

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155103	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/22/2014
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NAME OF PROVIDER OR SUPPLIER IRONWOOD HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1950 RIDGEDALE RD SOUTH BEND, IN 46614
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F000000	<p>This visit was for the Investigation of Complaint IN00148482, Complaint IN00149378, and Complaint IN00149440.</p> <p>Complaint IN00148482 – Substantiated. Federal/state deficiencies related to the allegations are cited at F309.</p> <p>Complaint IN00149378 –Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00149440 – Substantiated. No deficiencies related to the allegation are cited.</p> <p>Unrelated deficiencies are cited.</p> <p>Survey dates: May 21–22, 2014</p> <p>Facility number: 000042 Provider number: 155103 AIM number: 100291540</p> <p>Survey team: Honey Kuhn, RN</p> <p>Census bed type: SNF/NF: 101 Total: 101</p> <p>Census payor type:</p>	F000000	<p>This plan of correction constitutes this facilities written allegation of compliance for the deficiencies cited. This submission of this Plan of Correction is not an admission of or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's inspection report. Ironwood Health and Rehabilitation Center requests consideration for a desk review of the plan of correction.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F000225 SS=D	<p>Medicare: 4 Medicaid: 76 Other: 21 Total: 101</p> <p>Sample: 6</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on May 27, 2014 by Randy Fry RN.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 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</p>						

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	<p>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 record review and interviews, the facility failed to report to ISDH (Indiana State Department of Health) a right shoulder fracture of unknown origin for 1 of 3 residents in a sample of 6 reviewed for accidents. (Resident "C")</p> <p>Findings include:</p> <p>The record of Resident "C" was reviewed on 05/21/14 at 11:30 a.m. Resident "C" was admitted to the facility on 05/23/14 with diagnoses which included, but were not limited to, (L) (Left) ankle fracture, depression, anxiety, colon cancer, anxiety, and severe dementia. The record indicated Resident "C" was diagnosed with a</p>	F000225	F225 It is the practice of this facility that all alleged violations involving mistreatment, neglect, or abuse and misappropriation of resident property are reported immediately to the administrator of the facility. It is not the policy to obtain approval from corporate staff prior to reporting an allegation of abuse or incident to ISDH. Corrective Action: Resident C chart and care plan was reviewed and updated to reflect current status. Facility will continue to follow Policy and Procedure related to Abuse Prohibition. How others identified: Residents residing in facility will be addressed by following policy and procedure and re-education and/or disciplinary action per policy of employees. Preventative Measures: Staff re-educated on reporting procedure related to Abuse Prohibition. Monitoring:	06/18/2014

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	<p>fracture to the (R) (Right) shoulder on 04/01/14.</p> <p>Review of the most recent quarterly MDS (Minimum Data Set: a tool to assist in plan of care), dated 04/11/14, indicated Resident "C" was cognitively impaired and exhibited behaviors of hitting, kicking, pushing, & grabbing for 1 to 3 days and was verbally abusive to others for 4 to 6 days during the MDS assessment time frame. The MDS indicated Resident "C" required the assist of 2 for bed mobility, transfers and toileting and the assist of 1 for personal hygiene, bathing, dressing & eating.</p> <p>Review of "PROGRESS NOTES" indicated: "04/01/14 10:00 p.m. Went to [Hospital Name] ER. Acute Fx [Fracture: broken bone] Rt [Right] sholder [sic] in sling. N.O. [New Order] PRN [as needed] Norco [narcotic pain medication] & [and Zofran at [medication to treat nausea/vomiting]. Returned [sic] s [without] incidence. Has been sleeping since return..."</p> <p>The Administrator was interviewed on 05/22/14 at 9:30 a.m. The</p>		<p>Administrator and/or designee will continue to follow up on all allegation of abuse immediately. A grievance form and accident/incident will be completed on any allegation of abuse and will be followed up by Administrator and/or designee immediately per policy. All grievance and accident /incident forms are reviewed daily during morning meeting. Monitoring will continue on an indefinite basis per policy. All findings will be reviewed at monthly QPI meeting. Any identified non-compliance will be addressed through one to one re-education up to and including termination. Systems Changes: Completed by June 18, 2014.</p>	

