

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155241	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/13/2012
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NAME OF PROVIDER OR SUPPLIER FOREST CREEK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 525 E THOMPSON RD INDIANAPOLIS, IN 46227
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F0000	<p>This visit was for Investigation of Complaints IN00104644 and IN00104667.</p> <p>Complaint IN00104644 Substantiated, no deficiencies related to the allegations are cited.</p> <p>Complaint IN00104667 Substantiated. Federal/State deficiency related to the allegations is cited at F323.</p> <p>Survey dates: March 12 & 13, 2012</p> <p>Facility Number: 000145 Provider Number: 155241 AIM Number: 100275110</p> <p>Survey Team: Mary Jane G. Fischer, RN</p> <p>Census Bed Type: SNF: 25 SNF/NF: 94 Total: 119</p> <p>Census Payor Type: Medicare: 25 Medicaid: 76 Other: 18 Total: 119</p>	F0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation.	

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>Sample: 5 Supplemental Sample: 3</p> <p>These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on March 15, 2012 by Bev Faulkner, RN</p>			

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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 observation, interview and record review, the facility failed to ensure residents were protected from injury and the potential for injury during transport: in that when cognitively impaired residents were transported via a wheelchair, the nursing staff failed to ensure the residents were moved safely throughout the unit and ancillary areas of the facility. This resulted in two residents falling forward from the wheelchair in which one resident's fall resulted in a head laceration which required emergency room intervention.</p> <p>In addition the nursing staff failed to provide supervision of a resident while toileting, which resulted in the resident falling to the floor.</p> <p>This deficient practice affected 3 of 5 sampled and 2 of 3 supplemental sampled residents. [Residents "F", "A", "C", "G", "H" and "D"].</p> <p>Findings include:</p>	F0323	<p>Resident F was evaluated by therapy for proper positioning in wheelchair. Interventions are in place for the resident, including the use of a specialty wheelchair. Staff education and discipline was provided to the nursing assistant. Resident A no longer resides at facility. Care plan for Resident C was updated to include supervision while toileting. Staff education and discipline was provided. Resident G no longer resides at facility. Resident H received treatment, per physician's order for skin tear. Geri sleeves were ordered to protect resident skin from injury. Care plan updated to include interventions. Employee referenced is no longer employed at facility. Resident D was provided footrests to wheelchairs. Resident care plan and assignment sheet were updated to include use of foot pedals while transporting resident throughout facility. Director of Nursing Services (DNS) will conduct an audit of all residents who are risk for falls and/or require staff assistance with transfer/mobility. All residents identified will be reviewed by the Interdisciplinary</p>	04/12/2012	

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	<p>1. The record for Resident "F" was reviewed on 03-13-12 at 10:15 a.m. Diagnoses included but were not limited to dementia, cerebral vascular accident, glaucoma, hypertension and osteoporosis. These diagnoses remained current at the time of the record review.</p> <p>The record indicated the resident fell from the wheelchair while being transported down the hallway and sustained a head laceration.</p> <p>During an observation on 03-13-12 at 9:45 a.m., Resident "F" was observed lying on a mattress which had been placed on the floor. During this observation the resident appeared to have bruising to bilateral eyes areas.</p> <p>Interview on 03-13-12 at 9:50 a.m., Licensed Practical Nurse, employee #4, verified the resident had bruising after falling from the wheelchair. When further interviewed, the employee indicated a "CNA [certified nurses aide] was pushing the resident, while seated in a wheelchair, down the hall and [resident] placed [resident] feet on the floor and went out the front of the wheelchair head first. [Resident] ended up with a laceration and a skin tear, we had to send [resident] to the hospital where they had to suture the laceration." The Licensed</p>		<p>Team (IDT) to ensure each resident receives adequate supervision and assistive devices as indicated. IDT includes Rehabilitation Services Manager (RSM), DNS, Social Services, Activities, and Minimum Data Set (MDS) Nurse Coordinator. Interventions and devices will be added to each resident's individual plan of care. All residents will be assessed for fall risk and mobility status upon admission, at least quarterly, and upon change in condition. Residents identified at risk will have appropriate interventions added to their plan of care by nursing staff and/or IDT upon admission, during quarterly assessment, or upon change in resident condition. Rounds will be conducted daily by charge nurse on each shift to ensure fall interventions are in place and followed per plan of care/assignment sheets. Staff Development Coordinator (SDC) or designee will in-service all staff on fall and accident prevention. Training will include safely transporting residents and appropriate assistive devices. In-service training will be completed by April 12, 2012. Fall and accident prevention will be added to New Employee Orientation. Fall and accident prevention training will be added to Annual In-Service Calendar. IDT will review all new admissions, residents</p>		

