

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155708	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/20/2011
NAME OF PROVIDER OR SUPPLIER HILLSIDE MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1109 EAST NATIONAL HIGHWAY WASHINGTON, IN47501		
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F0000	<p>This visit was for the Investigation of Complaint IN00091676.</p> <p>Complaint IN00091676 - Substantiated. Federal/State deficiencies related to the allegations are cited at F-323 and F-514.</p> <p>Survey date: 06/20/11</p> <p>Facility number: 000303 Provider number: 155708 AIM number: 100287530</p> <p>Survey Team: Sharon Whiteman RN</p> <p>Census bed type: SNF: 0 SNF/NF: 43 Total: 43</p> <p>Census payor type: Medicare: 06 Medicaid: 34 Other: 03 Total: 43</p> <p>Sample: 03</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2.</p> <p>Quality review completed 6/24/11 by Jennie Bartelt, RN.</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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F0323 SS=D	<p>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 and record review, the facility failed to ensure a resident was supervised and provided appropriate seating to prevent a fall, and failed to assess the resident after a fall for 1 of 3 residents reviewed for falls in a sample of 3. (Resident #B)</p> <p>Findings include:</p> <p>During initial observation tour on 06/20/11 at 8:50 a.m. with the DON (Director or Nursing) present, Resident #B was identified as being a fall risk, as having had a recent fall, and as being cognitively impaired.</p> <p>Documentation titled "Incident/Accident Report" was provided by the DON on 06/20/11 at 10:30 a.m. The report indicated Resident #B was "Talking on phone. Found on floor next to phone." The documentation indicated the incident occurred on the "p.m." shift. The exact time of the fall was not documented. The "Incident/Accident Report" lacked documentation supporting whether or not the resident sustained any injuries during the fall. The report indicated Resident</p>			F0323	<p>Please accept the POC as Hillside Manor's creditable allegation of compliance.F 323Resident B so cited was being supervised by the nurse on duty at the public telephone area. Resident B sat in a convenient wheelchair and, missing it, sat on the floor. Resident B had no injury.The no injury fall was properly documented in the nurses notes and reported. The thorough and complete documentation of the no injury fall, including timely assessments was completed by the attending nurse. Included within the assessment was an immediate intervention of a wide arm chair that was placed at the telephone site.In accordance to our established policy, the comprehensive documenatation and interventions was reviewed the next day following the fall by the "Fall Committee" (that meets daily each am).The appropriate and complete documentation was reviewed by the administrator, D.O.N., and the MDS coordinator (three of the members on the fall committee). Each approved, without change, the nurses notes on 5-24-2011. Subsequent to this: the nurse that wrote the comprehensive documentation,</p>		06/30/2011

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	<p>#B's family was present at the time of the fall and the physician had been notified. This documentation was dated 05/23/11.</p> <p>Review of Resident #B's clinical record on, 06/20/11 at 11:10 a.m., indicated the following:</p> <p>Resident #B had diagnoses which included, but were not limited to, vascular dementia, morbid obesity, osteoporosis, and osteoarthritis.</p> <p>A quarterly MDS (minimum data set) assessment, dated 03/09/11, indicated Resident #B had impaired cognition, required extensive assistance of staff with transfers, and had no falls during the assessment period.</p> <p>A nursing note, dated 05/16/11, was followed by no further documentation in nursing notes until 05/24/11 at 3:00 p.m.</p> <p>A nursing note, dated 05/24/11 at 3:00 p.m., indicated, "Resident [B] pleasant et [and] in good spirits this shift. [symbol for the word no] C/O [complaints of] pain or discomfort voiced. Alert [symbol for with] occasional confusion. Speech clear. Verbalizes wants (sic) needs. Ambulates [symbol for with] walker et [symbol for assistance of] 1. Resting in chair at this time. Will cont [continue] to</p>		<p>quit and left employment. The nurses note from 5-16-2011 to 5-24-2011 (1 page front and back) apparently left the facility also.Changes implemented: (1) Hillside Manor shall so record any fall incidents in "medical record" and not limit documenation to only the nurses notes. (2) The fall committee shall make a copy of all documents reviewed from the nurses notes and medical record (3)These copies shall be retained in the fall log and kept securely in the Adminstrators office for the next 6 months. The Quality Assurance Committee met on 6-28-2011 and agreed to monitor the saftey and security of the copied records of the fall log for the next 6 months. The administrator shall be responsible for compliance and implementation of the QA review.</p>				