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	<p>Administrator indicated the DNS (Director Nursing Services) initiated an investigation for ISDH (Indiana State Department of Health). The Administrator indicated it is corporate policy to consult with the Regional Nurse for approval before submitting an incident report to ISDH. The Administrator indicated there was no record the report was submitted to ISDH.</p> <p>The DNS (Director Nursing Services) was interviewed on 05/22/14 at 9:00 a.m. The DNS indicated the facility had initiated an investigation following the fracture diagnosis and provided, at the time, a copy of the "SBAR [Situation Background Assessment Request] Communication Form", dated 04/01/14. The DNS indicated the form as the investigation tool and there was no indication the resident fell, as the Hospital/ER record indicated. The DNS indicated the facility did not establish how the resident's fracture occurred.</p> <p>Review of a Policy & Procedure, provided by the DNS on 05/22/14 at 10:15 a.m., indicated: "PROCEDURE: Prevention and reporting: Resident Mistreatment,</p>			

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	<p>Neglect, Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property – 04/2013", indicated:</p> <p>"POLICY: Injuries of Unknown Source; Classify as an 'injury of unknown source' when both of the following conditions are met. * The source of the injury was not observed by any person or the resident could not explain the source of the injury. * The injury is suspicious because of the extent of the injury or the location of the injury or the number of injuries observed at one particular point in time, or the incidence of injuries over time."</p> <p>"Identification:...2. Instruct staff, resident, family, visitor, etc. to report immediately, without fear of reprisal, any knowledge of abuse, neglect, mistreatment, injuries of unknown source, and/or misappropriation of property...."</p> <p>Investigation: 1. Review and investigate using the electronic Accident/Incident (eAI) report. 2. Enter details of the investigation into eAI report. 3. Complete investigation</p>						

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F000226 SS=D	<p>summaries and final outcome questions....</p> <p>4. Complete and submit eAI.</p> <p>5. Report the results to other officials in accordance with State law (including to the Sate survey and certification agency) within 5 working days of the incident, ..."</p> <p>Confidential staff interviews were conducted with 5 Administrative/Nursing staff which indicated it is corporate policy to consult with the Regional Nurse for approval before submitting an incident report to ISDH.</p> <p>3.1-28(c) 3.1-28(d) 3.1-28(e)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interviews, the facility failed to</p>	F000226	F226 It is the practice of this facility to ensure the implementation of policies and	06/18/2014			

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	<p>follow their Policy and Procedure in regards to investigating and reporting a right shoulder fracture of unknown origin for 1 of 3 residents in a sample of 6 reviewed for accidents. (Resident "C")</p> <p>Findings include:</p> <p>The record of Resident "C" was reviewed on 05/21/14 at 11:30 a.m. Resident "C" was admitted to the facility on 05/23/14 with diagnoses which included, but were not limited to, (L) (Left) ankle fracture, depression, anxiety, colon cancer, anxiety, and severe dementia. The record indicated Resident "C" was diagnosed with a fracture to the (R) (Right) shoulder on 04/01/14.</p> <p>Review of the most recent quarterly MDS (Minimum Data Set: a tool to assist in plan of care), dated 04/11/14, indicated Resident "C" was cognitively impaired and exhibited behaviors of hitting, kicking, pushing, & grabbing for 1 to 3 days and was verbally abusive to others for 4 to 6 days during the MDS assessment time frame. The MDS indicated Resident "C" required the assist of 2 for bed mobility, transfers and toileting and</p>		<p>procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. It is not the policy to obtain approval from corporate staff prior to reporting an allegation of abuse or incident to ISDH. Corrective Action: All staff to be re-educated on all the different types of abuse, how, when, and who to report all abuse. How others identified: All residents who reside at this facility have potential to be affected. Residents residing in the facility will be addressed by following policy and procedure and re-educated and/or disciplinary action of employees who are found in violation. Systemic Changes: All staff to be re-educated on all the different types of abuse, including who to report abuse and when to report any and all types of abuse. Monitoring: The UM, ADON, DON, or designee will monitor the staff to ensure they know the different types of abuse, how, when, and who to report abuse. The UM, ADON, DON, or designee will use a monitoring log to check compliance daily for 2 weeks, 3 times a week for 2 weeks, weekly for 4 weeks, then monthly for 4 months. Trends will be reviewed in QA monthly times 3 months and quarterly thereafter to determine further education and/or further monitoring needs. Identified non-compliance will result in one to one re-education</p>	

