

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 07/05/2012	
NAME OF PROVIDER OR SUPPLIER YORK HOUSE				STREET ADDRESS, CITY, STATE, ZIP CODE 725 W 50TH ST MARION, IN 46953			
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R0000	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: July 2, 3, 5, 2012</p> <p>Facility number: 004028 Provider number: 004028 AIM number: n/a</p> <p>Survey team: Ginger McNamee, RN, TC Betty Retherford, RN</p> <p>Census bed type: 31 Residential: 31 Total: 31</p> <p>Census payor type: Other: 31 Total: 31</p> <p>Sample: 8</p> <p>These state residential findings are cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 7/9/12 Cathy Emswiler RN</p>			R0000	<p>Plan of Correction Disclaimer Statement Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.</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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R0091	<p>410 IAC 16.2-5-1.3(h)(1-4) Administration and Management - Noncompliance (h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request.</p> <p>Based on record review and interview, the facility failed to ensure the nursing staff implemented facility policy in regards to resident falls and follow up monitoring for 3 of 3 residents reviewed for falls in a sample of 8. (Resident #'s 1, 30, and 13)</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #30 was reviewed on 7/2/12 at 11 a.m.</p> <p>Diagnoses for Resident #30 included, but were not limited to, dementia and diabetes mellitus.</p> <p>A "Folstein Mini Mental Status Examination" form, dated 2/28/12, indicated Resident #30 had a score of 8. The form indicated a score of 10 or less indicated a severe cognitive deficit.</p> <p>A nursing note, written by CNA #6, dated</p>	R0091	<p>R091 – Administration and Management - Noncompliance Resident #30, Resident #1, and Resident #13 are free from injuries relating to stated falls. Residents who had a fall from July 20, 2012 through present have completed fall assessments and monitoring documentation in their files. Wellness Director (WD) will conduct an in-service of current clinical staff relating to resident fall actions and documentation. The contents of the in-service will include: · Assisted Living Concepts, Inc. policy on incident reporting · Policy on Resident</p>	07/21/2012			

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	<p>2/17/12 (no time designated), indicated "[name of resident] was going around corner shoes got stuck on carpet he triped [sic] fell gracefully to ground [sic] and almost caught himself. Just got out of bed, his shoes are cracked on bottom causing him to trip more often. Rt [right] hip hurting him." The note lacked any information related to vital signs having been taken or an evaluation of the resident having been completed r/t possible fracture or other injury.</p> <p>During an interview with the Administrator on 7/5/12 at 10:30 a.m., she indicated the incident report for this fall indicated the fall occurred at 10:35 p.m. on 2/17/12.</p> <p>The next nursing note entry after the entry noted above was written by QMA #3, dated 2/17/12 at 10:15 a.m., indicated the resident's vital signs were taken and the DoN and resident's brother were notified of the fall. The note lacked any other assessment of the resident for possible injury. The note lacked any instructions given by the DoN related to the fall.</p> <p>This indicated a period of 11 hours and 45 minutes from the time the fall occurred until the DoN was notified of the fall and the resident's vital signs were taken.</p>		<p>Fall Response</p> <ul style="list-style-type: none"> Fall documentation guideline's <p>Residence Director and/or Wellness Director will instruct staff in assessment needs and interventions at time of initial call to administration relating to resident falls. Residence Director and/or Wellness Director will review incident reports at daily "stand up" meeting to ensure proper documentation and actions have taken place. The Regional Director Quality and Care Management will review medical records of residents who fell monthly for 4 months, then quarterly thereafter to ensure compliance.</p>				

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	<p>The next nursing note entry, made by the DoN, dated 2/21/12 at 1 p.m., indicated the resident's physician was notified of the fall and the resident denied injury at that time.</p> <p>A Short Term Monitor form, dated 6/13/12, indicated Resident #30 had a problem with falls. Approaches for this problem included, but were not limited to, "monitor for c/o [complaints of] pain, notify doctor of fall, monitor change of consciousness (notify WD (facility term for Wellness Director - DoN)...."</p> <p>A nursing note, written by QMA (Qualified Medication Aide) #2, dated 6/18/12 at 5:45 p.m., indicated, "Resident stood up from chair and lost balance and slid down wall to floor." The note lacked any information related to an assessment or evaluation of the resident for possible injury or fracture. A 6/18/12 at 6 :00 p.m. nursing note indicated the Administrator was notified of the resident's fall. The note lacked any information related to instructions given by the Administrator.</p> <p>During an interview on 7/3/12 at 4:25 p.m., the Administrator reviewed the Incident Report completed related to the 6/18/12 fall. She indicated the resident's vital signs had been taken at the time of</p>				

