

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155715	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/23/2012
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NAME OF PROVIDER OR SUPPLIER  LUTHERAN COMMUNITY HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274
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F0000	<p>This visit was for the Investigation of Complaint IN00113886.</p> <p>Complaint IN00113886 Substantiated. Federal/state deficiency related to the allegations is cited at F323.</p> <p>Unrelated deficiencies are cited.</p> <p>Survey dates: August 22 and 23, 2012</p> <p>Facility number: 000347 Provider number: 155715 AIM number: 100275440</p> <p>Survey team: Barbara Gray RN</p> <p>Census bed type: SNF/NF: 101 Residential: 33 Total: 134</p> <p>Census payor type: Medicare: 14 Medicaid: 51 Other: 69 Total: 134</p> <p>Sample: 4</p> <p>These deficiencies reflect state findings</p>	F0000	Submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirements under state and federal law. Please accept this plan of correction as our credible allegation of compliance.	

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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	cited in accordance with 410 IAC 16.2.  Quality review 8/28/12 by Suzanne Williams, RN				

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F0225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on observation, interview, and</p>	F0225	F 225 It is the policy of this facility	09/10/2012			

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	<p>record review, the facility failed to investigate and report a large bruised area of unknown origin timely, for 1 of 1 resident reviewed for bruises, in the sample of 4. (Resident #B)</p> <p>Findings include:</p> <p>On 8/22/12 at 1:25 P.M., Resident #B was seated in his wheelchair in the hallway, looking through some hats on a table. Resident #B had a bruised area on his right inner lower forearm. The center of the bruise was purple and approximately the size of a dime and extending out from the center to the approximate size of a quarter or half dollar was red. The Director of Nursing (DoN) at that time, indicated the bruised area extended across the top of his right wrist when it was first noted.</p> <p>Resident #B's record was reviewed on 8/23/12 at 10:20 A.M. Diagnoses included, but were not limited to, joint pain, fatigue, malaise, dementia, and mental disorders.</p> <p>Resident #B's quarterly Minimum Data Set assessment dated 8/5/12, indicated the following: Resident #B's cognitive skills for daily decision making were moderately impaired. Resident #B required extensive assistance of 2 persons</p>		<p>to report and to investigate immediately bruises of unknown origin. Corrective Action For The Resident Affected: The bruise was reported to the Director of Nursing and Administrator the following morning. An investigation was initiated immediately. The resident takes Aspirin daily which may account for the large size of the bruise. The staff member who originally found the bruise was educated on the facility policy to immediately report a bruise of this size from a known or unknown origin. He verbalized understanding of this instruction. Other Residents Having The Potential To Be Affected: All residents with injuries of unknown origin have the potential to be affected. All nurses were educated in staff meetings held 8-30-2012, 9-4-2012- and 9-5-2012 on reportable unusual occurrences. A copy of the facility policy was provided to each employee and each employee signed a form stating that they had been provided a copy of the policy, that they read the policy, and that they understand the policy. (Attachment titled Reportable Policy Employee Form). The reporting form for Injury of Known Origin was updated with a reminder for nurses to report a bruise greater than 15 cm immediately to the administrator. (Attachment titled Reporting Form of Known Origin). The reporting</p>				

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	<p>for bed mobility and transfers, and extensive assistance of 1 person for hygiene, bathing, and toileting.</p> <p>A care plan for Resident #B dated 10/12/11, indicated the following: Problem-Resident #B had potential for impaired skin integrity related to required assistance with turning, impaired mobility, cognitive deficits, incontinence, history of weight loss, history of pressure, and pain. Interventions-Resident #B would have his skin integrity observed during routine care and weekly skin assessments. An intervention was added 8/14/12-Monitor bruising until clear.</p> <p>A care plan for Resident #B dated 10/12/11, indicated the following: Problem-Resident #B was high risk for abnormal bruising or bleeding related to aspirin therapy. Intervention-Staff would promptly report any abnormal signs or symptoms such as unusual bruising.</p> <p>A nurses note for Resident #B dated 8/13/12 at 6:00 P.M., indicated the following: A purple bruise was noted on Resident #B's right forearm. The bruise measured 16 centimeters (cm) long and 5 cm wide.</p> <p>An Investigation, provided by the Director of Nursing (DoN) on 8/23/12 at</p>		<p>form for Injury of Unwitnessed Origin was updated with a reminder for nurses to report any bruise greater than 15 cm immediately to the administrator. (Attachment titled Reporting Form of Unwitnessed Origin). Systemic Changes And Steps To Ensure That The Deficient Practice Does Not Recur: All new nurses will be educated on the facility policy during new employee orientation. A copy of the facility policy will be provided to the new staff member. The new employee will read the policy, have an opportunity to ask questions regarding the policy, and will then sign off on a form indicating that they received, read, and understand the policy. The Director of Nursing or her designee will review all reporting forms of known and unknown origin to ensure that the appropriate notification occurred. If the appropriate notification did not occur, individual re-education of the staff member will occur. The Director of Nursing or her designee will keep an audit tool to track these results. (Attachment titled Skin Injury Report Summary/Audit Tool). Monitoring of Corrective Action: Audit results will be reviewed by the Quality Assurance Committee monthly for six months. If the appropriate care and documentation is completed 100% of the time, monthly monitoring will be stopped and</p>				