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	<p>the assist of 1 for personal hygiene, bathing, dressing & eating.</p> <p>Review of "PROGRESS NOTES" for Resident "C", indicated:</p> <p>"03/31/14 1:30 p.m. Very agitated this a.m. Gave 8 a.m. med's didn't receive relief until app [approximately] 9:30 a.m..."</p> <p>"03/31/14 11:45 p.m. Alert confusion c/o's [complain's of] pain (R) arm. Yelling out as CNA trying to clean her up. Capillary refills within 3 seconds. (R) hand warm no swelling noted. Will monitor."</p> <p>"04/01/14 0530 [5:30 a.m.] Resident holding her (R) hand with her left hand stating it hurts. (R) hand remains warm no swelling noted. Continues with sch [scheduled] Tylenol."</p> <p>"04/01/14 8:00 a.m. Con [continues] to cry out about (R) arm. > [increased] anxiety. Received order for X-ray of (R) arm/shoulder noted..."</p> <p>"04/01/14 1:00 p.m. X-ray results fax/called [Physician's name] &</p>		<p>up to and including termination. Any identified trends will be forwarded to the administrator for review and presented to QA to determine further educational needs. System changes: Completed by June 18, 2014</p>	

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	<p>send to [Hospital Name] ER for eval/tx [evaluate/treat]..."</p> <p>"04/01/14 10:00 p.m. Went to [Hospital Name] ER. Acute Fx [Fracture: broken bone] Rt [Right] sholder [sic] in sling. N.O. [New Order] PRN [as needed] Norco [narcotic pain medication] & [and Zofran at [medication to treat nausea/vomiting]. Returned [sic] s [without] incidence. Has been sleeping since return..."</p> <p>Review of the Mobile X-ray report, dated 04/01/14 and performed in the facility, indicated: "...IMPRESSION: Views of the right humerus were obtained. The visualized osseous [bone like] structures demonstrate a complete displaced fracture involving the right humeral surgical neck..."</p> <p>The Administrator was interviewed on 05/22/14 at 9:30 a.m. The Administrator indicated the DNS (Director Nursing Services) initiated an investigation for ISDH (Indiana State Department of Health). The Administrator indicated it is corporate policy to consult with the Regional Nurse for approval before submitting an incident report to ISDH. The Administrator indicated</p>			

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	<p>there was no record the report was submitted to ISDH.</p> <p>The DNS (Director Nursing Services) was interviewed on 05/22/14 at 9:00 a.m. The DNS indicated the facility had initiated an investigation following the fracture diagnosis and provided, at the time, a copy of the "SBAR [Situation Background Assessment Request] Communication Form", dated 04/01/14. The DNS indicated the form as the investigation tool and there was no indication the resident fell, as the Hospital/ER record indicated. The DNS indicated the facility did not establish how the resident's fracture occurred.</p> <p>The SBAR form indicated: "Situation: The change in condition, symptoms, or signs I am calling about: > pain of (R) arm/shoulder". The Situation aspect further indicated the onset as 04/01/14 and it had become worse with any movement of the arm. The symptom became better when the arm was secure. The Situation portion indicated the resident had fractured her (L) ankle, prior to her admission to the facility while living at home. Review</p>						

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	<p>of the 2 page form did not indicate any further investigation of the incident prior to the complaint of pain.</p> <p>Review of an initial ISDH Incident form, initiated by the DNS on 04/01/14, indicated: "Brief Description of Incident: On 04/01/14 at approx. [approximately] 5:30 a.m. CNA noted during care resident complain of right arm pain. Resident guarding right arm, verbalizing pain. No swelling noted. MD and family notified. X-ray ordered. X-ray results indicate complete displaced fracture involving the right humeral surgical neck. DJD [Degenerative Joint Disease] AC joint. Resident is a extensive assist with transfers and bed mobility. Due to dx of Dementia she is unable to recall events. Diagnosis of Osteoporosis, Hypothyroidism, Hx [History] of Colon CA, Vulvar Cancer and breast cancer. Resident has a hx of pathological fractures. She was admitted here 5/23/13 due to a pathological ankle fracture In the operative report from the ankle fracture it states 'bones are thin, frail nature.'</p>						