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	<p>the fall and provided that information. The vital signs were within normal limits.</p> <p>A nursing note entry, written by the Director of Nursing (DoN), dated 6/19/12 at 10:00 a.m. indicated "Notified [name of Nurse Practitioner (NP)] of fall. Res. [resident] ambulatory has normal ROM [range of motion] for res."</p> <p>The nursing notes above lacked any information related to monitoring of the resident following the fall prior to the entry at 10:00 a.m. on 6/19/12.</p> <p>A nursing note entry written by QMA #3, dated 6/24/12 at 8:30 p.m., indicated "Res. was found sitting on floor in hallway outside of his room. No apparent injuries noted at this time" The note included the resident's vital signs which were within normal limits. The note indicated the DoN and resident's brother were notified of the fall. The note lacked any information related to instructions received from the DoN.</p> <p>The next nursing note entry was made by the DoN and dated 6/25/12 at 10 a.m. The note indicated "[name of NP] notified of fall. Res ambulating slowly but normally for res. No reports of pain."</p> <p>The nursing notes above lacked any</p>						

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	<p>information related to any follow up vital signs and/or monitoring of the resident following the fall prior to the 10:00 a.m. entry noted above.</p> <p>During an interview with the Administrator and DON on 7/3/12 at 2:30 p.m., additional information was requested related to the lack of follow-up monitoring and/or timely contact with the DoN or Administrator following the falls on 2/17/12, 6/18/12, and 6/24/12.</p> <p>During an interview with the Administrator and DoN on 7/5/12 at 10:30 a.m., they indicated they had no information to provide related to the lack of resident monitoring following the falls noted above and/or the lack of timely contact with the Administrator of DoN following the falls.</p> <p>2.) The clinical record for Resident #1 was reviewed on 7/2/12 at 3:15 p.m.</p> <p>Diagnoses for Resident #1 included, but were not limited to, Parkinson's disease, malnutrition, hypertension, and history of left hip fracture 8/09.</p> <p>A nursing note entry, written by CNA #10, dated 1/29/12 at 2:40 a.m., indicated "Answered res call light, found hey laying on her back next to toilet. Got her back to</p>						

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	<p>bed no apparent injuries...." Vital signs were documented. The note lacked any evaluation by a licensed staff member at the time of the fall prior to getting the resident back into bed.</p> <p>The next nursing note entry, written by QMA #4, dated 1/30/12 at 9:30 a.m., indicated "[name of Administrator] made aware of residents [sic] fall. The note lacked any information related to instructions given by the Administrator.</p> <p>This indicated a time period of 6 hours and 50 minutes from the time of the resident's fall until a licensed staff member was notified of the fall. No follow-up monitoring was documented during this time period.</p> <p>A nursing note entry, written by CNA #8, dated 2/26/12 at 12:20 a.m., indicated "Res pulled call light. Went into room. Res on floor beside bed. Res stated she tried to get into wc [wheelchair] and missed the seat. Res stated she fell on her bottom and was alright. Vitals taken." The note lacked any evaluation of the resident by a licensed staff member.</p> <p>The next nursing note entry, written by CNA #9, dated 2/26/12 at 8:00 a.m., indicated "Res started having pain upon movement in right hip. Wanted to be sent</p>						

