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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155778 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 03/29/2012 |
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| F0000 | <p>This visit was for a Recertification and State Licensure survey.</p> <p>Survey Dates: March 26, 27, 28, 29, 2012</p> <p>Facility Number: 000323 Provider Number: 155778 AIM Number: 100288440</p> <p>Survey Team: Linda Campbell, RN, TC Rita Mullen, RN</p> <p>Census Bed Type: SNF/NF: 42 Total: 42</p> <p>Census Payor Type: Medicare: 6 Medicaid: 24 Other: 12 Total: 42</p> <p>Sample: 11 Supplemental Sample: 4</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on April 2, 2012 by Bev Faulkner, RN</p> | F0000 | | |

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

TITLE

(X6) DATE

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

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| F0279 SS=D | <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to update a plan of care for a resident with multiple falls. This affected 1 of 6 residents reviewed for falls in a sample of 11. (Resident #20)</p> <p>Findings include:</p> <p>The clinical record of Resident #20 was reviewed on 3/27/12 at 3:00 P.M. Resident #20 was admitted to the facility on 11/14/11.</p> <p>Diagnoses for Resident #20 included, but</p> | F0279 | F279 What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident #20's clinical record and comprehensive care plan will be reviewed by the Interdisciplinary Team (IDT), and the care plan will be revised with added interventions to the already established fall risk plan. Interventions were updated to include the use of a pressure alarm on the bed and chair. How other residents having the potential to be affected by the same deficient practice will be identified and whet corrective | 04/28/2012 | |

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| | <p>were not limited to, dementia, depression, high blood pressure, anxiety and a history of falls.</p> <p>An initial Minimum Data Set (MDS) assessment, dated 11/20/11, indicated Resident #20 had fallen once at the facility, was cognitively impaired, required the supervised assist of one to ambulate, wandered and required the extensive assist of two to transfer.</p> <p>A Quarterly MDS, dated 2/14/12, indicated Resident #20 had fallen twice, was severely impaired cognitively and required the extensive assist of two to ambulate and transfer.</p> <p>A Fall Risk assessment, dated 11/21/11, indicated a score of 19, (a score greater than 10 represents a high risk for falls) and had balance problems while standing.</p> <p>A Fall Risk assessment, dated 2/9/12, indicated a score of 20.</p> <p>A Resident Care Plan for Falls, dated 11/14/11 and reviewed on 2/14/12, indicated Resident #20 was at risk for falls, had fallen prior to admit, ambulated with a walker and took medications that increased the risk for falls. "Note: fell x 3 since admit 11/18/11, 11/28/11, 12/28/11" (dates were also added for 2/5/12 and</p> | | <p>action will be taken Each resident care plan will be reviewed by the Director of Nursing, the Assistant Director of Nursing, the MDS Coordinator and or designated nurse. Any resident care plan identified as lacking measurable objectives and timetables to meet the residents' medical, nursing, and mental and psychosocial needs with be updated by April 28th, 2012. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The DON and MDS Coordinator or designee will review all new physician orders obtained from the previous day or days. The new physician orders with serve as an indication of a possible change and or update need to the care plan. On April 16th 2012 the DON shall conduct an educational session with the MDS Coordinator and or designee to include information regarding care plan updates. How the corrective actions will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into practice and by what date the systemic changes will be completed. The method for monitoring the care plans will be as follows: the care plans shall be audited by DON, ADON, or designated nurse on a weekly basis to ensure updates completed. The Frequency of the</p> | | | | |

