

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155481	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/01/2015
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NAME OF PROVIDER OR SUPPLIER ARBOR TRACE HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3701 HODGIN RD RICHMOND, IN 47374
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F 000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00171577.</p> <p>Complaint # IN00171577-Substantiated. Federal/State deficiencies related to the allegation are cited at F-323.</p> <p>Survey date: May 1, 2015</p> <p>Facility number: 000455 Provider number: 155481 AIM number: 100291010</p> <p>Census bed type: SNF: 18 SNF/NF: 75 Total: 93</p> <p>Census payor type: Medicare: 34 Medicaid: 40 Other: 19 Total: 93</p> <p>Sample: 3</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 000	<p>Arbor Trace request paper compliance review for this deficiency. This plan of correction is to serve as Arbor Trace Health and Living Community's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Arbor Trace or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.</p>	
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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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F 323 SS=D Bldg. 00	<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 observation, interview and record review, the facility failed to implement fall interventions as careplanned, failed to investigate the root cause analysis of falls and failed to implement interventions to prevent falls for residents identified as high risk for falls for 3 of 3 residents reviewed for accidents (Resident #C, Resident #A and Resident #B).</p> <p>Findings include:</p> <p>Review of the record of Resident #C on 5/1/15 at 9:55 a.m., indicated the resident's diagnoses included, but were not limited to, shortness of breath, weakness, pneumonia, atrophy, congestive heart failure, Parkinson disease and hypertension.</p> <p>The admission fall risk assessment, dated 3/25/15, indicated Resident #C was at high risk for falls.</p>	F 323	<p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice;</p> <ul style="list-style-type: none"> ·Resident A no longer resides in the facility ·Resident B no longer resides in the facility ·Resident C no longer resides in the facility <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;</p> <ul style="list-style-type: none"> ·Every resident that is a fall risk has the potential to be affected. ·Residents who are at risk for falls, those residents who have had falls and residents with fall interventions have been reviewed to ensure: (1) interventions from the care plan are in place, (2) interventions are based on root cause analysis, and (3) interventions are implemented to prevent further falls for each resident who has the potential to be affected. <p>What measures will be put into</p>	05/26/2015

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	<p>The fall careplan for Resident #C, dated 4/2/15, indicated the resident was at at risk for falling and fall related injuries related to weakness. The interventions included, but were not limited to, "do not leave alone in room when in chair".</p> <p>Resident #C was admitted to the facility on 4/1/15. His Admission Minimum Data Set (MDS) assessment for Resident #C, dated 4/8/15, indicated he made himself understood and had the ability to understand others. He required extensive assistance of one person to transfer and toileting. He required limited assistance of one person to walk in his room. He utilized a wheelchair and walker for mobility devices. He had one fall with an injury since admission.</p> <p>The fall event report for Resident #C, dated 4/5/15 at 7:07 a.m., indicated the resident had a fall in his room and was found beside his bed. The fall was unwitnessed. The resident bumped a previous skin tear and pressure was applied to the wound. The intervention in place at the time of the fall was a low bed. The intervention initiated after the fall was an bed alarm.</p> <p>The Interdisciplinary team (IDT) post fall assessment for Resident #C, dated 4/6/15,</p>		<p>place or what systemic changes will be made to ensure that the deficient practice does not recur;</p> <ul style="list-style-type: none"> ·The administrative team, IDT and staff have been trained to utilize the "5 Whys" and perform a root cause analysis for falls to ensure effective interventions are put into place to prevent additional falls. ·Current fall prevention interventions have been audited to ensure they are in place for each resident ·Staff have been trained to know what interventions must be in place to prevent falls for those residents affected and those who have the potential to be affected. ·The IDT will review each fall in the morning meeting to ensure: the care plan has been updated to reflect the current interventions, the staff are aware of the current fall interventions and the interventions are in place for the residents. <p>How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place and by what date the systemic changes will be completed?</p> <ul style="list-style-type: none"> ·Any resident with a fall will be reviewed daily by the nurse management team or designee to ensure the care plans, staff assignment sheets and fall interventions are put into place. This will be done daily including Saturday and Sunday ongoing to 	