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	<p>Nurse further indicated, the foot pedals were on the wheelchair but the CNA didn't place [resident's] feet on them, "they dangled in between them. Once [resident] feet hit the floor, that's all it took."</p> <p>Interview on 03-13-12 at 10:20 a.m., the Director of Nurses indicated "I reviewed the video and I could see that [name of resident] was fidgeting in the wheelchair and was kind of sitting on the edge of the seat. The CNA repositioned the resident but you could see [resident] was still fidgeting. The video showed the CNA pushing [resident] in the wheelchair, and then [the CNA] reaching forward. The video didn't show the fall and I couldn't really see what happened."</p> <p>Review of "Resident Progress Notes" indicated the following:</p> <p>"03-07-12 11:00 p.m. - Resident leaning forward in W/C [wheelchair] fell forward and hit forehead on W/C peddles [sic] while CNA was pushing resident down hallway to room. Noted resident had 2 cm laceration noted to forehead."</p> <p>"03-08-12 3:32 a.m. - Resident's [family member] arrived at facility prior to resident arrival. ER nurse called to give report, stated resident has 2 sutures to</p>		<p>scheduled for quarterly assessments, and all residents with change in condition during daily clinical meeting Monday thru Friday. Clinical records will be reviewed to ensure all residents have interventions and assistive devices in place as indicated. IDT will review all falls during daily clinical meetings to ensure interventions are in place and make recommendations as appropriate. Interventions may include Physical Therapy, Occupational Therapy evaluation and treatments, application of monitoring devices, safety devices such as hipsters, room modifications, or other recommendations by IDT or physician orders. Staff training and/or disciplinary actions will be given for non-compliance of resident's plan of care. Interventions and follow up will be added to facility Continuous Quality Improvement (CQI) log daily by IDT. DNS or designee will audit CQI weekly to ensure appropriate actions were taken. CQI logs will be reviewed weekly for 2 months, then bi-weekly for 2 months, then monthly for 2 months. CQI logs will be reviewed by Quality Assurance (QA) Committee monthly. QA Committee will continue monitoring until compliance is maintained for 2 consecutive quarters. QA committee includes the Medical Director, Administrator, DNS,</p>		

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	<p>forehead. covered with dry dressing. Skin tear to resident's right arm, covered with dry dressing. ER nurse instructed this nurse to monitor both sites for s/s [signs and symptoms] of infection and any increased drainage. Resident's [family member] voiced frustration about fall."</p> <p>"03-09-12 10:52 p.m. - Continues with laceration on forehead and blue sutures intact. Nose is also scrapped alittle [sic]. Several purple and blue discolorations on face."</p> <p>A review of the facility incident report, dated 03-07-12 at 10:30 p.m., indicated the following:</p> <p>"Witnessed fall, [location] hallway, non compliant resident, totally dependent. In wheelchair with CNA pushing res. [After fall] resident sitting on buttocks with back on wall. Resident hit head and noted to have 2 cm laceration to forehead. CNA stated resident was leaning forward and fell out of wheelchair when she [CNA] was pushing [resident] down the hallway. Resident was incontinent at the time of the fall. Resident leaning forward and hit forehead on wheelchair pedals while nursing CNA was pushing resident down the hallway to room."</p> <p>Review of additional information and</p>		RSM, MDS Nurse Coordinator, SDC, Social Service Director, Activity Director, or other disciplines or designees. If 95% threshold is not achieved, and action plan will be developed.	

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	<p>documented by the Hospice nurse indicated the following in regard to the incident, and dated 03-10-12: "Pt. [patient] is a fall risk with a hx. [history] of falls. Pt. has fallen times 2 this past week. The first fall resulted in a trip to the ER [Emergency Room]. Pt. sustained a forehead skin tear requiring sutures...and has bruising surrounding the skin tear. Bruising is also present to both eyes. Pt. also sustained a skin tear to RFA [right forearm] requiring steristrips. Numerous large bruises noted to BLE's [bilateral lower extremities]. Activity Mobility - wheelchair mobility assist, poor coordination and balance, bed or chair bound. Pt. is total care for ADL's [activities of daily living]."</p> <p>Review of CNA #9 employee's file indicated the following in regard to the circumstances with the fall which involved Resident "F."</p> <p>"On 03-07-12 employee was witnessed via facility camera sitting in dining room on her cell phone while a resident who was anxious and in need of attention sat nearby. This employee failed to provide the necessary attention to the resident. Shortly after this incident while pushing resident in [resident] wheelchair to room by this employee, resident fell forward out of wheelchair causing injury. This</p>			