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| | <p>2/13/12). Interventions included, but were not limited to, "Keep walk ways clear and pathways adequate (sic) lighting, Use assistive device as ordered (walker)..., assist with ambulation and transfer, can use clip-on alarm at night." The Care Plan was update one time on 2/14/12 adding the following: "Monitor Res (resident) for attempts (sic) self transfer, Amb (ambulate) & assist, involve res in activities as much as possible and resident doesn't like to be alone"</p> <p>A review of the Alleged Incident/Accident Reports, dated for the months of November 18, 2011 through March 25, 2012, indicated Resident #20 had fallen eight times.</p> <p>During an interview with the Director of Nursing, on 3/29/12 at 11:10 A.M., she indicated regarding falls: On 11/18/11, "Staff was not with her and after the second fall a clip alarm was added. The girls should have been with her." On 12/23/11, "She was not being assisted, she was being monitored. Her behaviors caused the fall. We did a medication review and Haldol was added for behaviors." On 2/5/12, "There were no changes to the care plan, I talked to the family and hospice about the falls." On 2/13/12, "There were no new</p> | | <p>care plan audits will be 100% initially then, 50% of the care plans for 2 weeks, and then 25% of the care plans for 4 weeks and then on an as needed basis. The results of the audits will be presented and reviewed by the IDT/QA Committee on a bi-monthly basis. At the end of the audit period the IDT/QA committee shall deem that the high frequency audits continue until 100% compliance is achieved or the Committee can recommend a reduction or cessation of the audits if compliance rate at 100%, ie.. all of the care plans reviewed are updated and reflect the current status of the resident.</p> | | | | |

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| | <p>interventions, we reviewed things but didn't make any changes." On 3/25/12, "We put a pressure alarm on the bed and chair."</p> <p>A Policy for "Procedures-Falls and incidents received from the MDS Coordinator, on 3/29/12 at 11:00 A.M., indicated the following:</p> <p>"...Purpose: To assess the individual's condition, to identify the reason the fall and prepare a plan to reduce the potential for future falls....</p> <p>8. The Quality Assurance and Improvement Committee shall review all falls of the past quarter to ensure that interventions are in place to prevent further falls and the interventions are effective."</p> <p>3.1-35(a)</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>A. Based on record review and interview, the facility failed to develop new interventions to prevent falls for a resident with a history of falls, who experienced eight falls over the past four months, resulting in bruising, a skin tear and a visit to the emergency room. This effected 1 of 6 residents reviewed for falls in a sample of 11. (Resident #20)</p> <p>B. Based on observation, interview, and record review, the facility failed to ensure the environment was free of accident hazards related to chemical storage and equipment functioning for 2 of 4 halls in the facility. (D Hall, E Hall).</p> <p>Findings include:</p> <p>A.1. The clinical record of Resident #20 was reviewed on 3/27/12 at 3:00 P.M. Resident #20 was admitted to the facility on 11/14/11.</p> <p>Diagnoses for Resident #20 included, but were not limited to, dementia, depression, high blood pressure, anxiety and a history</p> | F0323 | F323 What corrective action will be accomplished for those resident found to have been affected by the deficient practice? The clinical record and care plan of Resident #20 will be reviewed by the IDT and the new interventions including the use of a pressure alarm on bed and chair have been added to the already established plan of care. The hoier lift battery that was sitting on a wooden table in the lounge on D hall was immediately removed and inspected for proper functioning by the Maintenance Supervisor. The charger was placed in the proper area for charging which is not an area accessible to residents. The bottles of lotion, perineal skin cleanser and hand sanitizer were immediately removed from the linen cart on E Hall. The bottles of lotion were placed in a locked storage closet, the hand sanitizer was placed in the locked medication room and the perineal skin cleanser was discarded. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken. 100% of | 04/28/2012 | | | |

