

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/17/2014
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NAME OF PROVIDER OR SUPPLIER  MANORCARE HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN 46011
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F000000	<p>This visit was for the Investigation of Complaints IN00151272 and IN00152518.</p> <p>Complaint IN00151272 - Substantiated. Federal/State findings related to the allegations are cited at F309, F312, and F315.</p> <p>Complaint IN00152518 - Substantiated. Federal/State findings related to the allegations are cited at F315, F323, and F514.</p> <p>Survey date: July 15, 16, and 17, 2014</p> <p>Facility number: 000005 Provider number: 155005 AIM number: 100270840</p> <p>Surveyor: Betty Retherford RN</p> <p>Census bed type: SNF/NF: 129 SNF: 22 Total: 151</p> <p>Census payor type: Medicare: 18 Medicaid: 111 Other: 22</p>	F000000		

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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F000309 SS=D	<p>Total: 151</p> <p>Sample: 6</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.-3.1.</p> <p>Quality review completed by Debora Barth, RN.</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a monthly steroid injection was given as ordered for 1 of 1 resident reviewed with the diagnosis of multiple sclerosis in a sample of 6. (Resident #B)</p> <p>Findings include:</p> <p>The clinical record for Resident #B was reviewed on 7/15/14 at 1:20 p.m. Diagnoses for the resident included, but were not limited to, multiple sclerosis,</p>	F000309	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>A review has been completed of Resident B's clinical record, physician's orders and their MAR (Medication Administration Record). Resident B is currently receiving medications timely and as per physician order.</p> <p><b>How will other residents having the potential to be affected by the same deficient practice be identified and what corrective</b></p>	08/16/2014			

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	<p>depressive disorder, and hyperlipidemia.</p> <p>An admission Minimum Data Set (MDS) assessment for the resident, dated 5/18/14, indicated he had no cognitive impairment.</p> <p>A health care plan problem, dated 5/12/14, indicated the resident had neurological deficiencies related to multiple sclerosis. One of the approaches for this problem was "Administer meds per physician orders."</p> <p>An admission order, dated 5/10/14, indicated the resident was to receive Solu-Medrol (a corticosteroid solution) 1 gram in 100 milliliters of fluid per IV over one hour each month on the 26th of the month for 6 months ending on 9/26/14.</p> <p>The Medication Administration Record (MAR) for May 2014 indicated the IV medication was given on 5/28/14 when it was delivered from pharmacy. The nursing notes for 5/28/14 documented the starting of the IV and the administration of the medication.</p> <p>A pharmacy order sheet indicated the next dose of the Solu Medrol was delivered on 6/25/14. The June MAR contained a section that was squared off</p>		<p><b>actions will be taken:</b></p> <p>Residents who reside in the facility and who receive medication have the potential to be affected by this deficient practice. Resident clinical records were reviewed to ensure medications are administered per physician's orders and documented in the clinical record.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur:</b></p> <p>RN #3 was re-educated on the Medication Administration Guidelines.</p> <p>Licensed nursing staff have been re-educated on the Medication Administration Guidelines including Medication Errors. Please see Attachment A.</p> <p>The Director of Care Delivery or designee will complete an audit at least five times per week to include weekends and all shifts to ensure Medication Administration is documented per physician order. Please see attachment B.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e. what quality assurance program will be put into place:</b></p> <p>Audit findings will be presented to QA&amp;A committee weekly for 4 weeks and monthly thereafter. Ongoing monitoring will continue for a minimum of six months. QA&amp;A committee will review findings and determine need for further</p>	

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	<p>on the 26th of June for the documentation of the IV Solu Medrol having been given. The box for documentation of the med having been given was blank. The June 2014 nursing notes lacked any information related to an IV having been started and the medication having been given.</p> <p>Resident #B was interviewed on 7/16/14 at 3:35 p.m. LPN #13 was present in the room during part of the interview. When queried as to how many times he had been given his special "steroid" medication since he had been admitted, he indicated "only one time." When asked if he thought the medication helped him, he indicated he thought his hands were not as numb and raised them up and closed his fingers slightly to demonstrate his hand function.</p> <p>During an observation on 7/16/14 at 3:45 p.m., LPN #12 was unable to find any Solu Medrol medication in the unit refrigerator for Resident #B.</p> <p>During an observation on 7/16/14 at 3:50 p.m., LPN #13 was unable to find any Solu Medrol medication in the medication cart for Resident #B.</p> <p>The DoN was interviewed on 7/16/14 at 4:05 p.m. Additional information was</p>		<p>monitoring and/or education per the QA&amp;A process.</p>	

