVED

OMB NO. 0938-0391

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F0272 SS=D	<p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment.</p> <p>Based on interview and record review the facility failed to ensure MDS (minimum data set) assessments were accurate, in that falls were not reflected on two residents assessments, Resident #1 and Resident #41, for 2 of 24 residents reviewed for MDS accuracy.</p>	F0272	What corrective actions will be accomplished for those found to have been affected by the deficient practice?Residents #1 & #41 MDS' have been evaluated and corrected to adequately reflect falls.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?All residents have the potential to be	12/23/2011	

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	<p>Findings include:</p> <p>1. Resident #1's was identified on the initial tour of the locked dementia unit, with the Director of Nursing, on 12/5/11 at 9:00 A.M. as cognitively impaired and having had falls in the facility. Resident #1 was observed on 12/5/11 at 11:00 A.M. to have been sitting in a wheelchair in the activity area of the facility.</p> <p>Resident #1's clinical record was reviewed on 12/7/11 at 11:00 A.M. Diagnoses included, but were not limited to: Alzheimer disease. The most recent MDS (minimum data set) assessment, dated 9/29/11 indicated the resident required extensive assistance of two staff members with bed mobility, transfers and ambulation, and had 1 fall with no injury since the past assessment. The previous MDS assessment, dated 7/20/11, indicated the resident had no falls since the last assessment.</p> <p>Nurses notes indicated the resident had a fall on 8/22/11 with no injury and a fall on 7/2/11 at 2045 (8:45 p.m.). The resident continued to complaint of pain following this fall with an x-ray on 7/5/11 revealing a "pubic ramus fracture." (pelvis fracture).</p>		<p>affected. All MDS have been audited to ensure falls are being accurately coded. What measures will be put in place or what systemic changes will you make to ensure that deficient practice does recur?The nursing staff was inserviced on 12/7/11 and again on 12/20/11 to report all falls, including falls in the community and update fall assessments as needed. MDS are adding all falls to MDS schedule, as well as MDS began keeping fall log of all falls, including community falls. MDS also began attending fall committee meetings.How will the corrective changes be monitored to ensure the deficient practice does not recur? Who will monitor?The MDS Coordinator or designee will monitor the 24 nursing reports for falls, and monitor the admission questionnaire for falls. The MDS Coordinator or designee will monitor 3 times weekly for 4 weeks. If no deficiencies found, monitoring will be weekly for 4 weeks, then quarterly. If not 100% compliant frequency of monitoring will again increase. All audit results will be forwarded to the QA&A Committee for review. The MDS Coordinator or designee will be responsible to monitor.</p>		

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	<p>During interview with the MDS Coordinator #1, on 12/7/11 at 10:00 A.M., she offered no reason why the fall with fracture had been missed on the 7/20/11 assessment.</p> <p>2. The clinical record for Resident # 41 was reviewed on 12/5/11 at 10:45 A.M. The record indicated Resident # 41 had diagnoses that included but were not limited to osteoarthritis and vascular dementia. The MDS [minimum data set] assessment, dated 11/3/11, indicated Resident # 41 had moderately impaired cognition and required assistance of two with bed mobility, transfers, and ambulation. Resident # 41 had no falls since the last assessment.</p> <p>The Nurses Notes, dated 9/12/11 at 5:00 P.M., indicated "Res [resident] on bed at this time. res was previously LOA [leave of absence] with wife. res did not notify staff of his return to facility. res was not back to facility at 4:15 p when checked on res stated arrived to facility at 450 p at this time res stated he did not want to get up and eat dinner because he had fallen at home and his R [right] hip was hurting. no bruises or reddened areas noted at this time. no s/s [signs or symptoms] of dislocation noted at this time..."</p>			

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	<p>The Nurses Notes, dated 9/30/11 at 8:30 P.M., "Resident returned to facility. Reported falling at home. Stated "my right leg gave out and I fell onto my R side" Reported calling ambulance for assistance up. No c/o [complaints of] pain at this time. 0.3 cm x [by] 1.5 cm skin tear noted to top of L [left] hand. Area cleansed with water and soap and i [one] steri strip applied."</p> <p>The Nurses Notes, dated 10/11/11 at 3:00 P.M., indicated "Res returned form being LOA with wife and reported he fell at home. Res stated I walked up on the back porch sat down. Mom told me to hold the dog in the wash bucket I got up to walk over to her bent down and hollered Mom I'm going down Mom I'm going down. Res fell backwards on to R hip and buttock. Bumped head on bottom rung of walker. No c/o pain, no bruising or bump on head noted. Res said he is no longer going to get out of the vehicle on his outings with wife. Res had to call ambulance to home to help pick him up. Wife brought him back to facility."</p> <p>The Nurses Notes, dated 10/21/11 at 3:30 P.M., indicated "Res arrived to facility at this time from being LOA [leave of absence] with wife. At this time res stated that he had fallen in Wal-mart while</p>			

