

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155727	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2012
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NAME OF PROVIDER OR SUPPLIER STONEBRIDGE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 SHAWNEE DR S BEDFORD, IN 47421
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F0000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00107458 and IN00107223.</p> <p>Complaint IN00107458 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00107223 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: 5/14, 15, 16 and 17, 2012</p> <p>Facility number: 003924 Provider number: 155727 AIM number: 200472040</p> <p>Survey team: Marla Potts, RN Sharon Whiteman RN</p> <p>Census bed type: SNF: 07 SNF/NF: 39 Residential: 36 Total: 82</p> <p>Census payor type: Medicare: 12 Medicaid: 26</p>	F0000	<p>The submission of this plan of correction does not indicate an admission by StoneBridge Health Campus that the findings and allegations contained herein are inaccurate and true representation of the quality of care provided to our residents of StoneBridge Health Campus. This facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities. (for Title 18/19 programs) To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only.</p> <p>_____</p> <p>_____ Any</p> <p>deficiency statement</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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	<p>Other: 44 Total: 82</p> <p>Sample: 12 Residential Sample: 11</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 5/23/12 by Suzanne Williams, RN</p>				

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F0282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to ensure nursing staff followed physician's orders and the plan of care for prevention of skin issues, in that the facility failed to ensure the resident's chair had a pressure reducing cushion and that the ordered dressing was applied, for 1 of 5 residents observed during care in a sample of 12. (Resident #5)</p> <p>Findings include:</p> <p>During initial observation tour on 05/14/12 at 9:10 a.m. with RN #1 present, Resident #5 was identified by RN #5 as having a supra-pubic catheter (catheter inserted directly into the bladder), as wanting to sit in his recliner, and as being a recent admission to the facility from a hospital due to pneumonia.</p> <p>On 05/15/12 at 10:50 a.m., CNA #1 and CNA #2 were observed to transfer Resident #5 from his wheelchair to a recliner chair. The seat of the recliner chair was observed to not have any type of cushion.</p>	F0282	<p>F 282</p> <p>Resident #5 suffered no ill effects from the deficient practice. Resident #5's care plan and physician orders have been reviewed and staff have been in serviced on plan of care and physician orders Completion Date 6-13-2012</p> <p>All residents have the potential to be affected by the deficient practice and through alterations in processes and in servicing will ensure nursing staff follow physician's orders and the plan of care for prevention of skin issues.</p> <p>Nursing staff in serviced on importance of following plan of care and physician orders for prevention of skin issues. Systemic change C.N.A. assignment sheets to identify prevention interventions of skin issues. Completion Date 6-13-2012</p> <p>Nurse managers to audit three random residents to assure</p>	06/13/2012			

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	<p>On 05/15/12 at 2:55 p.m., CNA #3 and CNA #4 were observed to transfer Resident #5 from his recliner to his wheelchair and from his wheelchair to a commode. The resident was observed to have been incontinent of BM. The CNAs were observed to provide incontinence care. The resident asked the CNAs if they could "put some of that cream on those raw places on my rear-end." The CNAs were observed to assist the resident to stand up using a gait belt and pulled the adult brief and the resident's trousers down and applied "Calazyme" ointment (preventative barrier cream) to the resident's bottom. The resident indicated "Oh, that's touchy" when the barrier cream was applied. The CNAs were then observed to transfer the resident from his wheelchair to his recliner. The seat of the recliner was observed to not have a cushion.</p> <p>On 05/16/12 at 10:45 a.m., CNA #1 and CNA #5 were observed to assist Resident #5 to stand and removed a soiled adult brief. The resident was observed to be soiled with feces. The resident was observed to not have any type of dressing on his bottom. CNA #5 indicated she did not know whether or not the resident had a dressing on his bottom earlier because she did not get him up.</p>		<p>nursing staff following physician's orders and the plan of care for prevention of skin issues. 5x a week for a month then 3x a week for a month then weekly with results forwarded to QA committee monthly x6 months and quarterly thereafter for review and further suggestions/comments</p> <p>Completion Date 6-13-2012</p>				

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	<p>On 05/16/12 at 11:05 a.m., CNA #1 and CNA #5 were observed to transfer the resident from his wheelchair to recliner. The recliner was observed to not have a cushion in the seat of the chair.</p> <p>Resident #5's record was reviewed on 5/15/12 at 2:25 p.m. A physician's re-write order for May 2012 included an order dated 05/11/12 for, "Foam pressure dressing to buttocks and coccyx every 72 hours for protection."</p> <p>A care plan, dated 05/14/12, indicated, "...Potential for alteration in skin integrity due to frequency of bowel incontinence... Foam drsg [dressing] buttocks & coccyx as preventative....Pressure reducing mattress and chair cushion...."</p> <p>3.1-35(g)(2)</p>			