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	<p>requested related to Resident #B not receiving his IV Solu Medrol medication on 6/26/14 as ordered by the physician and why no one had questioned whether the medication had been given when the box remained empty for the remainder of June 2014.</p> <p>The DoN was interviewed on 7/17/14 at 9 a.m. She indicated the staff had again searched for the Solu Medrol medication delivered on 6/25/14. She indicated no medication had been found. She indicated she was still trying to reach the nurse on duty that day to see if it had been given, but not charted.</p> <p>RN #3 (the nurse who should have given the medication on 6/26/14) was interviewed on 7/17/14 at 11:15 a.m. She indicated she started IVs all over the building every day and could not remember if she had given the medication on that particular day or not.</p> <p>Resident #B was interviewed on 7/17/14 at 11:25 a.m. He was again asked about his "steroid" medication. A description of an IV being started and the medication being given thru a bag of IV fluids was provided. When asked how many times this had been done since he had been admitted, he indicated once around the end of the month after he came in. When</p>			

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	<p>queried if he was sure it had only been done one time, he indicated "Yes".</p> <p>Review of the current facility policy, dated 3/2010, titled "Medication Administration: Medication Pass", provided by the DoN on 7/17/14 at 9 a.m., included, but was not limited to, the following:</p> <p>"Purpose: To safely and accurately prepare and administer medication according to physician order and patient needs.</p> <p>...Procedure:</p> <p>...3. Open MAR to patient record and review physician medication order against medication label</p> <p>...6. Read special medication administration instructions</p> <p>...8. Prepare medication of administration</p> <p>...9. Administer medication... document initials on MAR for each medication administered..."</p> <p>This federal tag relates to Complaint IN00151272.</p>			

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F000312 SS=D	<p>3.1-37(a)</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, interview, and record review, the facility failed to ensure a dependent resident who needed assistance with oral care/hygiene received those services in accordance with his plan of care for 1 of 1 resident reviewed who was dependent on the staff for oral hygiene in a sample of 6. (Resident #B)</p> <p>Findings include:</p> <p>The clinical record for Resident #B was reviewed on 7/15/14 at 1:20 p.m. Diagnoses for the resident included, but were not limited to, multiple sclerosis, depressive disorder, and hyperlipidemia.</p> <p>An admission Minimum Data Set (MDS) assessment for the resident, dated 5/18/14, indicated he had no cognitive impairment. The MDS indicated the resident required extensive assistance from the staff for toileting and was totally dependent on the staff for transfers, bed mobility, hygiene, and bathing. The</p>	F000312	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>Resident B's clinical record including the care plan and CNA assignment tasks has been reviewed and updated and to reflect the resident's needs for assistance with oral hygiene.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;</b></p> <p>Residents who reside in the facility and require assistance with oral care have the potential to be affected by this deficient practice. Baseline audit of like residents completed to ensure that their care plans and</p>	08/16/2014			

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	<p>MDS indicated the resident had not rejected care.</p> <p>A health care plan problem, dated 7/9/14, indicated the resident was unable to perform his own activities of daily living due to multiple sclerosis, physical limitations, and poor trunk control. Interventions for this problem included, but were not limited to "Assist with daily hygiene, grooming, dressing, oral care and eating as needed."</p> <p>A CNA task/assignment sheet, provided by the DoN on 7/16/14 at 2:10 p.m., for Resident #B included, but was not limited to: "Special Need: Teeth to be brushed twice daily."</p> <p>Resident #B was interviewed on 7/16/14 at 8:45 a.m., he indicated his teeth had not been brushed in several days. The resident was able to lift his arms and move his fingers, but indicated his dexterity and strength were impaired. An electric toothbrush was observed on a stand on the counter of the resident's sink. No toothpaste was observed. While in the resident's room, CNA #5 entered the resident's room and asked if the resident would go back to bed for toileting. He indicated he was going to go smoke first but would then return for toileting.</p>		<p>their CNA assignment instructions include their need for assistance with oral care. Please see attachment C.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur;</b></p> <p>Nursing staff were educated on the Oral Care Guidelines. Please see attachment D.</p> <p>The Director of Care Delivery or designees will conduct daily observations on a minimum of 10 like residents, to include weekends and all shifts, validating that proper oral care is being delivered. Please see attachment E.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place;</b></p> <p>Audit findings will be presented to QA&amp;A committee weekly for 4</p>	