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	<p>shopping there with his wife. Res complaining of bilateral knee pain and slight pain in back of head...no injuries noted at this time. Res resting on bed at this time."</p> <p>The Nurses Notes, dated 10/24/11 at 10:05 P.M., indicated "Given Lortab (pain medication) at this time. Res stated he was having slight leg and back pain. When res was first asked what had happened, res stated that he hit his leg on the car. He later stated that he had fallen while out with his wife. Bilateral knees slightly reddened res complaining of mild back pain..."</p> <p>In an interview with MDS Coordinator # 1, on 12/7/11 at 11:30 A.M., she indicated the information for falls is gathered from the Fall Risk Assessment Form. The falls placed on the Fall Risk Assessment form are in-house falls only. She indicated that since the five falls between assessments happened while the resident was out of the facility with his wife they would not be documented on the Fall Risk Assessment form. She further indicated this is why the falls were not documented on the 11/3/11 MDS.</p>				

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F0323 SS=G	3.1-31(d) 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 a resident at risk of falls, with a history of falls, care planned to be with staff when up in the wheelchair on 5/2/11, was sitting where staff could not get to the resident on 7/2/11 resulting in her sliding out of	F0323	What corrective actions will be accomplished for those found to have been affected by the deficient practice?The fall risk assessments for resident #1 & #41 have been reviewed and appropriate interventions are in place.How will you identify other	12/23/2011	

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	<p>the chair with a resulting pelvic fracture, and then fell again while being toileted by a Certified Nursing Assistant on 8/22/11 who failed to utilize a gait belt, Resident #1, failed to ensure Resident #41 received timely interventions to prevent falls, resulting in an ankle fracture, for 2 of 8 residents reviewed for falls, in the sample of 24.</p> <p>Findings include:</p> <p>1. Resident #1's was identified on the initial tour of the locked dementia unit, with the Director of Nursing, on 12/5/11 at 9:00 A.M. as cognitively impaired and having had falls in the facility. Resident #1 was observed on 12/5/11 at 11:00 A.M. to have been sitting in a wheelchair in the activity area of the facility.</p> <p>Resident #1's clinical record was reviewed on 12/7/11 at 11:00 A.M. Diagnoses included, but was not limited to, Alzheimer disease. The most recent MDS (minimum data set) assessment, dated 9/29/11 indicated the resident required extensive assistance of two staff members with bed mobility, transfers and ambulation, and had 1 fall with no injury since the past assessment. The residents admission assessment, dated 4/21/11, indicated the resident required extensive</p>		<p>residents having the potential to be affected by the same deficient practice and what corrective action will be taken?All residents have the potential to be affected. All residents fall risk assessments have been reviewed and appropriate interventions put in place.What measures will be put in place or what systemic changes will you make to ensure that deficient practice does not recur? Nursing staff have been inserviced on fall prevention on 12/20/11. The Interdisciplinary Fall Committee are reviewing all falls.How will the corrective changes be monitored to ensure the deficient practice does not recur? Who will monitor?The Assistant Director of Nursing or designee will audit falls weekly to ensure fall risk assessments and care plans are updated. Audit results will be presented to the QA&A Committee for review.</p>		

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	<p>assistance of one staff with transfers, bed mobility and ambulation at that time with a fall prior to admission.</p> <p>The care plan, included a problem, dated 4/19/11 and updated through 12/28/11, for "risk for falls characterized by history of falls/injury, multiple risk factors related to impaired balance, poor coordination, unsteady gait, impaired cognition, which included interventions of "assist resident with transfers with assist of 1 and gait belt initiated 4/19/11, revision 8/24/11, call light in reach, scoop mattress on low bed next to wall, gripper socks/non-slip footwear-4/27/11, resident to be close to staff when up 5/2/11, scoop mattress against wall with bed alarm 6/23/11, revised 8/24/11, when resident is awake, sit with staff close to nurses station, 7/5/11.</p> <p>The fall risk assessments indicated the following concerning falls and interventions added: 4/26/11 resident fell in hallway, high risk of falls, sensor alarm placed in room 5/2/11 resident sitting on floor in front of wheelchair 4/29/11 res to be with staff when up in wheelchair, score 22, above 10 high risk of falls. 7/5/11 resident fell in MDR (Main Dining room) on 7/2/11, neuro checks, chair</p>			