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F0314 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, interview, and record review, the facility failed to ensure nursing staff provided preventative measures to prevent pressure ulcers for 1 of 5 residents observed during care in a sample of 12. (Resident #5)</p> <p>Findings Include:</p> <p>During initial observation tour on 05/14/12 at 9:10 a.m. with RN #1 present, Resident #5 was identified by RN #5 as having a supra-pubic catheter (catheter inserted directly into the bladder), as wanting to sit in his recliner, and as being a recent admission to the facility from a hospital due to pneumonia.</p> <p>On 05/15/12 at 10:50 a.m., CNA #1 and CNA #2 were observed to transfer Resident #5 from his wheelchair to a recliner chair. The seat of the recliner chair was observed to not have any type</p>	F0314	<p>Resident #5 has had a skin sweep. Completion Date 6-13-2012</p> <p>All residents have the potential to be affected by the alleged deficient practice and through altercations in processes and in servicing the campus will ensure measures to prevent the development of pressure sores. Completion Date 6-13-2012</p> <p>Nursing staff have been in serviced on pressure ulcer prevention and the "Skin Assessment" sheets. Systemic change is the C.N.A. have been instructed to utilize the "Skin Assessment" sheets not only at time of a shower but anytime a new area of impairment is noted or worsening of area. Completion Date 6-13-2012</p> <p>DHS or designee will perform</p>	06/13/2012			

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	<p>of cushion.</p> <p>On 05/15/12 at 2:55 p.m., CNA #3 and CNA #4 were observed to transfer Resident #5 from his recliner to his wheelchair and from his wheelchair to a commode. The CNAs were observed to remove a soiled brief. CNA #3 was observed to cleanse a large amount of feces from Resident #5's bottom using a cleansing wipe. The resident was observed to not have any type of dressing on his bottom. Resident #5 was observed to have reddened/excoriated inner buttocks. CNA #4 indicated Resident #5 "sits in his recliner a lot." After cleansing the feces from the resident's bottom, the CNAs were observed to apply a clean adult brief and to pull the resident's trousers back up and transfer him to his wheelchair. The resident asked the CNAs if they could "put some of that cream on those raw places on my rear-end." The CNAs were observed to assist the resident to stand up using a gait belt and pulled the adult brief and the resident's trousers down and applied "Calazyme" ointment (preventative barrier cream) to the resident's bottom. The resident indicated "Oh, that's touchy" when the barrier cream was applied. The CNAs were then observed to transfer the resident from his wheelchair to his recliner. The seat of the recliner was observed to not have a</p>		<p>random audits of C.N.A. care to assure following standards of care to prevent pressure ulcers on 3 random residents 5x a week x one month 3x a week x one month then weekly with results forwarded to the QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments.</p> <p>Completion Date 6-13-2012</p>				

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	<p>cushion.</p> <p>On 05/16/12 at 10:45 a.m., CNA #1 and CNA #5 were observed to assist Resident #5 to stand and removed a soiled adult brief. The resident was observed to be soiled with feces. The resident was observed to not have any type of dressing on his bottom. CNA #5 was observed to cleanse the resident's bottom using cleansing wipes. The resident's bottom was observed to be reddened/excoriated. CNA #5 indicated she did not know whether or not the resident had a dressing on his bottom earlier because she did not get him up. CNA #5 indicated the resident did have a "little open area" on his inner buttocks. CNA #1 indicated she did not notice any open areas yesterday. CNA #5 indicated she needed to let LPN #3 know, because LPN #3 wanted to put a "patch" on the resident's bottom. The resident was assisted back to his wheelchair. A cushion was observed to be in the seat of the wheelchair.</p> <p>On 05/16/12 at 11:05 a.m., CNA #1 and CNA #5 were observed to transfer the resident from his wheelchair to a recliner. The recliner was observed to not have a cushion in the seat of the chair.</p> <p>On 05/16/12 at 1:04 p.m., CNA #6 and CNA #5 were observed to transfer</p>			