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	<p>out for x-ray. Picked up by EMS [emergency medical service] and taken to ER [emergency room].</p> <p>The next nursing note entry, written by CNA #9, dated 2/26/12 at 12:15 p.m., indicated the resident returned from the hospital. A hip x-ray report, dated 2/26/12, indicated generalized osteopenia was noted but no fracture or dislocation.</p> <p>The nursing notes lacked any information related to the DoN being aware of the resident's fall at the time of the fall and/or follow up monitoring after the fall prior to the resident being sent to the hospital.</p> <p>During an interview with the Administrator and DON on 7/3/12 at 2:30 p.m., additional information was requested related to the CNAs having evaluated the resident for injury following the falls on 1/29/12 and 2/26/12, the lack of vital signs and follow up monitoring, and the lack of DoN or Administrator notification of the resident's fall on 2/26/12.</p> <p>During an interview on 7/3/12 at 4:25 p.m., the Administrator indicated she had reviewed the incident report for the fall on 2/26/12. She indicated the DoN had been notified of the fall on 2/26/12 at 7 a.m. This indicated a time period of 6 hours</p>			

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	<p>and 40 minutes from the time of the resident's fall until the DoN was notified of the fall.</p> <p>During an interview with the Administrator and DoN on 7/5/12 at 10:30 a.m., they indicated they had no information to provide related to additional vital signs and/or monitoring completed following the falls on 1/29/12 and 2/26/12.</p> <p>3.) Resident #13's clinical record was reviewed on 7/2/12 at 9:20 a.m. The resident's diagnoses included, but were not limited to, dementia, cerebral vascular disease, and history of right knee replacement.</p> <p>A 4/14/12, 12:45 p.m., Resident Services Notes indicated the resident fell in the dining room. Other residents indicated Resident #13 hit her head when she fell. The vital signs were obtained and within normal ranges at the time. The Director of Nursing was notified and the resident's daughter. The resident's daughter declined to have the resident sent to the emergency room for an evaluation. The record lacked any further observations of the resident related to this fall nor did it reflect if the physician or nurse practitioner were called. This notation was made by QMA #3.</p>						

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	<p>A 4/15/12, 5:20 p.m., Resident Services Notes indicated the resident fell in the dining room and hit her head twice. The resident's vital signs were noted at time of the fall. The note indicated the resident's daughter was coming to take the resident to the emergency room. This note was written by QMA #3.</p> <p>An untimed 5/9/12, Resident Service Notes written by CNA #7 indicated the resident was found on the floor in front of the resident's restroom. The note indicated the resident complained of back pain. The note indicated only the family was notified. Review of the Medication Record for May lacked an indication of pain medication being offered or given. The record reflected the licensed nurse did an evaluation of the resident on 5/10/12 at 3:00 p.m. and notified the Nurse Practitioner at that time.</p> <p>During an interview with the Administrator on 7/3/12 at 4:25 p.m. further information was requested.</p> <p>During an interview with the Director of Nursing on 7/5/12 at 10:30 a.m., further information was requested related to evaluations by a licensed staff for the above dates and times.</p> <p>Review of the current facility policy,</p>						

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	<p>dated 1/2006, provided by the DoN on 7/3/12 at 8:20 a.m., titled "Resident fall response", included, but was not limited to, the following:</p> <p>"Assess Situation</p> <p>Always communicate with the resident and ask if he or she is in any pain and, if so, the location of the pain.</p> <p>Do not move the resident. Make the resident as comfortable as possible; use pillows and blankets as needed. An evaluation of pain or injury is needed first.</p> <p>Take vital signs This information will be useful to paramedics and the Residence Wellness Director [facility title for DoN), if needed. Assess resident's discomfort (none, slight, moderate or extreme).</p> <p>Perform a brief check of the resident to include feeling elbows, shoulders, back, hips, and knees.</p> <p>If the resident is suspected to have struck their head or the resident was witnessed striking head (regardless if any injuries are noted), IMMEDIATELY CALL 9-1-1. Emergency personnel should be informed that the resident needs to be</p>						

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	<p>assessed for a possible closed head injury....</p> <p>Summon Assistance ...Call the Wellness Director to notify him/her of the fall and report all observations and information reported by the resident. Based on this the Wellness Director will:</p> <p>Decide that transporting the resident to the hospital is not necessary. If so, ask for additional instructions.</p> <p>Direct staff to call 9-1-1...</p> <p>Direct staff to arrange non-emergency transportation to the hospital....</p> <p>If unable to reach the Wellness Director or Residence Director [facility title for Administrator], call 9-1-1 immediately....</p> <p>...Follow-up</p> <p>...Staff should check on a resident who has fallen as described below and monitor the resident for sign/symptoms of pain. Checks should also include resident complaints of nausea, vomiting, lethargy, headaches, visual disturbances, difficulty moving extremities or any other unusual symptoms or complaints. These observations should be documented in the</p>						