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	<p>indicated the cause of the fall on 4/5/15 was the resident lost his balance. The resident was found on the floor and was unable to state what happened. The resident indicated he did not fall. The resident was assisted to the bathroom and back to bed with a bed alarm for safety.</p> <p>The fall event report for Resident #C, dated 4/10/15 at 11:30 p.m., indicated the resident had an unwitnessed fall in his room with no injury. The interventions in place at the time of the fall was low bed and bed alarm. The interventions initiated immediately after the fall was resident offered food and/or drink, toileting and rest.</p> <p>The progress note for Resident #C, dated 4/11/15 at 12:24 a.m., indicated a Certified Nursing Assistant (CNA) had found the resident next to his bed on his knees. The resident stated he was attempting to go the bathroom. The resident had arms placed on bed alarm causing the alarm not to go off. The staff assisted the resident to the bathroom and back to bed. Staff instructed the resident to use the call light for assistance.</p> <p>The IDT post fall assessment for Resident #C, dated 4/13/15, indicated the resident had an unwitnessed fall in his room. The cause of the fall was lost</p>		<p>ensure all interventions are in place.</p> <ul style="list-style-type: none"> ·The corporate nurse consultant will evaluate the care plans, staff assignment sheets and fall interventions being in place and ensure root cause analysis is being conducted on 5 residents with falls two times monthly and this will be part of the QA meeting in 4 weeks, The corporate nurse consultant will then monitor 5 residents with falls monthly thereafter to total 12 months of monitoring to ensure compliance. The results of these audits will be discussed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. ·The administrator is responsible to ensure compliance. ·The corrective actions will be in place and the facility will be in compliance on Tuesday, May 26, 2015. 		

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	<p>balance and lost strength/weakness. The root cause was the resident was self transferring to go the bathroom. The new intervention was to do a 3 day voiding pattern to assess the need for a scheduled toileting plan.</p> <p>The fall event report for Resident #C, dated 4/17/15 at 9:59 p.m., indicated the resident had an unwitnessed fall in his room. The resident acquired an injury of "bump, redness, swelling". The interventions in place at the time of the fall were low bed, non-skid footwear, resident in close proximity to nurse's station, chair alarm, bed alarm, night light and therapy treating resident. The new immediate interventions put in place was "rest, chair alarm and bed alarm".</p> <p>The progress note for Resident #C, dated 4/17/15 at 10:44 p.m., indicated a loud "thump" was heard. Went into the resident's room and found him lying on the floor between the bed and the dresser. The resident had a "large swollen knot" on the back of his head, redness and swelling noted to his jaw. The resident was sent by the local fire department to the emergency room.</p> <p>The local emergency room instructions for Resident #C, dated 4/17/15, indicated apply ice to the left sided facial swelling</p>			

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	<p>three times a day for 15 minutes and apply bacitracin to left elbow and change dressing twice a day. The resident was to return to the emergency room if he experienced vomiting, headache or not "acting right".</p> <p>The fall event report for Resident #C, dated 4/19/15 at 7:00 a.m., indicated the resident had an unwitnessed fall in his room. The resident was sitting in his wheelchair. The resident acquired an abrasion and direct pressure was applied to the wound. The intervention in place at the time of the fall was the resident was to be at the nurses station when up in the wheelchair. The interventions initiated immediately after the fall was rest, chair alarm and bed alarm.</p> <p>The progress note dated 4/19/15 at 7:00 a.m., indicated the staff heard Resident #C's alarm sounding and went into his room. The resident had fell out of his wheelchair. The resident had an abrasion on the bridge of his nose and left cheek and had a small amount of bleeding areas that were cleaned.</p> <p>The IDT post fall assessment for Resident #C, dated 4/20/15, indicated the resident had an unwitnessed fall in his room. The cause was lost strength/weakness. The root cause was</p>			

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	<p>the resident was confused. The new intervention was bolstered mattress.</p> <p>Interview with the Director Of Nursing (DON) on 5/1/15 at 12:45 p.m., indicated the intervention for Resident #C's fall on 4/10/15 was a three day voiding pattern to assess for a toileting program. The DON indicated Resident #C was not placed on a toileting program because the three day voiding pattern indicated the resident was continent. The DON indicated sometimes the resident will tell staff if he needs to go to the bathroom and sometimes he will not. The DON indicated the resident had confusion. The DON indicated she believed a bolster mattress was put in place for the fall on 4/17/15, but was unable to provide documentation that this was put into place. The DON indicated the fall intervention put into place for the 4/19/15 fall was not to leave the resident unattended in his wheelchair in his room.</p> <p>During observation on 5/1/15 at 1:30 p.m., Resident #C was sitting in his room in his wheelchair asleep, covered with a blanket. The resident's roommate was asleep in the room in his bed. The resident had a scab on his left jaw and a scab on the left side of his forehead. There were no staff present.</p>			