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| | <p>of falls.</p> <p>An initial Minimum Data Set (MDS) assessment, dated 11/20/11, indicated Resident #20 had fallen once at the facility, was cognitively impaired, required the supervised assist of one to ambulate, wandered and the extensive assist of two to transfer.</p> <p>A Quarterly MDS, dated 2/14/12, indicated Resident #20 had fallen twice, was severely impaired cognitively and required the extensive assist of two to ambulate and transfer.</p> <p>A Fall Risk assessment, dated 11/21/11, indicated a score of 19, (a score greater than 10 represents a high risk for falls) and had balance problems while standing.</p> <p>A Fall Risk assessment, dated 2/9/12, indicated a score of 20.</p> <p>A Resident Care Plan for Falls, dated 11/14/11 and reviewed on 2/14/12, indicated Resident #20 was at risk for falls, had fallen prior to admit, ambulated with a walker and took medications that increased the risk for falls. "Note: fell x 3 since admit 11/18/11, 11/28/11, 12/28/11" (dates were also added for 2/5/12 and 2/13/12). Interventions included, but were not limited to, "Keep walk ways</p> | | <p>residents' clinical record and fall risk assessment will be reviewed. All residents with a high score of "10" or more on the completed fall risk assessment shall have their care plan reviewed and revised if needed. Interventions will be added to all residents identified as having frequent falls and/or safety issues. A tour of the facility shall be completed by the Administrator and or Maintenance Supervisor on a weekly basis for four weeks to ensure no further battery charges or other potential hazards are in resident common areas and/or in reach of residents. The frequency of these tours may be reduced to monthly after the initial weekly tours if the QA Committee recommends a reduction. The Director of Nursing or designated person shall check the linen carts three times weekly to ensure that only linens are stored on carts. An in-service shall be conducted for all staff. The in-service content will include proper storage of proper storage of personal care supplies and proper charging of lift batteries in areas not in reach or accessible by the residents. What measures will be put into place or what systemic changes will be made to ensure that deficient practice does not recur. The DON and MDS Coordinator and/or designee will on a daily basis review all new physician orders obtained from the previous day or days. The new Physician Orders</p> | | | | |

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| | <p>clear and pathways adequate (sic) lighting, Use assistive device as ordered (walker)..., assist with ambulation and transfer, can use clip-on alarm at night, monitor Res (resident) for attempts (sic) self transfer, Amb (ambulate) & assist, involve res in activities as much as possible and resident doesn't like to be alone."</p> <p>A Nursing note, dated 11/18/11 at 3:15 A.M., indicated "resident yelling help from room, CNA (certified nursing assistant) found res sitting on her buttocks in doorway beside rolling walker...Yelling "I'm getting out of here! I'm going home!"</p> <p>An Alleged Incident/Accident Report, dated 11/18/11 fall occurred at 3:15 A.M., indicated "...Final Disposition: [no] injuries, able to move all extremities WNL (within normal limits), 1:1 [with] staff, neuro checks being done, q [every] 15 min - elopement risk checks. Added walker to use when amb."</p> <p>A Nursing note, dated 11/28/11 at 6:10 A.M., indicated "Staff called writer to MDR (main dining room), res had tripped [and] was sitting on (sic floor...noted small skinned area to [left] elbow, superficial [and] < (less than) 1 cm (centimeter). Noted bruise to buttocks appears to have been present before fall."</p> | | <p>will serve as an indication of a possible change and/or update to the care plan. An Incident/Accident form will be presented to the IDT during daily "stand-up" meetings. The IDT will immediately review the intervention and changes/updates will be made and/or initiated to the resident's plan of care. A new form titled "Linen Cart Check" shall be developed and placed on each linen cart. The check sheet shall be completed by the floor nursing staff each shift indicating they have checked the cart and it is free of personal care items such as lotions, sanitizer, and perineal skin cleanser. The form shall contain the date, time, staff initials and title. Maintenance and/or housekeeping supervisor shall complete weekly walk through rounds to ensure that all battery chargers are placed in areas not accessible to residents and are in good working order. This specific weekly check will be added to the already established maintenance/housekeeping rounds list. How the corrective actions will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place and by what date the systemic changes will be completed. The IDT/OA Committee shall be presented with the care plan updates and the updated intervention that are pertaining to falls that occurred</p> | | | | |