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	<p>alarm times 72 hours, sit with staff close to nurses station x-ray right wrist.</p> <p>Nurses notes indicated:</p> <p>4/25/11 11:30 P.M. resident (sleeping pill) given restoril 15 mg orally for sleeplessness...given at 9 p.m."</p> <p>The 2010 Nursing Spectrum Drug Book, indicated side effects for restoril, included but were not limited to, "depresses the central nervous system, use cautiously in elderly patients,adverse effects include dizziness, light headedness,in-coordination, confusion, irritability, hangover."</p> <p>"4/26/11 3:40 A at 2:45 A.M. a resident walked to me as I was checking another resident and stated that a lady had fell. I walked to the end of the front hall with him and found resident in question on the floor of the doorway across the hall from her room..found no injuries other than numerous bruises..complained of light pain right arm intermittently but mostly pain in left hip. Resident assisted back to bed with assist times 2...order for motion alarm on."</p> <p>"4/29/11 7:50 p.m. Resident attempted to exited wheelchair without assistance and fell. Another resident family hard noise</p>			

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	<p>and saw resident on floor between wheelchair and door of front hall...Resident new bruise on left elbow .7 cm by .4 with small abraised area oozing blood, small bruise on left ribs...possible bruise under left eye..."</p> <p>"7/2/11 2045 (8:45 p.m.) Nurses reported to this writer that res fell out of chair at 1800 (6 p.m.) Res reported that she was up in wheelchair in main dining room and leaned over to pick up puzzle piece from floor and fell forward. Res had skin tear right wrist and swelling was noted....chair alarm while up items 72 hours for fall prevention...staff is to sit with resident while at table at all times as a nursing measure..."</p> <p>During interview with the Director of Nursing on 12/7/11 at 12:30 p.m. the resident was sitting in the dining room and the nurse who observed the fall was behind the desk.</p> <p>The resident continued to complain of pain following this fall with an x-ray on 7/5/11 revealing a "pubic ramus fracture." (pelvis fracture).</p> <p>"8/22/11 1230 a.m. This nurse called to shower room, upon entry res noted to be sitting on her bottom in front of the toilet...assisted resident to sit on toilet.</p>				

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	<p>floor noted to be wet, dried floor and used gait belt for transfers...."</p> <p>During interview with the Unit Manager who had written this nurses note on 12/7/11 at 12:00 p.m. she indicated a Certified Nursing Aide had taken the resident to the bathroom, who was fairly new and had not used a gait belt during the transfer. She indicated the CNA was counseled and reeducated concerning proper transfers. The Unit Manager indicated gait belts are to be used with any resident who requires actual assistance with transfers.</p> <p>2. The clinical record for Resident # 41 was reviewed on 12/5/11 at 10:45 A.M. The record indicated Resident # 41 had diagnoses that included but were not limited to osteoarthritis and vascular dementia. The MDS [minimum data set] assessment, dated 11/3/11, indicated Resident # 41 had moderately impaired cognition and required assistance of two with bed mobility, transfers, and ambulation. Resident # 41 had no falls since the last assessment.</p> <p>A Care plan, dated 5/19/11, indicated a problem of "Risk for falls characterized by history of falls/injury, multiple risk factors related to: impaired balance, unstable health condition, use of diuretic, history of falls, requires assist to transfer."</p>				