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	<p>Type of Injury/Injuries: complete displaced fracture involving the humeral surgical neck."</p> <p>During the survey, confidential interviews were conducted with 7 Administrative and Nursing staff. Staff indicated incidents are to be reported to ISDH following corporate approval. The Initial Incident form was not reported to ISDH.</p> <p>Review of a Policy & Procedure, provided by the DNS on 05/22/14 at 10:15 a.m., indicated: "PROCEDURE: Prevention and reporting: Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property – 04/2013", indicated:</p> <p>"POLICY: Injuries of Unknown Source; Classify as an 'injury of unknown source' when both of the following conditions are met. * The source of the injury was not observed by any person or the resident could not explain the source of the injury. * The injury is suspicious because of the extent of the injury or the location of the injury or the number of injuries observed at one</p>			

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	<p>particular point in time, or the incidence of injuries over time."</p> <p>"Identification:...2. Instruct staff, resident, family, visitor, etc. to report immediately, without fear of reprisal, any knowledge of abuse, neglect, mistreatment, injuries of unknown source, and/or misappropriation of property....</p> <p>Investigation: 1. Review and investigate using the electronic Accident/Incident (eAI)report. 2. Enter details of the investigation into eAI report. 3. Complete investigation summaries and final outcome questions.... 4. Complete and submit eAI. 5. Report the results to other officials in accordance with State law (including to the Sate survey and certification agency) within 5 working days of the incident, ..."</p> <p>Confidential staff interviews were conducted with 5 Administrative/Nursing staff which indicated it is corporate policy to consult with the Regional Nurse for approval before submitting an incident report to ISDH.</p>						

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F000309 SS=D	<p>3.1-28(a)</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 record review and interviews, the facility failed to ensure bowel assessments were completed for 1 resident with a history of constipation and was diagnosed with a fecal impaction. This deficiency effected 1 of 4 residents in a sample of 6 who were reviewed for bowel and bladder assessments. (Resident "G")</p> <p>Findings include:</p> <p>The record of Resident "G" was reviewed on 05/22/14 at 8:45 a.m. Resident "G" was admitted to the facility on 12/03/13 with diagnoses including, but not limited to, rectal</p>	F000309	F309 It is the practice of this facility to ensure each resident receive and the facility 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 Corrective Action: Resident G no longer resides at facility. A complete chart review will be completed for those residents identified with a history of constipation and an assessment will be completed with physician notification as needed. How Others Identified: All residents have the potential to be affected. Residents residing in the facility will be addressed by following policy and procedure and re-educated and/or	06/18/2014	

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	<p>cancer, perineal radiation burns, oral mass, scrotal swelling, and anemia. The resident was admitted to the facility following a 15 day ACF (Acute Care Facility: Hospital) inpatient admission.</p> <p>Review of the ACF H&P (History & Physical) for Resident "G" indicated: "11/18/13...History of Present Illness: Has not had medical care for 30+ years until he went to the ER (Emergency Room) on 07/21/13 for a growth on the back of his throat; scrotal swelling; and a mass protruding from his rectum.... Pt (Patient) states the mass on his rectum has been present for at least 12 years and keeps growing. Has had recent constipation due to the mass; and has difficulty with walking and sitting due to the pain....Gastrointestinal: Constipation,... no BM X 1 week..."</p> <p>The resident had excision of the rectal mass while in the ACF and continued with chemotherapy and radiation while in the ECF (Extended Care Facility: Nursing Home). The resident was discharged home from the ECF on 05/05/14.</p>		<p>disciplinary action of employees. Preventative Measures: Nursing staff will be re-educated on the Interact process including the "Early Warning Tools." Licensed nurses will be re-educated on the use of the SBAR, care paths and 24 hour report sheets. Monitoring: Unit managers/DON/or designee will pull BM report from Care Tracker for review during Triage/Clinical after morning meeting. These reports will be given to the assigned nurse for follow up following meeting. Unit managers will monitor 24 hour sheets and SBARs and follow up with BM sheets daily for 2 weeks, 3 x a week for two weeks, then weekly for two month, and then monthly. Any trends will be reviewed and presented to the monthly Quality Performance committee to determine further action if needed. System Changes: Completed by June 18, 2014</p>	