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| | <p>An Alleged Incident/Accident Report, dated 11/28/11 fall occurred at 6:10 A.M., indicated "...Final Disposition: Fall investigation in progress, using rolling walker - Had another fall [with] in close time proximity & required ER (emergency room) visit/eval (evaluation) [no] fx (fractures) - pull tab alarm ordered."</p> <p>A Nursing note, dated 11/28/11 at 7:45 A.M., indicated "Res fell down leaving DR (dining room) onto [right] side,...c/o complaints of) pain [right] side down into lower back...N.O. (new order) to send to ER for eval [and] tx (treatment)...."</p> <p>An Alleged Incident/Accident Report, dated 11/28/11 fall occurred at 7:45 A.M., indicated "...Final Disposition: Res sent to ER for eval [and] tx - 11 A.M. will try clip alarm...."</p> <p>A Nursing Note, dated 11/28/11 at 10:45 A.M., indicated "[Name of ER staff] from ER called. [no] new fractures seen, however old fractures noted...."</p> <p>A Physicians order, dated 11/28/11, indicated "Clip alarm @ all x's (times)."</p> <p>A Nursing note, dated 11/29/11 at 6:00 A.M., indicated "Res has had clip alarm</p> | | <p>over the previous two weeks. the IDT/QA Committee will determine if the interventions have been carried through and are effective to ensure the deficient practice will not recur. The IDT/QA will anticipate a reduction in the number of reoccurring falls. The numbers of falls shall be presented to the IDT/QA Committee on a monthly basis to ensure the effectiveness of the interventions. The IDT/QA Committee shall deem interventions effective if the results of residents with reoccurring falls have decreased. This monitoring practice shall be ongoing. The results of the maintenance/housekeeping rounds and the Linen Cart Check form shall be reviewed by the QA/IDT Committee on a quarterly basis, the QA/IDT Committee can determine if the frequency of the completed rounds and linen cart cart checks can be reduced or ceased based on the results of the audits (100% compliance for at least 2 quarters). However, if the audits reveal continued accident hazards/supervision/device problems the IDT/QA will recommend of audits/checks. All corrections and systemic changes will complete by April 28, 2012.</p> | | |

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| | <p>go off x 3 this A.M. when she gets [up] out of bed. All 3 x's resident screams, becomes agitated [and] scared. Clip alarm removed to prevent [increased] behaviors..."</p> <p>A Physicians order, dated 12/2/11, indicated "Clarification, pull tab alarm on at night only. D/C (discontinue) alarm at all times."</p> <p>A Nursing note, dated 12/23/11 at 7:05 A.M., indicated "...Res was following CNA in the hallways that was passing HS (night time) snacks. Res cont (continued) to follow CNA. [down by the CR (craft room) & ambulated into CR. Upon Res leaving CR, she rammed walker up against CNA from behind & Res lost balance & fell & landed on her bottom...."</p> <p>An Alleged Incident/Accident Report, dated 12/23/11 fall occurred at 7:05 A.M., indicated "...Final Disposition: "...This fall r/t (related to) behavior, medication review...."</p> <p>An Alleged Incident/Accident Report, dated 2/5/12 fall occurred at 8:30 A.M., indicated "...Description of Incident and Treatment Administered: Res was in room & CNA just finished bath, when Res got [up] from recliner to ambulate [with] walker. As Res got [up] she lost</p> | | | |

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| | <p>balance (sic) & fell backward on the floor & when she fell Res hit (sic) head on wall heater...Res c/o head hurting right [after] incident but pointed to a different area on head then....Final Disposition: "...[after] about an hour no further c/o's...n[no] changes in fall interventions. alarms at this time cause more harm than good at this time..." No new interventions were added to the care plan.</p> <p>An Alleged Incident/Accident Report, dated 2/13/12 fall occurred at 2:15 P.M., indicated "...Description of Incident and Treatment Administered: Res found on floor on [right] side...unable to state what happened....Final Disposition: X 2 transfer to w/c (wheelchair) c/o buttock discomfort...Spoke with family and hospice about alarms, cont to feel more harm than good...." No new interventions were added to the care plan.</p> <p>An Alleged Incident/Accident Report, dated 3/25/12 fall occurred at 2:00 A.M., indicated "...Description of Incident and Treatment Administered: Resident climbed out of bed. Fell on floor, did not hit head. Landed on her left side...Alarm on. Final Disposition: Investigation started- spoke with IDT (interdisciplinary team) regarding falls over weekend - A pressure alarm was applied after this fall - not causing agitation, fear etc @ this</p> | | | |