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	<p>Interview with CNA #3 on 5/1/15 at 1:40 p.m., indicated she did not know who brought Resident #C to his room. CNA #3 indicated Resident #C should never be left in his wheelchair alone in his room.</p> <p>Interview with Resident #C's family member on 1:45 p.m., indicated the resident thinks he can get up and walk, but he could not. The family member indicated the resident was confused and did not realize he was unable to get up alone. The family member indicated the resident had always been independent and now he could not be. The family member indicated the resident had Parkinson and confusion and she had never seen him use the call light for assistance. The family member indicated she visited the resident daily. The family member indicated Resident #C should never be left alone in his wheelchair in his room.</p> <p>Interview with the DON on 5/1/15 at 2:05 p.m., indicated LPN #4 had put Resident #C in his room because the resident was getting agitated. The DON indicated LPN #4 was unaware that Resident #C was not suppose to be left alone in his room in his wheelchair.</p> <p>2. Review of the record of Resident #A on 5/1/15 at 9:25 a.m., indicated her</p>			

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	<p>diagnoses included, but were not limited to, vascular dementia with depressed mood, muscular disuse, muscle weakness, communication deficit, urinary tract infection, hypopotassemia, senile dementia, hypertension, essential.</p> <p>Resident # A was admitted to the facility on 3/17/15, from the local hospital and was discharged from the facility on 4/18/15 to her home.</p> <p>The admission Observation Report for Resident #A dated 3/17/15, indicated she had a history of falls in the last 3 months, one or two falls. Score of 10 or higher represents a high risk for falls. Her fall risk score was 7.0.</p> <p>Review of Resident #A's Admission Minimum Data Set (MDS) assessment dated 3/24/15, indicated she was confused and had difficulty with her memory. She required the assistance of 1 person for bed mobility, transfer, walking in her room, and toileting. She utilized a walker and a wheelchair for mobility devices. She has had 4 falls since admission.</p> <p>Review of "Accident Investigation Form Unusual Occurances dated 4/8/15 at 3:00 p.m., indicated Accident/Incident Description: Resident found lying on</p>			

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	<p>floor on right side. Had gotten up out of chair per self. Alarm was sounding. Time Physician returned call and gave instructions 3:15 p.m., List Instructions: send to local emergency room. Corrective Action: will discuss different slippers with family." No root cause analysis documented.</p> <p>Review of "Accident Investigation Form Unusual Occurances dated 4/11/15 at 12:31 a.m., indicated Nature of the illness (bruise, fall, skin tear)- left blank. Exact location of the accident/incident- resident room. Any witnesses?- left blank. Accident/Incident description: resident pull alarm sounding, found resident lying on floor next to bed. Neuro checks with in normal limits. Vital signs with in normal limits. No complaints of pain/discomfort. Disposition of injured person (hospital, put to bed, sent home, back to work)- left blank. Corrective Action: 3 day voiding." No root cause analysis documented.</p> <p>Review of "Accident Investigation Form Unusual Occurances dated 4/17/15 at 6:45 a.m., indicated Nature of the illness (bruise, fall, skin tear)- fall. Exact location of the accident/incident- resident room. Any witnesses?- No. Accident/Incident</p>			

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	<p>description: left blank. Disposition of injured person (hospital, put to bed, sent home, back to work)- toileted. Corrective Action: scheduled toileting." No root cause analysis documented.</p> <p>On 5/1/15 at 2:45 p.m., an interview with Director of Nursing(DON) indicated, root cause of fall on 4/8/15, "unknown, she was confused." The root cause of the fall on 4/11/15, she indicated, "I don't know if she was trying to go to the bathroom or not. We did a 3 day voiding to see if she needed to go to bathroom, she was continent." The root cause of fall on 4/17/15, DON indicated, "unknown."</p> <p>Care plans in place for falls with appropriate problem, goals and interventions after each fall.3. Resident #B's record was reviewed on 5/1/15 at 9:39 a.m. Diagnoses included but were not limited to chronic obstructive pulmonary disease, hypertension, osteoporosis, and urinary complications.</p> <p>Resident #B was admitted to the facility on 3/24/15. His Admission Minimum Data Set (MDS) assessment dated 3/31/15, indicated he made himself understood and had the ability to understand others. He required extensive assistance of 2 plus persons for bed mobility, transfer, walking in his room,</p>			

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	<p>and toileting. He utilized a walker and a wheelchair for mobility devices. He had an indwelling urinary catheter. He had a ruptured abdominal aortic aneurysm with aftercare following surgery. He had no falls since admission.</p> <p>Resident #B's Admission Fall Risk Assessment dated 3/24/15, indicated he was alert and oriented. He was chair bound requiring assistance with ambulation. He had no history of falls within the last 3 months.</p> <p>An IDT (Interdisciplinary) /Post Fall Assessment for Resident #B dated 4/2/15, indicated he had an unwitnessed fall in his room and was found on the floor. He had slid out of his wheelchair. His mental status prior to his fall was alert and oriented. His usual ambulatory status was assist of one. The immediate intervention initiated and communicated to staff was to place dycem in his wheelchair. A summary of the root cause/potential factors that could have contributed to the fall indicated "Resident slid from w/c (wheelchair)." His Fall Care Plan had been updated.</p> <p>An IDT/Post Fall Assessment for Resident #B dated 4/13/15, indicated he had unwitnessed fall in his room and was found on the floor. He had been getting</p>			