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	<p>employee failed to prevent this fall by not addressing this resident timely. Employee did assist resident in positioning prior to transporting but at this point the assistance was not able to prevent the fall."</p> <p>During interview on 03-13-12 at 2:00 p.m., the Director of Nurses indicated the CNA should have requested assistance from other nursing staff to provide safety while transporting this resident.</p> <p>2. The record for Resident "A" was reviewed on 03-12-12 at 9:15 a.m. Diagnoses included but were not limited to Alzheimer's disease, glaucoma, cataract - left eye, dementia and blindness to the right eye. These diagnoses remained current at the time of the record review. The record indicated the Resident had been admitted to the facility for Respite care on 02-20-12.</p> <p>The record indicated the resident required the use of nursing staff for ambulation on/off Unit as well as in room.</p> <p>Review of the Occupational Therapist Plan of Treatment, dated 02-21-12, indicated the resident has "low endurance - needs frequent rests. Fall risk. Patient presents with decreased functional mobility, balance, coordination, strength</p>			

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	<p>and endurance...."</p> <p>Review of the Progress Note, dated 02-24-12 at 7:22 p.m., indicated the following:</p> <p>"Res. was being pushed down the hall to be put to bed. CNA stated that resident planted foot on ground causing [resident] to fall forward out of chair. CNA stated resident did not hit head."</p> <p>"02-25-12 5:35 p.m. Care Plan meeting held with [family members]. Discussed fall prevention efforts... "</p> <p>"02-27-12 10:01 a.m., IDT [interdisciplinary team] fall review... resident landed on left side no injury noted. Family also requested footrests be placed on the wheelchair at this time. Res. has dx. [diagnosis] of Alzheimer's dementia and at time [sic] attempts to self transfer causing increased risk of falls if footrests in place. Staff attempted to explain risk to family. Family states they want footrests in place."</p> <p>A review of the employee file for CNA employee #5, who was identified by the Director of Nurses as the CNA who was involved with the fall for the resident, indicated the following:</p> <p>"On 02-24-12 this employee was</p>			

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	<p>transferring a resident down the hall when the resident planted feet in [sic] the floor and fell forward. By this employee's own admission she states that she was looking away at the time the incident occurred therefore playing part in the fall that occurred. Employee has been educated in the importance of giving resident her undivided attention when providing care and transportation. Also prior to transferring anyone, resident's positioning should be checked."</p> <p>During an interview on 03-12-12 at 11:43 a.m., a concerned family member indicated that when the family spoke with the Administrative staff at the facility "they made us feel as if [resident] was to blame for falling from the wheelchair. The foot rests should have been on the wheelchair."</p> <p>3. The record for Resident "C" was reviewed on 03-12-12 at 10:40 a.m. Diagnoses included but were not limited to malignant neoplasm colon, glaucoma, and atrial fibrillation. These diagnoses remained current at the time of the record review.</p> <p>The record indicated the resident had no cognitive impairment, but required extensive assistance and 2 staff members with toileting.</p>			

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	<p>Review of the resident's plan of care indicated the resident was at high risk for falls due to decreased balance, need for assistance with transfers"</p> <p>Review of the "fall event," dated 03-09-12 at 1:07 a.m., indicated the following: "Found on floor next to wheelchair sitting on buttocks. States [resident] was trying to sit in wheelchair and didn't realize the wheelchair was turned around... Resident educated to use assistance when transferring. Resident states thought [resident] had gotten strong enough to walk alone."</p> <p>A review of the facility Incident Report, dated 03-09-12 at 1:15 a.m., indicated the resident was "found on the floor - non compliant resident - unwitnessed - sitting on bottom with knees bent trying to get up."</p> <p>During interview on 03-13-12 at 11:00 a.m. the Director of Nurses indicated CNA employee #6 had taken the resident "to the bathroom and left the resident unattended while answering another call light."</p> <p>Review of the employee file indicated the CNA "assisted resident into bathroom and</p>			