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	<p>The interventions were "Assist resident with transfers with assist of :(blank). Call light within reach and answer promptly. Encourage resident to use handrails or assistive devices properly. Ensure environment is free of clutter. Have commonly used articles within easy reach. Provide toileting opportunities as needed and check for incontinence at least every 2 hours. Reinforce need to call for assistance. Resident to wear proper and non slip footwear. Transfer and Change positions slowly."</p> <p>A Therapy Home Assessment Summary, dated 7/1/11, no time, indicated "...Therapist assisted pt [patient] into house, modification is needed to make is needed to make exit and entry from car to house accessible. Wife is unable to lift w/c into out of trunk of car independently. Wife backed into carport poles entering carport, removing rear view mirror from car...Transfers are unsafe into recliner..."</p> <p>The Nurses Notes, dated 9/12/11 at 5:00 P.M., indicated "Res [resident] on bed at this time. res was previously LOA [leave of absence] with wife. res did not notify staff of his return to facility. res was not back to facility at 4:15 p when checked on res stated arrived to facility at 450 p at this time res stated he did not want to get up and eat dinner because he had fallen at</p>				

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	<p>home and his R [right] hip was hurting. no bruises or reddened areas noted at this time. no s/s [signs or symptoms] of dislocation noted at this time..."</p> <p>The Nurses Notes, dated 9/12/11 at 5:30 P.M., (nurse practitioner name) notified of res stating he had fallen at home and that he was complaining of R hip pain. (nurse practitioner name) ordered R hip x-ray at this time DT [due to] R hip pain from recent fall..."</p> <p>The Nurses Notes, dated 9/12/11 at 11:00 P.M., indicated "results of R hip x-ray showed no fracture or dislocation seen. mild osteoarthritis..."</p> <p>The fall care plan was updated on 9/12/11 to include the intervention of "hip xray."</p> <p>During an interview with Unit Manager # 3, on 12/7/11 at 9:30 A.M., she provided a timeline which indicated on 9/12/11 an intervention of "referral to physical therapy."</p> <p>The Physical Therapy Notes, dated 9/8/11, no time, indicated "Unable to evaluate patient for PT [physical therapy] d/t [due to] patient being unavailable (pt [patient] OOF [out of facility] with wife)."</p> <p>The Physical Therapy Notes, dated 9/9/11,</p>			

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	<p>no time, indicated "Unable to evaluate patient again for PT d/t pt being OOF with wife."</p> <p>The Physical Therapy Notes, dated 9/12/11, no time, indicated "Patient OOF with wife. Unable to initiate eval [evaluation]."</p> <p>The Physical Therapy Notes, dated 9/13/11, no time, indicated "Unable to eval pt. OOF with wife. I have spoken to wife and informed her of PT eval/tx [evaluation/treatment] order. Pt's wife wanted to take pt out today and wanted him to be eval'd tomorrow. Unit Manager aware of the plan."</p> <p>The Nurses Notes, dated 9/30/11 at 8:30 P.M., "Resident returned to facility. Reported falling at home. Stated "my right leg gave out and I fell onto my R side" Reported calling ambulance for assistance up. No c/o [complaints of] pain at this time. 0.3 cm x [by] 1.5 cm skin tear noted to top of L [left] hand. Area cleansed with water and soap and i [one] steri strip applied."</p> <p>The fall care plan was updated on 9/30/11 to include the intervention of "Chest xray as ordered."</p> <p>The Physical Therapy Notes, dated</p>				

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	<p>10/3/11, no time, indicated "Patient fell at home last weekend. I have spoken to patient regarding safety when going home for a visit. I have expressed to patient that I'm recommending to have somebody/another person aside from his wife when he goes home for safety (his and his wife's safety). Patient agreed. Will speak to patient's wife regarding my recommendations."</p> <p>The Physical Therapy Notes, dated 10/5/11, no time, indicated "I have spoken to patient's wife and patient about last weekend fall incident. I was informed by them that patient was amb [ambulating] with walker towards their vehicle when he turned and fell. Patient's wife claimed that she was beside patient and tried to keep him form falling but was unsuccessful. Patient's wife was educated in home safety measures and was advised to have another capable person to assist her at home when pt [patient] goes LOA with her. Patient and wife understood and agreed on recommendations..."</p> <p>The Nurses Notes, dated 10/11/11 at 3:00 P.M., indicated "Res returned form being LOA with wife and reported he fell at home. Res stated I walked up on the back porch sat down. Mom told me to hold the dog in the wash bucket I got up to walk over to her bent down and hollered Mom</p>				