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	<p>Resident #5 from his wheelchair to his bed and removed the resident's trousers and brief. The resident's bottom was observed to be reddened with excoriation. LPN #2 was observed to measure two areas on the resident's bottom. LPN #2 indicated she thought "the patch" was causing the areas to the resident's bottom. The DON [Director of Nursing] was present in the room and indicated she was going to get the patch discontinued and get something else for the resident's bottom.</p> <p>The DON was interviewed on 05/16/12 at 3:40 p.m. and indicated the areas on Resident #5 were "denuded areas due to excoriation." The DON indicated she did not know why staff didn't tell her of the worsening of Resident #5's bottom "yesterday."</p> <p>Interview of LPN#2 on 05/17/12 at 8:45 a.m. indicated the CNAs had not told her of any issues with Resident #5's bottom worsening, probably because he had been having so many loose stools.</p> <p>Review of Resident #5's clinical record on 05/15/12 at 2:25 p.m. indicated the resident had diagnoses which included, but were not limited to, urinary tract infection, dementia, and history of chronic edema.</p>			

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	<p>A quarterly MDS (minimum data set) assessment, dated 04/16/12, indicated Resident #5 had severe cognitive impairment and required extensive assistance with transfers, hygiene, and bathing, and had no skin impairment. The assessment indicated the resident was at risk for skin breakdown and had preventive interventions in place for a pressure reducing device for his chair and for his bed.</p> <p>A physician's re-write order for May 2012 included an, order dated 05/11/12 for, "Foam pressure dressing to buttocks and coccyx every 72 hours for protection."</p> <p>A care plan, dated 05/14/12 with a most recent update of 08/12/12, indicated Resident #5 was frequently incontinent of bowel.</p> <p>A care plan, dated 05/14/12, indicated, "...Potential for alteration in skin integrity due to frequency of bowel incontinence....Assess/record changes in skin status....Report pertinent changes in skin status to physician....Administer/monitor effectiveness of/response to preventive treatment(s) as ordered: Foam drsg [dressing] buttocks & coccyx as preventative....Pressure reducing mattress</p>			

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	<p>and chair cushion...."</p> <p>A form titled "Physician/Prescriber Please Sign and Return," dated 05/16/12 indicated, "...Hold foam dsg [dressing] to coccyx until denuded area is healed; Caz [Calazyme] cream to buttocks bid x 14 days et PRN [as needed] after incontinent episodes."</p> <p>Copies of forms titled "Other Skin Impairment Assessment" were provided by LPN #2 on 05/17/12 at 9:00 a.m. These forms were dated 05/16/12. One form indicated measurements on "site 1" were 1.0 centimeters (cm) length, 0.8 cm in width, and less than 0.1 in depth. The form indicated the "site 1" location was on Resident #5's right coccyx. One form indicated measurements on "site 2" were 1.2 cm in length, 1.0 cm in width, and less than 0.1 cm in depth and the location of "site 2" was on the resident's right buttock. Both forms indicated both areas were classified as "denuded" areas.</p> <p>A "Skin Assessment" form provided by the DON on 05/16/12 at 2:20 p.m. indicated the skin on Resident #5's face, neck, ears, chest, abdomen, shoulders, back, legs, and inner knees was normal. The section under "sacrum, hips, buttocks" had not been filled out or marked as to whether or not there was any</p>			

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	<p>impairment of these areas.</p> <p>During interview of the DON on 05/16/12 at 2:20 p.m. indicated the "Skin Assessment" sheet was a sheet the CNAs mark after showering residents to inform nursing of whether or not there are any skin problems.</p> <p>3.1-40(a)(1)</p>			

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F0315 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 observation, interview and record review, the facility failed to ensure urinary catheter tubing and catheter bag were handled appropriately during care of 1 of 1 resident observed for catheter care in a sample of 12. (Resident #5)</p> <p>Findings Include:</p> <p>During initial observation tour on 05/14/12 at 9:10 a.m. with RN #1 present, Resident #5 was identified by RN #5 as having a supra-pubic catheter (catheter inserted directly into the bladder), as wanting to sit in his recliner, and as being a recent admission to the facility from a hospital due to pneumonia.</p> <p>On 05/15/12 at 2:55 p.m., CNA #3 and CNA #4 were observed to propel Resident #5 in his wheelchair from his room to his adjoining bathroom. Resident</p>	F0315	<p>Resident # 5 suffered no ill effects from the alleged deficient practice. Completion Date 6-13-2012</p> <p>All residents have the potential to be affected by the alleged deficient practice and therefore through corrective actions and in servicing the campus will ensure residents who have a Foley catheter receive appropriate treatment and services to prevent urinary tract infections. Completion Date 6-13-2012</p> <p>All nursing staff has been in serviced on proper care of a Foley catheter. Systemic change care givers will complete a competency "care of resident with a Foley Catheter" now and annually thereafter. Completion Date 6-13-2012</p> <p>DHS and/or designee will monitor compliance with observation of</p>	06/13/2012	