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	<p>CNA #5 was interviewed on 7/16/14 at 8:50 a.m. When queried if she knew if the resident had any toothpaste, she indicated she thought he should have some. She checked the top drawer by the sink.. Two unopened boxes of toothpaste were present inside the drawer. She continued to look for an open tube of toothpaste and found one on the bottom of the drawer under numerous other items. She laid the toothpaste on the counter near the electric toothbrush. The resident left the room at this time for toileting.</p> <p>Resident #B was interviewed on 7/16/14 at 9:50 a.m. The resident was now in bed and the CNAs had left the room. The resident indicated his teeth had still not been brushed. He indicated he thought the staff were going to brush them when they got him back up. The toothpaste was on the counter in the same position and the brush on the electric toothbrush appeared dry.</p> <p>Resident #B was interviewed on 7/16/14 at 3:35 p.m. When queried if the staff had brushed his teeth for him, he indicated no, they had not been brushed yet. The resident smiled and some food debris was noted on both his upper and lower teeth. Unit Manger #2 was notified</p>		<p>weeks and monthly thereafter. Ongoing monitoring will continue for a minimum of six months. QA&amp;A committee will review findings and determine need for further monitoring and/or education per the QA&amp;A process.</p>	

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	<p>the resident wanted his teeth brushed and she indicated she would assist the resident with brushing them.</p> <p>The DoN was interviewed on 7/16/14 at 4:05 p.m. Additional information was requested related to the lack of dental hygiene services provided to Resident #B.</p> <p>Review of a statement, written by CNA #11 on 7/16/14 and provided by the DoN on 7/17/14 at 9 a.m., included but was not limited to, "Forgot to brush his teeth was very busy spaced it out...."</p> <p>Review of the current facility policy, dated 1/2011, titled "Oral Hygiene and Denture Care", provided by the DoN on 7/17/14 at 9 a.m. included, but was not limited to the following:</p> <p>"Purpose: To remove plaque and food debris from teeth and mouth, decrease mouth odor, massage gums and clean tongue and to promote moist lips and mouth...."</p> <p>This federal tag relates to Complaint IN00151272.</p> <p>3.1-38(a)(3)(C)</p>			
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F000315 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 a resident, dependent on the staff for incontinent care, received those services in accordance with his plan of care for 1 of 3 residents reviewed for incontinent care in a sample of 6. (Resident #B)</p> <p>Findings include:</p> <p>The clinical record for Resident #B was reviewed on 7/15/14 at 1:20 p.m. Diagnoses for the resident included, but were not limited to, multiple sclerosis, depressive disorder, and hyperlipidemia.</p> <p>An admission Minimum Data Set (MDS) assessment for the resident, dated 5/18/14, indicated he had no cognitive impairment. The MDS indicated the resident required extensive assistance from the staff for toileting and was totally dependent on the staff for transfers, bed</p>	F000315	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>Resident B's clinical record including the care plan and CNA assignment tasks has been reviewed and updated and to reflect the resident's needs for assistance with incontinent care.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;</b></p> <p>Residents who reside in the facility and require assistance with incontinence care have the potential to be affected by this deficient</p>	08/16/2014			