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	<p>Review of the Admission MDS (Minimum Data Set: a tool to assist in plan of care), dated 12/12/13, indicated Resident "G" was cognitively intact and independent with transfers, dressing, and ambulation.</p> <p>The MDS indicated Resident "G" required set-up only for bathing, was continent of bowel, incontinent of bladder on occasion and required extensive assistance of 2 for toileting needs.</p> <p>Review of the "Nursing Comprehensive Admission Data Collection and Assessment", dated 12/03/13 at 5:30 p.m., indicated in the "Gastrointestinal" area, the resident was continent of stool and there was no recent vomiting, bloating, diarrhea, or constipation. The form indicate the last BM (Bowel Movement) was on 12/03/14 and the "Usual Bowel Pattern" as "daily". The assessment area for "Abdomen" and "Bowel Sounds" was blank.</p> <p>Review of a Physician's Phone Order indicated: "04/12/14 Per [by] Res [Resident] insistence transport to [ACF name] ER for eval [evaluate] & tx [treat]."</p>			

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	<p>Review of "PROGRESS NOTES", from 04/08/14 through 04/27/14, indicated:</p> <p>"04/08/14 10:00 p.m. ...Abd [Abdomen] round, soft, non-tender. B.S. [Bowel Sounds] active in all 4 quads..."</p> <p>Subsequent entries, 6 total, did not address assessment for bowel sounds .The following entry indicated:</p> <p>"04/11/14 12:45 p.m. ...Resident had difficulty have BM stating it was painful, upon inspection soft stool at rectal opening. Resident would 'like to have time to allow this to happen,' referring to BM [Bowel Movement]."</p> <p>"04/12/14 2:00 p.m. ...had small BM early in shift. 0 [no] S/S [Signs/Symptoms] of pain or discomfort at this time. BM was soft and formed."</p> <p>"04/12/14 9:30 p.m. ...C/O [complained/of] diff [difficulty] having BM. Becomes very painful when attempting to bare (SIC) down. Took PRN [as needed] & routine meds [medications] in attempt to have BM c [with] 0</p>			

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	<p>results. Became > [increased] upset. Sure that he has another blockage. Also spoke of a person who died because their bowel ruptured & [and} was afraid of that happening to him. Upset & crying insisting on transporting to hosp [hospital]. {Transport ambulance name} called, transported to {ACF name} ER. Order written."</p> <p>"04/12/14 1:15 a.m. Resident back from ER [ACF name] via [by way of] stretcher c 2 assist....Prior coming back at 12:40 a.m. the nurse from ER called that resident had a fecal impaction and he had enema and Dilaudid IV for pain..."</p> <p>"04/13/14 2:00 p.m. ...Cont [Continues] to have loose BM due to PRN meds given to loosen BM prior resident going to ER. Resident stated, "I feel so much better". 0 S/S of pain or discomfort..."</p> <p>The remaining Progress Notes through 04/27/14 included 27 entries. Only 1 entry, dated 04/24/14, addressed assessment of bowel sounds, as indicated: "04/24/14 2:00 p.m. ...Abd round soft non-tender. B.S. active in all 4 quads..."</p>			

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	<p>Review of a Care Plan, titled, "ALTERATION IN BOWEL ELIMINATION PLAN OF CARE", initiated on 12/06/14, indicated: "Problem: History: Constipation...rectal mass/CA [Cancer] Goal: Will have BM q [every] 3 days. Will take prescribed medication as directed. Intervention: Review Care Tracker BM Reports. Encourage elimination in the upright position as able. Provide Privacy during time of elimination. Encourage resident to call with urge to evacuate to prevent weakening of urge. Monitor bowel elimination using Care Tracker. Provide medication as ordered to aid in elimination as ordered." The care plan did not address assessing the abdomen for bowel sounds.</p> <p>Review of the "Resident Bowel and Bladder by Shift", (Care Tracker) utilized by CNA's to record elimination, was reviewed from 03/2014 through 04/2013, in 3 day increments for bowel elimination.</p>			
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	<p>The record indicated no record of a BM for Resident "G" for: 03/04/14 through 03/06/14 (3 days) 04/06/14 through 04/08/14 (3 days) 04/24/14 through 04/30/14 (7 days)</p> <p>Review of the MAR (Medication Administration Record) dated 04/2014, indicated Resident "G" received MOM (Milk of Magnesia) 30 ml (milliliters) daily and Senexon S 8.6/50 mg (milligram) twice daily. The medications were to prevent constipation and the record indicated all doses were given.</p> <p>The DNS (Director Nursing Services) was interviewed on 05/22/14 at 11:30 a.m. The DNS indicated the "Care Tracker" record might not be accurate. The DNS provided an undated corporate, "SKILLED CARE ALERT CHARTING FORM", which indicated: "Please document on all the highlighted areas including other pertinent issues prn. Vital signs including evaluation of pain w/location, intensity, intervention, response must be documented with each Skilled Care note...."GI/GU Function:</p>						