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	<p>#5's urinary catheter tubing was observed to be hanging on the floor and was dragging on the floor while the CNAs were pushing the wheelchair. After the CNAs had provided incontinence care, they were observed to transfer the resident back to his wheelchair and to propel the wheelchair from the bathroom to the resident's room with his urinary catheter tubing again dragging on the floor. After the resident was transferred back to his recliner, CNA #3 was observed to drop the resident's catheter bag and urinary catheter tubing onto the floor before picking it up & securing it to the side of the resident's bed frame.</p> <p>On 05/16/12 at 10:30 a.m., CNA#1 and CNA #5 were observed to propel Resident #5 in his wheelchair from his bedroom to his adjoining bathroom. The resident's urinary catheter tubing was observed to drag on the floor while the CNAs pushed the wheelchair to the bathroom. After providing incontinence care, the CNAs assisted the resident back into his wheelchair. The resident's urinary catheter tubing was again observed to drag on the floor. The resident was left seated in his wheelchair per his request. His urinary catheter tubing remained touching the floor when the CNAs exited the resident's room.</p>		<p>care audits on 2 residents per day with a Foley catheter 5x a week x one month then 3x a week x one month then weekly thereafter with results forwarded to the QA committee for 6 months and quarterly thereafter for further review and suggestions/recommendations. Completion Date 6-13-2012</p>				

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	<p>Review of Resident #5's clinical record on 05/15/12 at 2:25 p.m. indicated the following:</p> <p>Resident #5 had diagnoses which included, but were not limited to, urinary tract infection, dementia, and history of chronic edema.</p> <p>A quarterly MDS (minimum data set) assessment, dated 04/16/12, indicated Resident #5 had severe cognitive impairment and required extensive assistance with transfers, hygiene, and bathing. The assessment indicated the resident had a urinary tract infection during the time of the assessment.</p> <p>A physician's re-write order for May 2012 included an order which was dated 05/11/12 for Bactrim DS (antibiotic medicine) for 10 days for diagnosis of urinary tract infection.</p> <p>A care plan, dated 05/14/12 with a goal date of 08/12/12, indicated, "Alteration in urinary elimination...suprapubic catheter (a catheter inserted directly into the bladder)...Resident will not exhibit symptomatic UTI [urinary tract infection]."</p> <p>A policy was provided by the ADON [Assistant Director of Nursing] on</p>			

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	05/16/12 at 3:10 p.m. The policy titled "GUIDELINES FOR URINARY CATHETER CARE" was not dated. The policy indicated, "Purpose: To prevent infection of the resident's urinary tract....Be sure the catheter tubing and drainage bag are kept off the floor...." 3.1-41(a)(2)			

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F0323 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.</p> <p>Based on interview, observation and record review, the facility failed to supervise a cognitively impaired resident, Resident #26, who had multiple falls, resulting in a fractured wrist, for 1 of 8 residents reviewed with falls, in the sample of 12.</p> <p>Findings include:</p> <p>Resident #26 was identified on the initial tour of the facility, on 5/14/12 at 9:00 A.M. by LPN #1, as cognitively impaired, having had a recent fall with fracture, and utilizing a wheelchair for transfers. The resident was observed to have been sitting in a wheelchair in the hallway, with a cast to her left lower arm. The resident was observed to have an alarming seat belt on her wheelchair.</p> <p>Resident #26's clinical record was reviewed on 5/14/12 at 10:30 A.M. Diagnoses included, but were not limited to: osteoporosis, congestive heart failure, and fracture left wrist. Resident #26's most recent MDS</p>	F0323	<p>Resident #26 's plan of care related to risk for falls has been reviewed and updated as necessary and staff have been in serviced on this plan of care. Completion Date 6-13-2012</p> <p>All other residents are at risk to be affected by the alleged deficiency and through alterations in processes and in servicing the campus will 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. Completion Date 6-13-2012</p> <p>Nursing staff have been in serviced concerning Fall/Safety Management and immediate interventions. Systemic change is the nurse will be required to conference with another nurse at the time of a fall to coordinate an immediate intervention Completion Date 6-12-2012</p> <p>DHS /designee will monitor 3 random resident at risk for falls to</p>	06/13/2012			