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	<p>mobility, hygiene, and bathing. The MDS indicated the resident had not rejected care.</p> <p>A health care plan problem, dated 7/9/14, indicated the resident was unable to perform his own activities of daily living due to multiple sclerosis, physical limitations, and poor trunk control. Interventions for this problem included, but were not limited to "Assist with daily hygiene, grooming, dressing, oral care and eating as needed." An additional intervention, added on 7/15/14, indicated "Encourage and assist resident to toilet and reposition while in wheelchair throughout the day."</p> <p>Resident #B was interviewed on 7/15/14 at 1:50 p.m. The resident had just completed therapy services and was up in his wheelchair in the therapy room. The resident indicated he had been assisted into his wheelchair around 6 a.m. that morning. He indicated he had not been back to bed since that time and his brief had not been changed since that time. He indicated he did not usually go back to bed until around 7 p.m. and his brief was changed at that time.</p> <p>Unit Manager #2 was interviewed on 7/15/14 at 1:55 p.m. and a request was made to observe a transfer and pericare</p>		<p>practice. Baseline audit of like residents completed to ensure that their care plans and their CNA assignment instructions include their need for assistance with incontinence care. Please see attachment F.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur;</b></p> <p>Nursing staff were educated on the Incontinence Care Guidelines. Please see attachment G.</p> <p>The Director of Care Delivery or designees will conduct daily observations on a minimum of 10 like residents, including weekends and all shifts, validating that proper incontinence care is being delivered. Please see attachment H.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place;</b></p>				

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	<p>for Resident #B.</p> <p>During an observation conducted with Unit Manager #2 on 7/15/14 at 2 p.m., CNA #6 and CNA #7 transferred the resident into bed using the hoier lift. The resident's brief was changed. The brief was wet, but was not saturated. The resident had numerous white grooved indentions in his buttocks and the back of his upper thighs. The resident's buttocks were slightly reddened. There was a small, approximately 1 cm (centimeter) in diameter, darker red area within the reddened skin of the right buttock. The area was not open. Unit Manager #2 indicated she was not aware of the darker discolored area. A barrier cream was applied on the buttocks by the CNAs.</p> <p>CNA #6 and CNA #7 were interviewed on 7/15/14 at 2:10 p.m.. They indicated they had assisted Resident #B out of bed around 6:30 a.m. that morning. They indicated they had asked the resident to go back to bed for toileting around 10 a.m. and he had refused to permit them to transfer him and provide incontinent care. No other information was provided related to additional attempts to toilet him after his refusal at 10 a.m.</p> <p>The DoN was interviewed on 7/16/14 at 4:05 p.m. Additional information was</p>		<p>Audit findings will be presented to QA&amp;A committee weekly for 4 weeks and monthly thereafter. Ongoing monitoring will continue for a minimum of six months. QA&amp;A committee will review findings and determine need for further monitoring and/or education per the QA&amp;A process.</p>				

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	<p>requested related to the lack of toileting services provided to Resident #B. The DoN indicated the resident had a history of refusing staff requests at times.</p> <p>The nursing notes for July 2014 lacked any information related to resident refusal of incontinent care.</p> <p>The DoN was interviewed on 7/17/14 at 9 a.m. She provided a copy of a physician's order, dated 7/15/14, which indicated "Z Guard (a topical protective cream) to buttocks bilaterally every shift. Diagnosis moisture acquired dermatitis." She indicated the resident's health care plan and CNA assignment sheet had been updated to include staff procedures to be followed if the resident was offered and then refused incontinent care.</p> <p>Review of the current facility policy, dated 1/2013, titled "Skin Practice Guide", provided by the DoN on 7/17/14 at 9 a.m., included, but was not limited to, the following:</p> <p>"...Purpose</p> <p>The purpose of the Skin Practice Guide is to describe the process steps for identification of patients at risk for the development of pressure ulcers, identify prevention techniques and interventions</p>			

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F000323 SS=D	<p>to assist with the management of pressure ulcers and skin alterations...</p> <p>...Risk factors for the development of skin alterations are dependent on the type of alteration...</p> <p>Moisture (excoriation, maceration) -incontinence....</p> <p>...Prevention Interventions</p> <p>...Use barrier cream products ...Manage continence with toileting programs...."</p> <p>This federal tag relates to Complaint IN00151272 and IN00152518.</p> <p>3.1-41(a)(2)</p> <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 record review and interview, the facility failed to ensure a resident was transferred safely resulting in the resident</p>	F000323	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient</b></p>	08/16/2014			