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	<p>Resident's Service Notes....</p> <p>It is recommended that a resident be checked:</p> <p>every hour for the first 4 hours after the fall</p> <p>then, at least 2 x [times] on the next shift</p> <p>and 1 x on the following shift....</p>						

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R0214	<p>410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident.</p> <p>Based on record review and interview, the facility failed to ensure each resident was evaluated by a licensed staff member following a fall and vital signs and assessments were completed in accordance with facility policy for 3 of 3 residents reviewed for falls in a sample of 8. (Resident #s 1, 30, and 13)</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #30 was reviewed on 7/2/12 at 11 a.m.</p> <p>Diagnoses for Resident #30 included, but were not limited to, dementia and diabetes mellitus.</p> <p>A "Folstein Mini Mental Status Examination" form, dated 2/28/12, indicated Resident #30 had a score of 8. The form indicated a score of 10 or less indicated a severe cognitive deficit.</p> <p>A nursing note entry, dated 2/17/12 at 10:20 a.m., indicated a housekeeper had</p>	R0214	<p>R214 – Evaluation - Deficiency Resident #30, Resident #1, and Resident #13 are free from injuries relating to stated falls.</p> <p>Residents who had a fall from July 20, 2012 through present have completed fall assessment and monitoring documentation in their files.</p> <p>Wellness Director (WD) will conduct an in-service of current clinical staff relating to resident fall actions and documentation.</p> <p>The contents of the in-service will include:</p> <ul style="list-style-type: none"> · Assisted Living Concepts, Inc. policy on incident reporting · Policy on Resident Fall Response · Fall documentation guideline's <p>Residence Director and/or Wellness Director will</p>	07/21/2012			

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	<p>observed the resident fall in the hallway. The note included an evaluation was completed by the Administrator (who is an RN) and vital signs were taken. No injuries was noted. The resident was encouraged to use his walker which was in his room at the time of the fall.</p> <p>A nursing note, written by CNA #6, dated 2/17/12 (no time designated), indicated "[name of resident] was going around corner shoes got stuck on carpet he triped [sic] fell gracefully to ground [sic] and almost caught himself. Just got out of bed, his shoes are cracked on bottom causing him to trip more often. Rt [right] hip hurting him." The note lacked any information related to vital signs having been taken or an evaluation of the resident having been completed r/t possible fracture or other injury.</p> <p>During an interview with the Administrator on 7/5/12 at 10:30 a.m., she indicated the incident report for this fall indicated the fall occurred at 10:35 p.m. on 2/17/12.</p> <p>The next nursing note entry after the entry noted above was written by QMA #3, dated 2/17/12 at 10:15 a.m., indicated the resident's vital signs were taken and the DoN and resident's brother were notified of the fall. The note lacked any other</p>		<p>instruct staff in assessment needs and interventions at time of initial call to administration relating to resident falls. Residence Director and/or Wellness Director will review incident reports at daily "stand up" meeting to ensure proper documentation and actions.. The Regional Director Quality and Care Management will review medical records of residents who fell monthly for 4 months, then quarterly thereafter to ensure compliance.</p>				

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	<p>assessment of the resident for possible injury.</p> <p>This indicated a period of 11 hours and 45 minutes from the time the fall occurred until the DoN was notified of the fall and the resident's vital signs were taken.</p> <p>The next nursing note entry, made by the DoN, dated 2/21/12 at 1 p.m., indicated the resident's physician was notified of the fall and the resident denied injury at that time.</p> <p>A Short Term Monitor form, dated 6/13/12, indicated Resident #30 had a problem with falls. Approaches for this problem included, but were not limited to, "monitor for c/o [complaints of] pain, notify doctor of fall, monitor change of consciousness (notify WD (facility term for Wellness Director - DON)...."</p> <p>A nursing note, written by QMA (Qualified Medication Aide) #2, dated 6/18/12 at 5:45 p.m., indicated, "Resident stood up from chair and lost balance and slid down wall to floor." The note lacked any information related to an assessment or evaluation of the resident for possible injury or fracture. The note lacked any information related to the resident being evaluated by a licensed staff member. A 6/18/12 at 6 :00 p.m. nursing note</p>						