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F000323 SS=D	<p>Description of Urine/Stool Frequency Continence... I&O Nausea & vomiting Abdominal Assessment..."</p> <p>This Federal tag relates to Complaint IN00148482.</p> <p>3.1-37(a)</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 safe environment for a resident with a diagnosis of osteoporosis (fragile/brittle bones) and a history of fractures, resulting in a fracture of unknown origin to the (R) (Right) shoulder, for 1 of 3 residents reviewed for accidents in a sample of 6. (Resident "C")</p>	F000323	<p>F 323 It is the practice of this facility to ensure a safe environment for each resident. Corrective Action: Chart review of those residents with diagnosis of osteoporosis and history of fractures to ensure their current status is reflective on care plans and on CNA assignment sheet. How Others Identified: Residents who reside in the facility have potential to be affected. Residents residing in the facility will be addressed by following policy and</p>	06/18/2014			

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	<p>Findings include:</p> <p>The record of Resident "C" was reviewed on 05/21/14 at 11:30 a.m. Resident "C" was admitted to the facility on 05/23/15 with diagnoses which included, but were not limited to, (L) (Left) ankle fracture, depression, anxiety, colon cancer, anxiety, and severe dementia</p> <p>Review of the most recent quarterly MDS (Minimum Data Set: a tool to assist in plan of care), dated 04/11/14, indicated Resident "C" was cognitively impaired and exhibited behaviors of hitting, kicking, pushing, & grabbing for 1 to 3 days and was verbally abusive to others for 4 to 6 days during the MDS assessment time frame. The MDS indicated Resident "C" required the assist of 2 for bed mobility, transfers and toileting and the assist of 1 for personal hygiene, bathing, dressing & eating.</p> <p>Review of the undated CNA worksheet (a tool to aid CNA's in providing resident care), provided prior to the initial tour of the facility on 05/21/14, indicated Resident "C" required a fall mat next to her</p>		<p>procedure and re-educated and/or disciplinary action of employees.</p> <p>Preventative Measures: Nursing staff will be re-educated on ensuring environment remains as free of accident hazards as is possible for each resident.</p> <p>Monitoring: Unit managers/ DON/ or designee will use the monitoring log to ensure environment remains as free of accident hazards as is possible for each resident.</p> <p>Monitoring log will include checking residents care plans with diagnosis of osteoporosis and history of fractures and CNA assignment sheets. This log will be completed daily for 2 weeks, 3 x a week for two weeks, then weekly for two months, and then monthly. Trends will be reviewed in QA monthly times 3 months and quarterly thereafter to determine further education and/or further monitoring needs. Identified non-compliance will result in one to one re-education up to and including termination. Any identified trends will be forwarded to the administrator for review and presented to QA to determine further educational needs.</p> <p>Systems Changes: Completed by June 18, 2014</p>	

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	<p>bed and a Hoyer [mechanical lift] for transfers. Resident "C" was observed on 05/21/14 at 9:40 a.m. and again at 11:30 a.m., in the hallway while seated in a wheelchair with a sling in place to her (R) arm.</p> <p>Review of "PROGRESS NOTES" for Resident "C", from 03/22/14 through 03/27/14, indicated the resident was being monitored for yelling towards staff. The entries indicated Resident "C" was overall alert, confused and rested quietly with no behaviors. Review of the next Progress Notes indicated:</p> <p>"03/31/14 1:30 p.m. Very agitated this a.m. Gave 8 a.m. meds didn't recieve relief until app [approximately] 9:30 a.m..."</p> <p>"03/31/14 11:45 p.m. Alert confusion c/o's [complain's of] pain (R) arm. Yelling out as CNA trying to clean her up. Capillary refills within 3 seconds. (R) hand warm no swelling noted. Will monitor."</p> <p>"04/01/14 0530 [5:30 a.m.] Resident holding her (R) hand with her left hand stating it hurts. (R) hand remains warm no swelling</p>			