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	<p>(Minimum Data Set) assessment, dated 4/27/12, indicated the resident was cognitively impaired, required extensive assistance from staff for transfers and bed mobility, had not ambulated, and had fallen since the last assessment.</p> <p>A care plan, for falls, dated 3/4/12, indicated interventions of "wheelchair with anti-roll back devices and anti thrust cushion," "educate/remind resident to ask for assistance prior to ambulation/transfers," "reorient to room as needed," "dycem to wheelchair," "bed against wall," " frequent used items in reach," "staff to take resident to dining room/hall not left alone in room," "recliner out of room," "phone at head of bed," "4/24/12 alarming seat belt in wheelchair." The previous fall care plan, dated 3/14/11, indicated the alarming floor mat was started 9/3/11. The care plan included a problem, dated 4/25/12, for "restraint/enabler, medical symptom-fracture left wrist from fall related to decreased safety awareness, impulsiveness-alarming seatbelt."</p> <p>A care plan, dated 2/7/12 to 5/7/12, indicated a problem of "impaired cognitive skills, as evidenced by memory problems, recall problems, dementia."</p> <p>The CNA assignment sheets, dated</p>		<p>assure safety interventions in place as per plan of care, staff following plan of care to prevent an accident, and new interventions implemented timely 5x a week for a month then 3x a week for a month then weekly with results forwarded to QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments Completion Date 6-12-2012</p>				

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	<p>3/28/12, provided by the Director of Nursing, on 5/15/12 at 1:00 P.M., indicated for Resident #26, "out of bed for all meals, no bedspread anytime, not to be alone in chair in room, bed to wall with alarming mat at bedside, alarm box out of reach."</p> <p>The fall circumstance, assessment and interventions forms and a time line of falls, provided by the Director of Nursing, on 5/15/12 at 12:30 P.M., indicated falls on the following dates:</p> <p>3/3/12 4 p.m. fall from recliner chair in room. added alarm to recliner, obtained urine sample. The timeline indicated an added intervention of alarm to recliner and obtain UA (urinalysis).</p> <p>3/4/12 6:30 A.M. fall from bed to floor mat.</p> <p>3/7/12 7:45 a.m. fall in room, fall from chair to floor mat. Being treated for urinary tract infection.</p> <p>3/15/12 found on floor, 7 p.m. sitting in wheelchair reaching for an object, landed on bottom. Intervention was allow up in wheelchair with objects close to her.</p> <p>Nurses notes, for this same time and date, indicated this occurred in the resident's room with the roommate yelling for help and alarm ringing.</p>			

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	<p>4/4/12 at 6 p.m. nurses notes indicated "resident reaching for clothes that daughter had brought to donate to staff...slid out of wheelchair..." The time line indicated the intervention of clothes removed.</p> <p>4/6/12 8:40 p.m. found on floor in resident's room, states rolled out of bed. Nurses notes, same date and time, indicated the alarm did sound.</p> <p>4/15/12 6:40 p.m. found on floor in room by bed, root cause- just got back form hospital for treatment of a urinary tract infection. Nurse's notes indicated the bed alarm was sounding. The timeline indicated for interventions" does have a possible urinary tract infection."</p> <p>4/18/12 8:45 P.M. found on floor in room, attempted to self ambulate, does not use call light, safety equipment was functioning at time of fall, resident was toileted by staff. Recent agitated or restlessness. The nurses notes entry for this same date and time indicated: "Received report from CNA resident was lying on the floor in front of her wheelchair. Resident stated she tried to get up to go home and she fell." The facility lacked documentation after the last three falls, of new interventions having been implemented, except testing</p>				

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	<p>and treatment for urinary tract infection.</p> <p>4/18/12 9:15 p.m. found on floor in resident's room, injury left wrist signs and symptoms of fracture, left wrist swelling, recent agitation or restlessness, states wants to go home. The report indicated the safety measures were in place. Nurses notes, dated 4/18/12 at 9:15 p.m. indicated: "Received report from CNA that resident got out of bed and fell in the doorway of her room. Resident was lying on her back with her knees bent. Resident was very confused and stated she wanted to go home...complains of left wrist pain, noticeable swelling..."</p> <p>The timeline provided by the DON indicated on 4/19/12 an antibiotic was ordered for increased confusion.</p> <p>Nurses notes indicated: "4/19/12 2:30 a.m. returned to facility at 1250 a.m. (sic) from hospital..found fracture to left wrist (colles fracture)...splinted left wrist..."</p> <p>4/23/12 7:10 p.m. found in floor of room, bed wheels were locked. Nurse notes, dated 4/23/12 at 7:15 p.m., indicated resident pulled self to room after meal, alarm sounded and resident found sitting slumped on floor, lethargic...self releasing alarming seat belt added.</p>			

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	<p>During interview with the Director of Nursing, on 5/15/12 at 1:30 p.m., she indicated the resident had a decline in condition in the past few months and had repeated urinary tract infections and anxiety.</p> <p>3.1-45(a)(2)</p>			