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	<p>I'm going down Mom I'm going down. Res fell backwards on to R hip and buttock. Bumped head on bottom rung of walker. No c/o pain, no bruising or bump on head noted. Res said he is no longer going to get out of the vehicle on his outings with wife. Res had to call ambulance to home to help pick him up. Wife brought him back to facility."</p> <p>The Nurses Notes, dated 10/21/11 at 3:30 P.M., indicated "Res arrived to facility at this time from being LOA [leave of absence] with wife. At this time res stated that he had fallen in Wal-mart while shopping there with his wife. Res complaining of bilateral knee pain and slight pain in back of head...no injuries noted at this time. Res resting on bed at this time."</p> <p>The Nurses Notes, dated 10/24/11 at 10:05 P.M., indicated "Given Lortab (pain medication) at this time. Res stated he was having slight leg and back pain. When res was first asked what had happened, res stated that he hit his leg on the car. He later stated that he had fallen while out with his wife. Bilateral knees slightly reddened res complaining of mild back pain..."</p> <p>The Physical Therapy Notes, dated 10/25/11, no time, indicated "Patient</p>				

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	<p>reported that he fell last night at home while attempting to walk to the car. Patient's wife was educated in proper bed to w/c transfers, car transfers, bathroom transfers, wheelchair to chair transfers and in stair climbing. Patient needs CGA [contact guard assistance] with transfers and CGA/minimum assist with ambulation and stair climbing. Constant verbal cues needed for safety. The following recommendation were discussed with patient and wife: 1. When going on LOA, wife is to have another capable person to assist her with transfers, stair climbing and ambulation. 2. Patient is to have gait belt when going on LOA. Nursing staff to apply gait belt before leaving facility. 3. Pt is to use wheelchair at home. Since wife is unable to load/unload wheelchair in car, she is to keep a wheelchair at home. 4. O2 at all times. Pt reported that he takes off O2 and wife carries O2 tank when on LOA. 5. Home assessment- temporarily scheduled for 10/28/11..."</p> <p>In an interview with Physical Therapist # 1, on 12/7/11 at 11:00 A.M., she indicated the resident and his wife refused the home assessment scheduled for 10/28/11. She stated they indicated they had one done previously with the modifications completed.</p>				

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	<p>The Nurses Notes, dated 11/14/11 at 10:30 A.M., indicated "Wife signed res out at this time. No c/o per res at this time. Encouraged resident to stay but wife refused..."</p> <p>The Nurses Notes, dated 11/15/11 at 7:30 A.M., "Generalized weakness and lethargy noted...Resident stated fell while LOA with wife and hit back of head. Resident alert oriented to self verbal response inappropriate at times. Speech somewhat slurred...Resident complains of pain on back of head that radiated along R side of head to eye. Confusion noted."</p> <p>The Emergency Room discharge orders, dated 11/15/11, indicated "...Diagnosis mild concussion, occipital contusion and headache..."</p> <p>The fall care plan was updated on 11/15/11 to include the interventions of "E. R. [emergency room] visit fall outside facility, not to go out with wife, neurochecks."</p> <p>The Nurses Notes, dated 11/15/11 at 4:45 P.M., indicated "Resident's wife in facility. Resident and his wife upset about resident not able to leave facility with wife. Evening shift supervisor and Social Services notified that resident and his wife requesting to speak to them."</p>			

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	<p>The Nurses Notes, dated 11/15/11 at 5:15 P.M., indicated "Resident pushed mattress extenders away from low bed and slid off bed onto floor. Assessed for injury then assisted into w/c. No apparent injury noted..."</p> <p>The fall care plan was updated on 11/16/11 to include the intervention of "dysem B/T [between] mattress."</p> <p>The Nurses Notes, dated 11/30/11 at 7:45 P.M., indicated "Res found on floor on his back by CNA at this time. Resident's pants and shoes were off and on floor by res urinal was by resident's side and was smashed. Resident's clothes were wet with urine res fell from wheelchair details of events prior to fall unclear D/T [due to] conflicting statements made by resident as to what happened no injuries noted. res denies pain...immediate interventions were gripper socks and dysem on wheelchair. Neuro checks started at this time..."</p> <p>The fall care plan was updated on 11/30/11 to include the intervention of "grripper socks and dysem to w/c."</p> <p>The Nurses Notes, dated 12/1/11 at 2:45 A.M., indicated "...Client c/o [complaints of] R [right] ankle pain upon assessment</p>			