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	<p>indicated the Administrator was notified of the resident's fall.</p> <p>A nursing note entry, written by the Director of Nursing (DON), dated 6/19/12 at 10:00 a.m. indicated "Notified [name of Nurse Practitioner (NP)] of fall. Res. [resident] ambulatory has normal ROM [range of motion] for res."</p> <p>The nursing notes above lacked any information related to any vital signs having been taken at the time of the fall and/or following the fall or any evaluation of the resident following the fall prior to the 10:00 a.m. entry noted above.</p> <p>A nursing note entry written by QMA #3, dated 6/24/12 at 8:30 p.m., indicated "Res. was found sitting on floor in hallway outside of his room. No apparent injuries noted at this time" The note included the resident's vital signs which were within normal limits. The note indicated the DON and resident's brother were notified of the fall. The note lacked any information related to the resident being evaluated by a licensed staff member following the fall.</p> <p>The next nursing note entry was made by the DON and dated 6/25/12 at 10 a.m. The note indicated "[name of NP] notified of fall. Res ambulating slowly but</p>						

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	<p>normally for res. No reports of pain.</p> <p>The nursing notes above lacked any information related to any follow up vital signs and/or evaluation of the resident following the fall prior to the 10:00 a.m. entry noted above.</p> <p>During an interview with the Administrator and DON on 7/3/12 at 2:30 p.m., additional information was requested related to a CNA and/or QMAs having evaluated the resident for injury following the falls on 2/17/12, 6/18/12, and 6/24/12 and the lack of vital signs and follow up monitoring.</p> <p>During an interview on 7/3/12 at 4:25 p.m., the Administrator reviewed the Incident Report completed related to the 6/18/12 fall. She indicated the resident's vital signs had been taken at the time of the fall and provided that information. The vital signs were within normal limits.</p> <p>During an interview with the Administrator and DoN on 7/5/12 at 10:30 a.m., they indicated they had no information to provide related to resident evaluations by a licensed staff member at the time of the falls and/or additional vital sign monitoring after the falls.</p> <p>2.) The clinical record for Resident #1</p>						

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	<p>was reviewed on 7/2/12 at 3:15 p.m.</p> <p>Diagnoses for Resident #1 included, but were not limited to, Parkinson's disease, malnutrition, hypertension, and history of left hip fracture 8/09.</p> <p>A nursing note entry, written by CNA #10, dated 1/29/12 at 2:40 a.m., indicated "Answered res call light, found hey laying on her back next to toilet. Got her back to bed no apparent injuries...." Vital signs were documented. The note lacked any evaluation by a licensed staff member at the time of the fall prior to getting the resident back into bed.</p> <p>The next nursing note entry, written by QMA #4, dated 1/30/12 at 9:30 a.m., indicated "[name of Administrator] made aware of residents [sic] fall.</p> <p>This indicated a time period of 6 hours and 50 minutes from the time of the resident's fall until a licensed staff member was notified of the fall.</p> <p>A nursing note entry, written by CNA #8, dated 2/26/12 at 12:20 a.m., indicated "Res pulled call light. Went into room. Res on floor beside bed. Res stated she tried to get into wc [wheelchair] and missed the seat. Res stated she fell on her bottom and was alright. Vitals taken."</p>						

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	<p>The note lacked any evaluation of the resident by a licensed staff member.</p> <p>The next nursing note entry, written by CNA #9, dated 2/26/12 at 8:00 a.m., indicated "Res started having pain upon movement in right hip. Wanted to be sent out for x-ray. Picked up by EMS [emergency medical service] and taken to ER [emergency room].</p> <p>The next nursing note entry, written by CNA #9, dated 2/26/12 at 12:15 p.m., indicated the resident returned from the hospital. A hip x-ray report, dated 2/26/12, indicated generalized osteopenia was noted but no fracture or dislocation.</p> <p>During an interview with the Administrator and DON on 7/3/12 at 2:30 p.m., additional information was requested related to the CNAs having evaluated the resident for injury following the falls on 1/29/12 and 2/26 and the lack of vital signs and follow up monitoring. Information was requested related to when the DoN or Administrator had been notified of the fall.</p> <p>During an interview on 7/3/12 at 4:25 p.m., the Administrator indicated she had reviewed the incident report for the fall on 2/26/12. She indicated the DoN had been notified of the fall on 2/26/12 at 7 a.m.</p>			