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	<p>monitor."</p> <p>A nursing note, dated 05/24/11 at 6:00 p.m., indicated, "Resident [#B] pleasant this shift. [Symbol for no] C/O [complaints of] pain/discomfort voiced. Resident [#B] ambulates [symbol for with] walker and 1 [symbol for assist]. (Family) here visiting at supper."</p> <p>The clinical record lacked documentation regarding the resident's fall on 05/23/11. The clinical record lacked documentation supporting the resident's physician being called and lacked documentation of follow-up fall assessments.</p> <p>Interview of the Administrator on 06/20/11 at 1:10 p.m., indicated nursing staff had witnessed the resident's fall on 05/23/11. The Administrator indicated the resident was assisted by LPN #2 and a gait belt to a phone in the hall. The Administrator indicated there was a wheel chair near the phone which was too narrow for the resident's bottom. The Administrator indicated the LPN #2 turned around for a second and the resident attempted to sit down in the wheel chair and caught the edge of the wheel chair and "plopped down" on her bottom. The Administrator indicated the resident sustained no injuries due to the fall. The Administrator indicated an arm</p>						

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	<p>chair had been placed near the phone as an intervention to prevent further falls.</p> <p>Documentation titled "Falls Management System" (no date) was provided by the DON on 06/20/11 at 12:05 p.m. The documentation indicated, "The facility is committed to promoting resident autonomy by providing an environment that remains as free of accident hazards as possible....each resident will be provided with appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurs. Additionally, all resident falls in this facility are analyzed and trended through the monthly Quality Assurance meeting to maintain a safe environment....Procedure - When a resident sustains a fall, an assessment for injury by a licensed nurse is completed and the results documented in the nurses' notes and the incident will be recorded on the 24 hour nursing report sheet. The attending Physician and family/responsible party are notified of the fall and the resident's status....Follow-up assessment and documentation will be conducted and recorded in the nurses' notes every shift for a minimum of 72 hours."</p> <p>This federal tag relates to Complaint IN00091676.</p>				

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F0514 SS=D	<p>3.1-45(a)(2)</p> <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 interview and record review the facility failed to ensure a resident's clinical record was complete and accurate with documentation in accordance with facility policy related to assessment, description, and follow-up of a resident's fall for 1 of 3 residents reviewed for falls in a sample of 3. (Resident #B)</p> <p>Findings Include:</p> <p>During initial observation tour on 06/20/11 at 8:50 a.m. with the DON</p>	F0514	F514Resident B so cited was being supervised by the nurse on duty at the public telephone area. Resident B sat in a convenient wheelchair and, missing it, sat on the floor. Resident B had no injury.The no injury fall was properly documented in the nurses notes and reported. The thorough and complete documentation of the no injury fall, including timely assessments was completed by the attending nurse. Included within the assessment was an immediate intervention of a wide arm chair	06/30/2011	

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	<p>Administrator indicated there was a wheel chair near the phone which was too narrow for the resident's bottom. The Administrator indicated the resident attempted to sit down in the wheel chair and caught the edge of the wheel chair and "plopped down" on her bottom. The Administrator indicated the resident sustained no injuries due to the fall. The Administrator indicated an arm chair had been placed near the phone as an intervention to prevent further falls.</p> <p>Documentation titled "Falls Management System" (no date) was provided by the DON on 06/20/11 at 12:05 p.m. The documentation indicated, "The facility is committed to promoting resident autonomy by providing an environment that remains as free of accident hazards as possible....each resident will be provided with appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurs. Additionally, all resident falls in this facility are analyzed and trended through the monthly Quality Assurance meeting to maintain a safe environment....Procedure - When a resident sustains a fall, an assessment for injury by a licensed nurse is completed and the results documented in the nurses' notes and the incident will be recorded on the 24 hour nursing report sheet. The attending Physician and</p>						

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	<p>family/responsible party are notified of the fall and the resident's status....Follow-up assessment and documentation will be conducted and recorded in the nurses' notes every shift for a minimum of 72 hours."</p> <p>This federal tag is related to Complaint IN00091676.</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>				