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	<p>didn't remain in the restroom. Resident had a fall that occurred due to the occurrence. Discussed importance of ensuring that resident when requiring assistance are not left unattended in restroom."</p> <p>4. The record for Resident "G" was reviewed on 03-13-12 at 2:00 p.m. Diagnoses included but were not limited to Alzheimer's disease, trans- ischemic attacks, cerebral vascular accident, hypertension and anxiety. These diagnoses remained current at the time of the record review.</p> <p>During a review of CNA employee #7 file indicated the following "Resident/Family Concern/Grievance Form," dated 09-02-11, "Staff member (Name of employee #7) in dining room wheeling [name of resident] to table got resident foot caught under chair. Res. yelled out. Staff member still unaware foot was caught. Another CNA let [name of employee #7] know foot was caught. [Name of employee] stated 'I do not have time for this' grabbed res. shorts to hold legs up and as [name of employee #7] was pushing res. ran res. into another resident in dining room. CNA noted to have poor attitude."</p> <p>During interview on 03-13-12 at 2:00</p>			

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	<p>p.m., the Director of Nurses indicated the CNA was a "really good CNA but just didn't have good customers service and came across as mean." The Director of Nurses indicated the CNA was also involved in another incident in which Resident "H" received a skin tear while providing care to the resident. "The family member indicated the CNA was rough with the resident."</p> <p>5. The record for Resident "D" was reviewed on 03-13-12 at 9:35 a.m. Diagnoses included but were not limited to schizophrenia, anxiety, dementia, moderate mental disorder and a history of alcohol abuse. These diagnoses remained current at the time of the record review.</p> <p>The record indicated the resident was severely cognitively impaired and required the assistance of the nursing staff for ambulation on and off the nursing unit.</p> <p>During an observation on 03-13-12 at 9:25 a.m., this resident was seated in a wheelchair and indicated a desire to go to the Activity area of the facility. Licensed Practical Nurse, employee #10, instructed the resident "Hold up your legs and I'll push you." The Licensed Nurse proceeded to push the resident down the hallway, and continued to instruct the</p>			

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	<p>resident "hold up your legs, remember what I said, hold your feet up [emphatic]." This dialog continued by the Licensed Nurse as she continued to push the resident down the hallway to the Activity area. During this observation, the resident did not have foot pedals on the wheelchair.</p> <p>6. During an observation on 03-12-12 at 9:30 a.m., Resident "C" was being transported from the Therapy area adjacent to the Administrator's office to another section in the front of the facility. The therapist indicated the resident needed to have "blood drawn" and was being transported to another area. The therapist instructed the resident multiple times, "hold your feet up, hold your feet up," while transporting the resident.</p> <p>7. During an interview on 03-13-12 at 10:00 a.m., the Therapy Director, employee #8, indicated "We don't ordinarily use foot pedals on the wheelchairs as they can cause a fall risk. If a resident has full range of the lower extremities we try to encourage them to continue to use the legs, but if a resident is cognitively impaired the pedals could increase the risk of falling." When further interviewed how an assessment was made for a resident who was admitted to the facility and was determined to be</p>			

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(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
	<p>cognitively impaired, and received therapy for strengthening, and after a therapy session, was too tired to "hold up their legs or feet," and the reasoning why foot pedals could not be used for the transportation of the resident from one area of the facility to another, the Director indicated that upon admission the "Occupational Therapist" checks for the need of a cushion, leg pedals, a high back wheelchair or hemi height wheelchair for the resident. After that we [in reference to the therapy department staff] do the evaluation quarterly. The nurses need to let us know if there is a change or decline in the resident's condition."</p> <p>When interviewed about the fall in regard to Resident "F" and if the equipment had been checked or deemed appropriate for the resident, the Director indicated, "Oh [resident] Hospice, we just picked [resident] up after the fall."</p> <p>In regard to Resident "A" and the foot pedals, the Director indicated "we tried to educate the family that the pedals could cause a fall if the resident tried to get up independently."</p> <p>During interview on 03-13-12 at 10:20 a.m., the Director of Nurses verified the family for Resident "A" wanted the foot pedals on the wheelchair and were very</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155241	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/13/2012
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	<p>upset that the resident had fallen forward from the wheelchair while being transported from the dining area to the resident room. The Director of Nurses further indicated that if foot pedals were placed on all wheelchairs, there would hardly be any room in the Activity area for the residents attending activities.</p> <p>This Federal tag relates to IN00104667.</p> <p>3.1-45(a)(2)</p>			