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	<p>11:00 A.M., indicated the following: Date/Description of Incident/Allegation: Resident #B had received a bruise to his right forearm, which was noted on a reporting form dated 8/13/12 at 6:00 P.M. On 8/14/12 at 1:15 P.M., an RN had called the DoN and reported to her the bruise measured 16 cm long by 5 cm wide, which was reportable per the facility's policy. The Administrator was notified of the bruise on 8/14/12 at 1:30 P.M.</p> <p>An interview with the DoN on 8/14/12 at 3:20 P.M., indicated the bruise on Resident #B's right wrist was reported to ISDH on 8/14/12 at 3:20 P.M.</p> <p>3.1-28(c) 3.1-28(d)</p>		<p>random audits will occur. A sample size of 25% will be completed monthly. If opportunities for improvement are identified through the random audit, a full audit will resume. If after six months of random audits, 100% compliance continues, auditing will stop.</p>		

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F0226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on observation, interview, and record review, the facility failed to implement their policy and procedure for investigating and reporting a bruise of unknown origin timely for 1 of 1 resident observed for bruises in the sample of 4. (Resident #B)</p> <p>Findings include:</p> <p>On 8/22/12 at 1:25 P.M., Resident #B was seated in his wheelchair in the hallway, looking through some hats on a table. Resident #B had a bruised area on his right inner lower forearm. The center of the bruise was purple and approximately the size of a dime and extending out from the center to the approximate size of a quarter or half dollar was red. The Director of Nursing (DoN) at that time, indicated the bruised area extended across the top of his right wrist when it was first noted.</p> <p>Resident #B's record was reviewed on 8/23/12 at 10:20 A.M. Diagnoses included, but were not limited to, joint</p>	F0226	<p>F 226 It is the policy of this facility to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Corrective Action For The Resident Affected: The bruise was reported to the Director of Nursing and Administrator the following morning. An investigation was initiated immediately. The resident takes Aspirin daily which may account for the large size of the bruise. The staff member who originally found the bruise was educated on the facility policy to immediately report a bruise of this size from a known or unknown origin. He verbalized understanding of this instruction. Other Residents Having The Potential To Be Affected: All residents with injuries of unknown origin have the potential to be affected. All nurses were educated in staff meetings held 8-30-2012, 9-4-2012- and 9-5-2012 on reportable unusual occurrences. A copy of the facility policy was provided to each employee and each employee signed a form stating that they</p>	09/10/2012			