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	<p>of R ankle area noted to have edema with light discoloration around ankle area et [and] pain to touch et pain with slight movement..."</p> <p>A Radiology Report, dated 12/1/11, indicated "...Ankle right....There is fracture involving distal fibula with minimal displacement..."</p> <p>The Nurses Notes, dated 12/2/11 at 9:45 P.M., indicated "Res found sitting on bathroom floor beside wheelchair by CNA. Res was trying to toilet himself and stated that when he grabbed the grab bar his hand slipped and he fell to the floor. Resident stated he did not hit his head and that he landed on his buttocks. No injuries noted. Res denies pain...immediate interventions is NO [new order] for res to be up in common areas when in w/c..."</p> <p>The fall care plan was updated on 12/2/11 to include the intervention of "Res [resident] in common areas when in w/c."</p> <p>3.1-45(a)(2)</p>				

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F0514 SS=D	<p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on observation, record review and interview the facility failed to ensure accurate clinical records were maintained for 1 of 24 sampled residents. (Resident #8)</p> <p>Findings Include:</p> <p>During observation of medication pass on 12/07/11 at 8:30 a.m., RN #1 was</p>	F0514	<p>What corrective action will be accomplished for those found to have been affected by the deficient practice? Resident # 8's order was clarified.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?All residents have the potential to be affected by the alleged deficient practice, but no other residents</p>	12/23/2011	

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	<p>observed to administer medications to Resident #8. RN #1 was observed to give Resident #8 medications which included, but were not limited to, (1) Losartan Potassium 100 milligram tablet.</p> <p>Review of Resident #8's clinical record on 12/07/11 at 9:00 a.m. indicated a physician's re-cap order for December, 2011. The re-cap order included an order, dated 01/11/11 for Losartan Potassium 100 milligram tablet to be given with HCTZ (blood pressure medication) 12.5 milligrams.</p> <p>Interview of RN #1 on 12/07/11 at 9:05 a.m. indicated she had never given Resident #8 the HCTZ 12.5 milligram tablet with the Losartan Potassium 100 milligram tablet. RN #1 indicated "there isn't any (HCTZ) to give her...never has been."</p> <p>Interview of Unit Manager #1 on 12/07/11 at 9:07 a.m. indicated "The order does say she (Resident #8) is supposed to get Losartan Potassium 100 milligrams with 12.5 milligrams of HCTZ, but she has not been getting the HCTZ. Unit Manager #1 indicated she would call the pharmacy to clarify this order.</p> <p>On 12/07/11 at 10:30 a.m. Unit Manager #1 provided copies of telephone orders.</p>		<p>were affected. The pharmacy reviewed all dispensing records. What measures will be put in place or what systemic changes will you make to ensure that deficient practice does not recur? In serviced the Nursing staff on 12/20/11. Unit manager or designee will check rewrites prior to the new month for accuracy. How will the corrective changes be monitored to ensure the deficient practice does not recur? Who will monitor? Unit manager or designee will monitor rewrites and present a rewrite audit form to QA&A monthly for 3 months. If 100% compliant then audits will be completed quarterly for 3 months. If non-compliant frequency will increase as needed.</p>		

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	<p>An order, dated 01/11/11, indicated, "Clarification D/C [discontinue] Losartan 100/12.5. Give Cozarr 100 milligrams (1) tablet by mouth daily. Give HCTZ 12.5 milligrams daily. An order, dated 03/01/11 indicated the HCTZ 12.5 milligrams was to be discontinued.</p> <p>Interview of Unit Manager #1 on 12/07/11 at 10:30 a.m. indicated the HCTZ 12.5 milligrams was discontinued, but the order had never been changed. Unit Manager #1 indicated the HCTZ was discontinued due to the resident's blood pressure being low.</p> <p>Review of Resident #8's clinical record on 12/07/11 at 9:00 a.m. indicated the following:</p> <p>Resident #8 had diagnoses, which included, but were not limited to, Alzheimer's disease and reactive confusion. and previous history of hypertension.</p> <p>Medication Administration Records for December, November, October, September, and August, 2011 included medications which were not limited to, Losartan Potassium 100 milligrams - take 1 tablet with 12.5 milligrams of HCTZ. The Medication Administration Records for these months included documentation</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155100	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/07/2011
NAME OF PROVIDER OR SUPPLIER GARDEN VILLA			STREET ADDRESS, CITY, STATE, ZIP CODE 2111 NORTON LN BEDFORD, IN47421		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	supporting nursing staff had initialed this medication as being given for each day of the month. 3.1-50(a)(3)				