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	<p>noted. Continues with sch [scheduled] Tylenol."</p> <p>"04/01/14 8:00 a.m. Con [continues] to cry out about (R) arm. > [increased] anxiety. Recieved order for X-ray of (R) arm/shoulder noted..."</p> <p>"04/01/14 1:00 p.m. X-ray results fax/called [Physician's name] & send to [Hospital Name] ER for eval/tx [evaluate/treat]..."</p> <p>"04/01/14 10:00 p.m. Went to [Hospital Name] ER. Acute Fx [Fracture: broken bone] Rt [Right] sholder [sic] in sling. N.O. [New Order] PRN [as needed] Norco [narcotic pain medication] & [and Zofran at [medication to treat nausea/vomiting]. Returned [sic] s [without] incidence. Has been sleeping since return..."</p> <p>"04/02/14 0430 [4:30 a.m.] Quiet noc [night]. Resident resting quietly threw [sic] out the noc..."</p> <p>Review of the Mobile X-ray report, dated 04/01/14 and performed in the facility, indicated: "...IMPRESSION: Views of the right humerus were obtained. The visualized osseous [bone like]</p>			

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	<p>structures demonstrate a complete displaced fracture involving the right humeral surgical neck..."</p> <p>Review of the ACF (Acute Care Facility: Hospital) Emergency Room report, dated 04/01/14, indicated: "CHIEF COMPLAINT: Fall. HISTORICAL DATA: The patient fell on her right shoulder, had an x-ray that showed a nondisplaced fracture of the right humerus..."</p> <p>Review of the ACF Radiology Report, dated, 04/01/14, indicated: "...There is a fracture of the proximal right humerus with transverse and/or oblique component through proximal shaft of the right humerus. Acute appearing....Mild shortening present..."</p> <p>The DNS (Director Nursing Services) was interviewed on 05/22/14 at 9:00 a.m. The DNS indicated the facility had initiated an investigation following the fracture diagnosis and provided, at the time, a copy of the "SBAR [Situation Background Assessment Request] Communication Form", dated 04/01/14. The DNS indicated the form as the investigation tool and there was no indication the</p>						

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	<p>resident fell, as the ACF: ER record indicated. The DNS indicated the facility did not establish how the resident's fracture occurred.</p> <p>The SBAR form indicated: "Situation: The change in condition, symptoms, or signs I am calling about: > pain of (R) arm/shoulder". The Situation aspect further indicated the onset as 04/01/14 and it had become worse with any movement of the arm. The symptom became better when the arm was secure. The Situation portion indicated the resident had fractured her (L) ankle, prior to her admission to the facility while living at home. Review of the 2 page form did not indicate any further investigation of the incident prior to the complaint of pain.</p> <p>Review of an initial Incident form, initiated by the DNS on 04/01/14, indicated: "Brief Description of Incident: On 04/01/14 at approx. [approximately] 5:30 a.m. CNA noted during care resident complain of right arm pain. Resident guarding right arm, verbalizing pain. No swelling noted. MD and family notified. Xray</p>			

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	<p>ordered. Sray results indicate complete displaced fracture involving the right humeral surgical neck. DJD [Degenerative Joint Disease] AC joint. Resident is a extensive assist with transfers and bed mobility. Due to dx of Dementia she is unable to recall events. Diagnosis of Osteoporosis, Hypothyroidism, Hx [History] of Colon CA, Vulvar Cancer and breast cancer. Resident has a hx of pathological fractures. She was admitted here 5/23/13 due to a pathological ankle fracture In the operative report from the ankle fracture it states 'bones are thin, frail nature.' Type of Injury/Injuries: complete displaced fracture involving the humeral surgical neck."</p> <p>3.1-45(a)(2)</p>			