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	<p>being lowered to the floor and failed to assess the reasons for the fall (lowering to the floor) and/or possible interventions to prevent recurrence for 1 of 3 residents reviewed for accident prevention in a sample of 6. (Resident #C)</p> <p>Findings include:</p> <p>The clinical record for Resident #C was reviewed on 7/16/14 at 9:40 a.m. Diagnoses for the resident included, but were not limited to, lupus erythematosus, rheumatoid arthritis, debility, muscle weakness, and difficulty walking.</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 5/20/14, indicated the resident was not cognitively impaired and required extensive assistance of two people for transfers, bed mobility, and ambulation in his room. The MDS indicated the resident was at risk for falls.</p> <p>A health care plan problem, last updated on 2/20/14, indicated the resident was at risk for falls due to a history of falls and the history of a knee replacement. One of the approaches for this problem was to "Provide assist to transfer and ambulate as needed."</p> <p>A CNA task/assignment sheet, provided by the DoN on 7/16/14 at 2:10 p.m., for</p>		<p><b>practice? Resident C no longer resides at the facility. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken;</b> Residents who reside in the facility and require assistance for transfers have the potential to be affected by this deficient practice. A 30 day look back audit was completed on like residents to validate that fall guidelines were followed. Please see attachment I. <b>What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur;</b> Nursing staff have been educated as to the necessity of following the plan of care for transfers as well as the Falls Practice Guide which includes guidance on appropriate follow up when a patient is lowered to the floor, assessment and interventions to prevent recurrence. Please see attachment J. The Director of Care Delivery or designee will conduct daily observations of 5 transfers daily, 5 days a week on like residents, including weekends and all shifts, validating that transfers are performed in accordance with the patient's plan of care. Please see attachment K. <b>How the corrective action(s) will be monitored to ensure the</b></p>	

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	<p>Resident #C included, but was not limited to: "Fall risk uses w/c [wheelchair] for mobility, encourage to come to dining room for meals, gripper socks on at all times, routine checks every two hours" The task sheet lacked any information related to the resident having a special hydraulic lift cushion in his chair.</p> <p>Resident #C was interviewed on 7/15/14 at 11:20 a.m. Resident #C indicated he had fallen within the last two weeks. He indicated he was being transferred by one CNA from the bed to his wheelchair when he was "dropped" to the floor. He indicated he was not injured. He indicated the CNA was not using a gait belt during the transfer. He indicated the CNAs rarely used a gait belt during transfers and sometimes he was transferred by one and sometimes two. He indicated it took three people to get him up off the floor and into his wheelchair following the fall. He indicated he was not wearing shoes during the transfer, but did have his special non-skid socks on at that time.</p> <p>The clinical record for Resident #C lacked any documentation of a fall for July 2014. The resident's name was not on a list of residents having fallen in June or July 2014 provided by the DoN on</p>		<p><b>deficient practice will not recur; i., e., what quality assurance program will be put into place;</b> Audit findings will be presented to QA&amp;A committee weekly for 4 weeks and monthly thereafter. Ongoing monitoring will continue for a minimum of six months. QA&amp;A committee will review findings and determine need for further monitoring and/or education per the QA&amp;A process.</p>				

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	<p>7/15/14 at 11:05 a.m.</p> <p>Unit Manager #1 (the Unit Manager for Resident #C) was interviewed on 7/16/14 at 2:40 p.m. She indicated she had no information to provide related to Resident #C having fallen, but was continuing to investigate the concern.</p> <p>The DoN was interviewed on 7/17/14 at 9 a.m. She indicated their investigation of a possible fall for Resident #C had identified an "lowering the resident to the floor" incident. She indicated CNA #8 had stated she lowered the resident to the floor sometime around the 8th of July and had reported the incident to the nurse on duty, LPN #4. She indicated the resident was checked by the nurse on duty and felt to be uninjured. She provided written statements from both CNA #8 and LPN #4.</p> <p>CNA #8 was interviewed on 7/17/14 at 9:25 a.m. She indicated she had "lowered the resident to the floor" recently on one occasion when she was unable to complete a transfer from the bed to the chair. She indicated she was using a gait belt during the transfer and the hydraulic cushion on the resident's chair did not lower when she transferred him so he slid down the front of the chair and was lowered to the floor. She</p>			