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	<p>pain, fatigue, malaise, dementia, and mental disorders.</p> <p>Resident #B's quarterly Minimum Data Set assessment dated 8/5/12, indicated the following: Resident #B's cognitive skills for daily decision making were moderately impaired. Resident #B required extensive assistance of 2 persons for bed mobility and transfers, and extensive assistance of 1 person for hygiene, bathing, and toileting.</p> <p>A care plan for Resident #B dated 10/12/11, indicated the following: Problem-Resident #B had potential for impaired skin integrity related to required assistance with turning, impaired mobility, cognitive deficits, incontinence, history of weight loss, history of pressure, and pain. Interventions-Resident #B would have his skin integrity observed during routine care and weekly skin assessments. An intervention was added 8/14/12-Monitor bruising until clear.</p> <p>A care plan for Resident #B dated 10/12/11, indicated the following: Problem-Resident #B was high risk for abnormal bruising or bleeding related to aspirin therapy. Intervention-Staff would promptly report any abnormal signs or symptoms such as unusual bruising.</p>		<p>had been provided a copy of the policy, that they read the policy, and that they understand the policy. (Attachment titled Reportable Policy Employee Form). The reporting form for Injury of Known Origin was updated with a reminder for nurses to report a bruise greater than 15 cm immediately to the administrator. (Attachment titled Reporting Form of Known Origin). The reporting form for Injury of Unwitnessed Origin was updated with a reminder for nurses to report any bruise greater than 15 cm immediately to the administrator. (Attachment titled Reporting Form of Unwitnessed Origin). Systemic Changes And Steps To Ensure That The Deficient Practice Does Not Recur: All new nurses will be educated on the facility policy during new employee orientation. A copy of the facility policy will be provided to the new staff member. The new employee will read the policy, have an opportunity to ask questions regarding the policy, and will then sign off on a form indicating that they received, read, and understand the policy. The Director of Nursing or her designee will review all reporting forms of known and unknown origin to ensure that the appropriate notification occurred. If the appropriate notification did not occur, individual re-education of the staff member will occur.</p>				

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	<p>A nurses note for Resident #B dated 8/13/12 at 6:00 P.M., indicated the following: A purple bruise was noted on Resident #B's right forearm. The bruise measured 16 centimeters (cm) long and 5 cm wide.</p> <p>An Investigation, provided by the Director of Nursing (DoN) on 8/23/12 at 11:00 A.M., indicated the following: Date/Description of Incident/Allegation: Resident #B had received a bruise to his right forearm, which was noted on a reporting form dated 8/13/12 at 6:00 P.M. On 8/14/12 at 1:15 P.M., an RN had called the DoN and reported to her the bruise measured 16 cm long by 5 cm wide, which was reportable per the facility's policy. The Administrator was notified of the bruise on 8/14/12 at 1:30 P.M.</p> <p>An interview with the DoN on 8/14/12 at 3:20 P.M., indicated the bruise on Resident #B's right wrist was reported to ISDH on 8/14/12 at 3:20 P.M.</p> <p>The Reportable Unusual Occurrences (Incidents) policy and procedure, provided by the DoN on 8/23/12 at 12:05 P.M., indicated the following: "Policy Statement: All unusual occurrences will be reported to the Indiana State Department of Health and will be</p>		<p>The Director of Nursing or her designee will keep an audit tool to track these results. (Attachment titled Skin Injury Report Summary/Audit Tool). Monitoring of Corrective Action: Audit results will be reviewed by the Quality Assurance Committee monthly for six months. If the appropriate care and documentation is completed 100% of the time, monthly monitoring will be stopped and random audits will occur. A sample size of 25% will be completed monthly. If opportunities for improvement are identified through the random audit, a full audit will resume. If after six months of random audits, 100% compliance continues, auditing will stop.</p>		

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	<p>monitored to ensure that residents are receiving appropriate care and services.</p> <p>Policy Interpretation and Implementation:</p> <p>1. All unusual occurrences are reported immediately to the Administrator and to the Indiana State Department of Health. Reportable and unusual occurrences include: Significant injuries-Large areas of contusion (15 cm or larger)...."</p> <p>3.1-28(a)</p>			

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F0323 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 implement interventions to prevent falls, for 1 of 3 residents reviewed for falls, in the sample of 4 (Resident #A).</p> <p>Findings include:</p> <p>On 8/22/12 at 2:24 P.M., Resident #A was observed being positioned in her wheelchair in her bedroom by CNA #1 and CNA #2. CNA #2 indicated they had just transferred Resident #A from the bed to her wheelchair with the use of a Hoyer Lift. Resident #A's bilateral feet were placed on a padded foot rest attached to the wheelchair. Resident A's bilateral feet were contracted. A clip alarm was attached to Resident #A's sweatshirt. Resident #A indicated she had hit her head the last time she fell.</p> <p>Resident #A's record was reviewed on 8/22/12 at 2:48 P.M. Diagnoses included, but were not limited to, neurologic weakness, other muscle weakness, gait disorder, and other acquired deformities</p>	F0323	F 323 Free Of Accident Hazards/Supervision/Devices: It is the policy of this facility to 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. Corrective Action For The Resident Affected: An intervention was added to this resident's care plan to unplug the lift chair once she was positioned appropriately to ensure that she would not attempt to use the remote control when she was left alone in her room. Other Residents Having The Potential To Be Affected: All residents who are at risk for falls have the potential to be affected. An audit was completed of each resident's fall interventions to ensure that the appropriate interventions are in use. Systemic Changes And Steps To Ensure That The Deficient Practice Does Not Recur: Fall intervention care cards were created for each resident who is at fall risk with interventions in place. (Attachment titled Fall Intervention Kardex). The fall	09/10/2012			

