

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155481	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/15/2013
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NAME OF PROVIDER OR SUPPLIER ARBOR TRACE HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3701 HODGIN RD RICHMOND, IN 47374
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F000000	<p>This visit was for the Investigation on Complaint IN00131066.</p> <p>Complaint IN00131066 - Substantiated. Federal/state deficiency related to the allegation is cited at F323.</p> <p>Survey dates: July 11, 12, and 15, 2013</p> <p>Facility number: 000455 Provider number: 155481 AIM number: 100291010</p> <p>Survey Team: Barbara Gray, RN, TC Angel Tomlinson, RN (7/15/13)</p> <p>Census bed type: SNF: 26 SNF/NF: 59 Residential: 34 Total: 119</p> <p>Census payor type: Medicare: 24 Medicaid: 30 Other: 65 Total: 119</p> <p>Sample: 3</p>	F000000	<p>This plan of correction is to serve as Arbor Trace Exceptional Senior Living's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Arbor Trace or its management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.</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>This deficiency reflects state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 7/18/13 by Suzanne Williams, RN</p>				

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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, interview, and record review, the facility failed to transfer a resident safely, and failed to coordinate and communicate care, to prevent falls, for a resident with a history of falls, for 1 of 3 residents reviewed for falls in the sample of 3. (Resident #B)</p> <p>Findings:</p> <p>On 7/11/13 at 10:22 A.M., CNA #1, and CNA #2, were observed transferring Resident #B, from her wheelchair, to her bed. A pressure alarm was visible on Resident #B's wheelchair seat. Resident #B stood with two CNAs assisting, holding her under her arms, and grasping the back of her slacks near the waistband. Resident #B was pivoted, so her back faced the bedside, and then lifted onto the side of the bed in a sitting position. She was then lifted again to move her back from the edge of the bed. She was then assisted to lay down. A gait belt was not utilized during the transfer observation.</p>	F000323	<p>The facility will ensure this requirement is met through the following corrective measures: 1. Resident B was not harmed. Once facility management became aware, staff involved were re-educated on transfer techniques and alarms were placed/engaged per her plan of care. 2. All residents requiring staff assistance with transfers and at risk for falls have the potential to be affected. Care plans for those residents at risk were reviewed, along with nurse aide assignment sheets to ensure accuracy. See below for additional measures. 3. The policies related to fall management and gait belt use were reviewed and no changes were indicated at this time. Staff were re-educated on transfers and gait belt use and use of assignment sheets to ensure all care planned safety measures are in place. Newly hired nursing employees will receive gait belt use training as part of orientation. The DON or her designee will observe 5 random transfers weekly to ensure proper technique is used for 4 weeks, then 5 per month for 12 months.</p>	07/29/2013			

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	<p>Resident #B then received perineal care and was positioned for comfort. Her bed was lowered close to the floor. At that time, CNA #2 indicated Resident #B "used to bear more weight." CNA #2, indicated, when Resident #B was transferred, she often stood on her tip toes, or would draw her legs up, when she was assisted to stand. CNA #2 indicated Resident #B did not utilize any bed alarm or bedside floor mat.</p> <p>On 7/11/13 at 2:15 P.M., CNA #2 stated, when she transferred Resident #B, "I usually just use the top of her pants, and put my arm under her arm, because the belt slides up when I use the belt, especially when she is standing, and all of the sudden, raises her feet off the ground, and it pulls the belt up." CNA #2 indicated she used a gait belt with most residents who could stand on their own, but with Resident #B, the belt pulled up and pulled her forward, so she used Resident #B's slacks instead. CNA #2 indicated again, Resident #B did not utilize any bed alarm or bedside floor mat. When queried, CNA #2 indicated she used her CNA Assignment Sheet to determine each resident's care. A review of Resident #B's CNA Assignment Sheet indicated Resident</p>		<p>Additionally, the DON or her designee will randomly check 5 residents per week to ensure care planned interventions related to fall prevention are in place for 4 weeks, then 5 observations per month for 12 months. 4. Findings of these observations will be reviewed during the facility's Quality Assurance/Quality Improvement meetings and the plan of action adjusted accordingly until 100% compliance is achieved.</p>				

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	<p>#B utilized a chair alarm and a bedside fall mat.</p> <p>On 7/11/13, at 2:35 P.M., the Assistant Director of Nursing (ADON) indicated Resident #B was supposed to utilize a bed alarm. She indicated the alarm should have been moved from her wheelchair to her bed when she transferred. She indicated Resident #B no longer used a bedside fall mat, because she didn't move around in bed much anymore, and she had a bolster bed mattress. She indicated the CNA Assignment Sheet had not been updated. She indicated she was not sure of the date the CNA Assignment Sheet was last updated.</p> <p>On 7/11/13 at 2:40 P.M., the ADON indicated nursing staff received a gait belt in their orientation. She indicated staff were not trained at the facility on gait belt procedures. She indicated CNA staff receive their gait belt training in CNA class prior to hire. She stated, "they should be using a gait belt with all transfers."</p> <p>Resident #B's record was reviewed on 7/12/13 at 10:20 A.M. Her diagnoses included, but were not limited to, osteoarthritis, senile dementia, and anxiety.</p>			

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	<p>Resident #B's quarterly Minimum Data Set assessment, dated 5/29/13, indicated Resident #B had unclear speech, was usually understood, and she understood others. She scored 5, on her Brief Interview for Mental Status, indicating her cognitive skills for daily decision making were severely impaired. She required extensive assistance of two persons for transfers, and she did not walk. She had functional limitation in range of motion on both sides of her upper and lower extremities.</p> <p>A Care Plan, for Resident #B, indicated the following: Problem-Resident #B was at risk for falling, related to poor safety awareness, and lower extremity weakness. Goal-Resident #B would remain free from injury. Approaches-12/29/11-A clutter free environment would be provided. Resident #B would be observed frequently, and placed in a supervised area, when out of bed. Personal item, and frequently used items would be kept within reach. A call light would be in reach at all times. Resident #B's bed would be kept in the lowest position, with the brakes locked. Use of restraints would be avoided. 1/16/13-A new wheelchair</p>			
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	<p>pad was obtained. 3/12/13-Resident #B would have a dycem under her chair alarm. 3/22/13-Resident #B was moved closer to the nurses station. 3/28/13-Resident #B's wheelchair pad was labeled, front and back, to assure proper positioning. 7/8/13-Resident #B would have dycem (non slip surface) on her chair.</p> <p>The Fall Care Plan did not document how Resident #B should be transferred. No bedside fall mat, or bed alarm, were documented on Resident #B's Fall Care Plan, as indicated on her CNA Assignment Sheet.</p> <p>The most recent policy and procedure for Gait Belts for Transfers, provided by the Director of Nursing (DoN), on 7/12/13 at 2:10 P.M., indicated the following: "Standard: Gait belts are provided to assist staff to safely transfer or ambulate residents."</p> <p>The most recent Fall Prevention Program, policy and procedure, provided by the DoN, on 7/15/13 at 12:40 P.M., indicated the following: "...A structured fall prevention program can substantially reduce the rate of falls and related injuries. Identifying risk factors and applying timely interventions are the keys to a</p>						

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	<p>successful program. The following lists the components of our fall prevention program:... Completion of care planning and implementation of interventions. Ongoing evaluation of fall prevention plans. Training and education for staff...."</p> <p>This federal tag relates to Complaint IN00131066.</p> <p>3.1-45(a)(2)</p>				