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	<p>indicated the resident told her he was not injured. She indicated she informed the nurse of the incident and the nurse told her to get some additional staff to help get him back up into his chair. She indicated she went and got CNA #9 and CNA #10 to help her put the resident back into his chair. She indicated one CNA lifted the resident's legs and the other two lifted the resident under his arms in order to get him back into his chair. She indicated they did not use the gait belt to lift the resident back into the chair. She indicated she does not remember if the nurse was present or observed the transfer of the resident back into the wheelchair. She indicated the resident seemed OK the rest of the day and was his normal self.</p> <p>Review of a phone interview statement for CNA #9, written by Unit Manager #1, dated 7/17/14, was as follows:</p> <p>"[Name of CNA #8 lowered [name of resident] to the floor. [Name of LPN #4] assessed him and then told us to get him up. He had no pain when we used the gait belt to lift him back into his chair."</p> <p>LPN #4 was interviewed on 7/17/14 at 9:35 a.m. The DoN was present during the interview. LPN #4 indicated she did check Resident #C for injuries after he</p>			

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	<p>was lowered to the floor. She indicated CNA #8 had gone to get additional staff during the assessment. She indicated she did not recall seeing a gait belt during the assessment. She indicated she forgot to chart the "lowering to the floor" in the nursing notes. When asked if she completed an Incident report or form for the resident being lowered to the floor or had taken any vital signs, she indicated "No". She indicated she felt if the resident was just "lowered to the floor" and there was no injury, then no incident report was necessary. When queried if the resident was a one person transfer assist, she indicated she was "not sure".</p> <p>The DoN was interviewed on 7/17/14 at 9:45 a.m. The DoN indicated while a "lowering to the floor" may not be considered a "fall", it still required an incident report to be filled out, vital signs taken, and follow-up to be done. She indicated problems with the resident could always develop later and the nursing notes should reflect the events that had occurred with the resident. She indicated the incident report would also require follow-up to the events that occurred so the reason for the lowering to the floor could be evaluated and possible interventions adjusted to prevent recurrence. She indicated she had not received an incident report for the above</p>						

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	<p>occurrence so no follow-up had been done.</p> <p>The DoN and Unit Manager #1 were interviewed on 7/17/14 at 10:00 a.m. They indicated Resident #C had a special hydraulic lift type cushion which had been provided by the therapy department to help the resident with rising. They indicated the cushion should go down when the resident was seated. They indicated the seat may not have lowered if the resident's buttocks and weight had not been placed far enough back on the cushion, This would leave the seat cushion at an angle allowing the resident to slide down the front of the cushion.</p> <p>Review of the current facility policy, dated 2011, titled "Falls Practice Guide", provided by the DoN on 7/17/14 at 9 a.m. included, but was not limited to, the following:</p> <p>"...Ongoing Management Strategies...</p> <p>The center may designate members from the interdisciplinary team to participate in post fall patient evaluation activities...It is recommended that a member of the interdisciplinary team conduct a bedside evaluation after a fall occurs or per a center identified schedule with findings documented in the clinical record. The</p>			

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F000514 SS=D	<p>bedside evaluation may include, but is not limited to the following:</p> <ul style="list-style-type: none"> <li>*review of all circumstances surrounding a patient's fall</li> <li>*evaluation of the patient's room and other areas to identify environmental risk factors</li> <li>*interview of the patient or others witnessing the fall, if possible</li> <li>*identification of any changes in patient's risk factors, condition and functional status</li> <li>*review of the patient's current plan of care</li> <li>*revision of the care plan to address the patient's current risk factors and needs...."</li> </ul> <p>This federal tag relates to Complaint IN00152518.</p> <p>3.1-45(a)(2)</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that</p>				

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	<p>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 record review and interview, the facility failed to ensure the clinical record was complete and accurately documented in regards to a resident falling and/or being lowered to the floor during a staff transfer for 1 of 3 residents reviewed for fall documentation in a sample of 6. (Resident #C)</p> <p>Findings include:</p> <p>The clinical record for Resident #C was reviewed on 7/16/14 at 9:40 a.m. Diagnoses for the resident included, but were not limited to, lupus erythematosus, rheumatoid arthritis, debility, muscle weakness, and difficulty walking.</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 5/20/14, indicated the resident was not cognitively impaired and required extensive assistance of two people for transfers, bed mobility, and ambulation in his room. The MDS indicated the resident was at risk for falls.</p>	F000514	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>Resident C no longer resides at the facility.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken;</b></p> <p>Residents who reside in the facility and require assistance for transfers have the potential to be affected by this deficient practice. A 30 day look back audit was completed on like residents to validate that fall guidelines were followed. Please see attachment I.</p>	08/16/2014