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	<p>of the ankle and foot.</p> <p>Resident #A's annual Minimum Data Set assessment dated 5/23/12, indicated the following: Resident #A's cognitive skills for daily decision making were cognitively intact. Resident #A required extensive assistance of 2 persons for bed mobility and transfers, and she did not walk.</p> <p>A Podiatry Exam for Resident #A dated 7/17/12, indicated the following: Musculoskeletal-Resident #A did not ambulate. Her muscle strength was decreased on her right and left feet. She had Hammer Toe deformities to her right 2nd and 3rd toe, and her left 2nd and 3rd toe. Her deformity on her right and left feet were a Hallux Valgus (bunion). Range of motion was limited on her bilateral feet.</p> <p>A care plan for Resident #A dated 12/12/11, indicated the following: Problem-Resident #A was at risk for falls and injuries related to psychotropic and pain medications, weakness, incontinence, non-compliance with safety equipment, unsteady gait, and a history of falls. Intervention-Resident #A was to have a chair alarm. Interventions added 7/28/12-Staff would make sure Resident #A's recliner controller was not in reach</p>		<p>care cards were placed on a ring and the CNA's and the nurses working on the nursing unit will carry them in their pocket for quick reference. The care cards will include all of the interventions that should be in place so that staff can double-check that they have implemented every intervention. The nursing management team will spot check three residents daily, at least five days per week, to check for the presence of the appropriate fall interventions. The result of their rounding will be documented on the enclosed audit tool. (Attachment titled Fall Intervention Audit Tool). Monitoring of Corrective Action: The results of the nursing management rounding will be reviewed by the Quality Assurance Committee monthly for six months. If the appropriate implementation of fall interventions occurs 100% of the time, monthly monitoring will be stopped and random audits will occur. A sample size of 25% will be completed monthly. Falls will always be an area of concern and will continue to remain on the agenda monthly for the Quality Assurance Committee to review and discuss.</p>		

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	<p>and her recliner would be kept unplugged at all times.</p> <p>Nurses notes for Resident #A indicated the following: 7/28/12 at 3:00 P.M. -Resident #A had been found on the floor in her bedroom on her left side, in front of her recliner. Resident #A had complained her head hurt and she had a 5 centimeter (cm) hematoma on the left side of her forehead. Resident #A's chair alert clip alarm had not been on her recliner. 7/28/12 at 9:45 P.M.-Resident #A had returned from a local hospital. She had a 1 cm by 1.5 cm abrasion on her left knee, an 8 cm by 8 cm hematoma on the left side of her forehead, her left hand was swollen and had bruising on her 2nd, 3rd, 4th, and 5th fingers.</p> <p>A Post Fall Reporting Form for Resident #A dated 7/28/12, indicated the following: Other cause-Resident #A had raised her recliner in high position and slid out onto the floor. Injuries-Resident #A had a hematoma 5 cm in diameter on her left forehead and a small 1/2 cm cut on her lip. Possible care plan interventions to prevent a future fall from occurring-Remove recliner chair control out of the resident's recliner. Double check that her clip alarms are on.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155715	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/23/2012
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	<p>An interview with the Director Of Nursing (DoN) on 8/22/12 at 4:38 P.M., indicated on 7/28/12, Resident #A used her lift recliner remote and fell out of the recliner on the floor. Resident #A did not have her clip alarm attached to her chair.</p> <p>An interview with the Administrator on 8/22/12 at 5:00 P.M., indicated on 7/28/12, Resident #A had her electric recliner remote in reach, raised herself out of the chair, and fell. The Administrator indicated she believed Resident #A would not have fallen if she had not had the remote. The Administrator indicated Resident #A did not have her clip alarm on her recliner when she fell.</p> <p>This federal tag relates to Complaint IN00113886.</p> <p>3.1-45(a)(2)</p>				