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	<p>out of bed and lost his balance. His mental status prior to his fall was confused. His usual ambulatory status was assist of one. He was barefoot. The immediate intervention initiated and communicated to staff was a 3 day voiding pattern. A pattern related to the resident's falls was attempting to toilet himself. A summary of the root cause/potential factors that could have contributed to the fall indicated "resident attempting to toilet self and lost balance." His Fall Care Plan had been updated.</p> <p>An intervention initiated on Resident #B's Fall Care Plan dated 3/25/15, indicated "Provide non-skid footwear." An intervention initiated on 4/2/15, indicated "dycem to w/c." An intervention initiated on 4/13/15, indicated "3 day voiding pattern to assess need for scheduled toileting."</p> <p>A 3 Day Bladder Record for Resident #B initiated 4/14/15, ending 4/16/15, indicated he was continent of his bladder.</p> <p>On 5/1/15 at 10:50 a.m., Resident #B was observed lying in bed on his back with oxygen running from a concentrator through a nasal cannula. The oxygen concentrator was in his bathroom and a large amount of oxygen tubing was on the floor leading from himself in bed to</p>			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>the concentrator in the bathroom. He indicated he was admitted to the facility after having stomach surgery. A rollator was positioned near the end of his bed and he indicated he used it to ambulate. He had socks on both feet and indicated that is what he wore when he ambulated and his daughter was going to bring him some house slippers. He had a wheelchair positioned near his bathroom door with a seat cushion and no dycem. He indicated he knew how to use his call light but sometimes the staff didn't get to him quick enough and he ambulated to the bathroom independently using his rollator.</p> <p>When LPN #1 was informed Resident #B was not wearing non-skid footwear and no dycem was in his wheelchair she indicated she had just started work on the unit at 10:00 a.m., and she hadn't checked his fall interventions yet. She indicated she would take care of it.</p> <p>An interview with Physical Therapist Assistant #2 on 5/1/15 at 11:52 a.m., indicated Resident #B was currently on therapy caseload. Resident #B required stand by contact assistance to the bathroom due to his compulsiveness and oxygen tubing management. Resident #B should used his rollator but would abandon it at times and wasn't consistent</p>			

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	<p>with it's use. Resident #B had achieved a good level of functional mobility but still required a good level of supervision.</p> <p>An interview with the Director of Nursing (DON) on 5/1/15 at 1:24 p.m., indicated Resident #B was continent of urine on his 3 Day Bladder Record. If a resident is continent of bladder they are not placed on a toileting program.</p> <p>Resident #B was observed seated upright on the side of his bed with his feet on the floor. He had non-skid socks on both feet and blue dycem was on his wheelchair cushion. He indicated he did not wear the non-skid socks daily; "no they give me these today." When queried what he normally wore on his feet to the bathroom he stated "my socks." When queried about the dycem on his wheelchair cushion he stated "they just put that on there today. I don't know what their going to do with that."</p> <p>The Fall Management Program provided by the DON on 5/1/15 at 9:50 a.m., indicated the following: "Purpose: To reduce the number of falls and minimize injuries related to falls. The goal of the interdisciplinary team is to identify residents with a history of and potential for falls and develop an effective individualized fall management plan.</p>						

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	<p>The Program will consist of four components: 1) Identify residents with history of and potential for falls. 2) Developing individualized fall management programs. 3) Implementing the program. 4) Monitor and evaluate the effectiveness of the program...</p> <p>SECTION 3: IMPLEMENTING THE PROGRAM - Initiate the plan of care identifying resident specific interventions. Fall risk residents will be identified on the C.N.A. assignment sheet listing the fall interventions. Following each resident fall: Complete an Incident Report... Complete Fall Event to include immediate measures taken. Complete IDT Post Fall Observation to identify Root Cause Analysis. Associate progress note and vital signs to Fall Event for 72 hours... Notify Therapy for Screening via Therapy/Nursing Interdisciplinary Communication Form as applicable. Complete Neurological Checks per protocol for any un-witnessed fall or fall in which resident hit their head.</p> <p>SECTION 4: MONITORING AND EVALUATING THE EFFECTIVENESS OF THE FALL MANAGEMENT PROGRAM... Following each fall the plan of care must be updated with the intervention based on the root cause of the fall...."</p> <p>3.1-45(a)(1)</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/01/2015
FORM APPROVED
OMB NO. 0938-0391

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	3.1-45(a)(2)				