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|---|---|---|---|--|--|---|--|
| NAME OF PROVIDER OR SUPPLIER WOODLAND MANOR NURSING CENTER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1212 E MAIN ATTICA, IN 47918 | | | |
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| | <p>[time] will cont alarm."</p> <p>An Alleged Incident/Accident Report, dated 3/25/12 fall occurred at 3:45 P.M., indicated "...Description of Incident and Treatment Administered: Res was attempting to get [up] out of recliner in Rm (room) as QMA (Qualified Medication Assistant) was coming to see who's (sic) alarm was sounding. As QMA came to doorway Res slid [down] to floor & landed on her bottom... Final Disposition: Assisted to w/c [after] taking to BR (bathroom). Alarm on & functional. Note - investigation started alarm in use..."</p> <p>During an interview with the Director of Nursing, on 3/29/12 at 11:10 A.M., she indicated regarding falls: On 11/18/11, "Staff was not with her and after the second fall a clip alarm was added. The girls should have been with her." On 12/23/11, "She was not being assisted, she was being monitored. Her behaviors caused the fall. We did a medication review and Haldol was added for behaviors." On 2/5/12, "There were no changes to the care plan, I talked to the family and hospice about the falls." On 2/13/12, "There were no new interventions, we reviewed things but didn't make any changes." On 3/25/12, "We put a pressure alarm on the bed and</p> | | | | | | |

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| | <p>chair."</p> <p>A Policy for "Procedures-Falls and incidents received from the MDS Coordinator, on 3/29/12 at 11:00 A.M., indicated the following:</p> <p>"...Purpose: To assess the individual's condition, to identify the reason the fall and prepare a plan to reduce the potential for future falls....</p> <p>7. When a fall occurs, the facility shall assess for factors that may have caused the fall and interventions shall be implemented to prevent future falls.</p> <p>B. 1. On 3/27/12 at 1:35 P.M., a lift battery charging unit was observed sitting on a wooden table in the resident lounge on the D Hall. The charging unit was plugged into the wall behind the table. The charging unit was hot to the touch. The temperature was measured at 130 degrees.</p> <p>Interview on 3/27/12 at 1:40 P.M., with the Maintenance Supervisor indicated the charging unit should not have been hot to the touch and indicated it may not have been functioning properly. He indicated the charging unit should not have been in the resident lounge in reach of residents.</p> | | | | | | |

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| | <p>There were 6 cognitively impaired residents located on the D Hall.</p> <p>B. 2. On 3/28/12 at 9:00 A.M., during an environmental tour with the Maintenance Supervisor and the Housekeeping Supervisor, a linen cart was observed sitting in the hallway on the E Hall. Further observation indicated the following in a plastic bin on the cart:</p> <p>Eight 8-ounce bottles of "Caring Body Lotion" labeled "External Use Only." One 4-ounce bottle of "Aloe Vesta Perineal Skin Cleanser" labeled "External Use Only" and "May cause eye irritation." Two 8-ounce bottles of "Epi-Clenz Instant Hand Antiseptic" labeled "For External Use Only."</p> <p>Interview at the time of the observation with the Housekeeping Supervisor indicated the listed bottles should not have been left on the linen cart.</p> <p>There were 7 cognitively impaired residents located on the E Hall.</p> <p>Review on 3/28/12 at 12:30 P.M., of a facility policy and procedure, dated 7/03, provided by the Administrator, identified as current, and titled "Storage of chemicals, resident bathing, care supplies" indicated "...Items shall not be</p> | | | |

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| | <p>kept in areas in which residents could access the item...Bathing and care supplies such as soaps, lotions, deodorant, shaving supplies for each resident shall be kept in a bathing container in each residents bedside table and or closets...."</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p> | | | | |