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	<p>Resident #C was interviewed on 7/15/14 at 11:20 a.m. Resident #C indicated he had fallen within the last two weeks. He indicated he was being transferred by one CNA from the bed to his wheelchair when he was "dropped" to the floor. He indicated he was not injured. He indicated the CNA was not using a gait belt during the transfer. He indicated it took three people to get him off the floor and into his wheelchair following the fall.</p> <p>The clinical record for Resident #C lacked any documentation of a fall for July 2014. The resident's name was not on a list of residents having fallen in June or July 2014 provided by the DoN on 7/15/14 at 11:05 a.m.</p> <p>Unit Manager #1 (the Unit Manager for Resident #C) was interviewed on 7/16/14 at 2:40 p.m. She indicated she had no information to provide related to Resident #C having fallen, but was continuing to investigate the concern.</p> <p>The DoN was interviewed on 7/17/14 at 9 a.m. She indicated their investigation of a possible fall for Resident #C had identified an "lowering the resident to the floor" incident. She indicated CNA #8 had stated she lowered the resident to the floor sometime around the 8th of July and had reported the incident to the nurse</p>		<p><b>What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur;</b></p> <p>LPN #4 was re-educated on the Falls Practice Guide including guidance on appropriate follow up when a patient is lowered to the floor, assessment and documentation in the clinical record.</p> <p>Nursing staff have been educated as to the necessity of following the plan of care for transfers as well as the Falls Practice Guide which includes guidance on appropriate follow up when a patient is lowered to the floor, assessment and interventions to prevent recurrence. Please see attachment J.</p> <p>The Director of Care Delivery or designee will conduct a minimum of 10 interviews of licensed nursing staff, 5 days a week on like residents, including weekends and all shifts, validating understanding of incident reporting guidelines and related documentation requirements. Please see attachment L.</p>	

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	<p>on duty, LPN #4. She indicated the resident was checked by the nurse on duty and felt to be uninjured.</p> <p>CNA #8 was interviewed on 7/17/14 at 9:25 a.m. She indicated she had "lowered the resident to the floor" recently on one occasion when she was unable to complete a transfer from the bed to the chair. She indicated the resident told her he was not injured. She indicated she informed the nurse of the incident and the nurse told her to get some additional staff to help get him into his chair.</p> <p>LPN #4 was interviewed on 7/17/14 at 9:35 a.m. The DoN was present during the interview. LPN #4 indicated she did check Resident #C for injuries after he was lowered to the floor. She indicated CNA #8 had gone to get additional staff during the assessment. She indicated she forgot to chart the "lowering to the floor" in the nursing notes. When asked it she completed an Incident report or form for the resident being lowered to the floor or had taken any vital signs, she indicated "No". She indicated she felt if the resident was just "lowered to the floor" and there was no injury, then no incident report was necessary.</p> <p>The DoN was interviewed on 7/17/14 at</p>		<p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place;</b></p> <p>Audit findings will be presented to QA&amp;A committee weekly for 4 weeks and monthly thereafter. Ongoing monitoring will continue for a minimum of six months. QA&amp;A committee will review findings and determine need for further monitoring and/or education per the QA&amp;A process.</p>				

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	<p>9:45 a.m. The DoN indicated while a "lowering to the floor" may not be considered a "fall" it still required an incident report to be filled out, vital signs taken, and follow-up to be done. She indicated problems with the resident could always develop later and the nursing notes should reflect the events that had occurred with the resident.</p> <p>The clinical record lacked any information related to the "lowering to the floor" occurring around 7/8/14. The clinical record lacked any information related to an assessment having been completed by LPN #4 following the incident.</p> <p>This federal tag relates to Complaint IN00152518.</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>						