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	<p>This indicated a time period of 6 hours and 40 minutes from the time of the resident's fall until the DoN was notified of the fall.</p> <p>During an interview with the Administrator and DoN on 7/5/12 at 10:30 a.m., they indicated they had no information to provide related to resident evaluations by a licensed staff member at the time of the falls and/or additional vital sign monitoring following the falls on 1/29/12 and 2/26/12.</p> <p>3.) Resident #13's clinical record was reviewed on 7/2/12 at 9:20 a.m. The resident's diagnoses included, but were not limited to, dementia, cerebral vascular disease, and history of right knee replacement.</p> <p>A 4/14/12, 12:45 p.m., Resident Services Notes indicated the resident fell in the dining room. Other residents indicated Resident #13 hit her head when she fell. The vital signs were obtained and within normal ranges at the time. The Director of Nursing was notified and the resident's daughter. The resident's daughter declined to have the resident sent to the emergency room for an evaluation. The record lacked any further observations of the resident related to this fall nor did it reflect if the physician or nurse practitioner were called. This notation</p>						

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	<p>was made by QMA #3.</p> <p>A 4/15/12, 5:20 p.m., Resident Services Notes indicated the resident fell in the dining room and hit her head twice. The resident's vital signs were noted at time of the fall. The note indicated the resident's daughter was coming to take the resident to the emergency room. This note was written by QMA #3.</p> <p>An untimed 5/9/12, Resident Service Notes written by CNA #7 indicated the resident was found on the floor in front of the resident's restroom. The note indicated the resident complained of back pain. The note indicated only the family was notified. Review of the Medication Record for May lacked an indication of pain medication being offered or given. The record reflected the licensed nurse did an evaluation of the resident on 5/10/12 at 3:00 p.m. and notified the Nurse Practitioner at that time.</p> <p>During an interview with the Administrator on 7/3/12 at 4:25 p.m. further information was requested.</p> <p>During an interview with the Director of Nursing on 7/5/12 at 10:30 a.m., further information was requested related to evaluations by a licensed staff for the above dates and times.</p>						

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	<p>During an interview with the Administrator on 7/5/12 at 2:40 p.m., she indicated the fall on 5/9/12, occurred at 1:20 p.m.</p> <p>During an interview with the Administrator on 7/5/12 at 2:50 p.m. she indicated the Director of Nursing and herself were the only licensed staff employed by the facility in the past year.</p> <p>Review of the current facility policy, dated 1/2006, provided by the DoN on 7/3/12 at 8:20 a.m., titled "Resident fall response", included, but was not limited to, the following:</p> <p>"Assess Situation</p> <p>Always communicate with the resident and ask if he or she is in any pain and, if so, the location of the pain.</p> <p>Do not move the resident. Make the resident as comfortable as possible; use pillows and blankets as needed. An evaluation of pain or injury is needed first.</p> <p>Take vital signs This information will be useful to paramedics and the Residence Wellness Director [facility title for DoN), if needed. Assess resident's</p>			

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	<p>discomfort (none, slight, moderate or extreme).</p> <p>Perform a brief check of the resident to include feeling elbows, shoulders, back, hips, and knees.</p> <p>If the resident is suspected to have struck their head or the resident was witnessed striking head (regardless if any injuries are noted), IMMEDIATELY CALL 9-1-1. Emergency personnel should be informed that the resident needs to be assessed for a possible closed head injury....</p> <p>Summon Assistance ...Call the Wellness Director to notify him/her of the fall and report all observations and information reported by the resident. Based on this the Wellness Director will:</p> <p>Decide that transporting the resident to the hospital is not necessary. If so, ask for additional instructions.</p> <p>Direct staff to call 9-1-1...</p> <p>Direct staff to arrange non-emergency transportation to the hospital....</p> <p>If unable to reach the Wellness Director or Residence Director [facility title for</p>						

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	<p>Administrator], call 9-1-1 immediately....</p> <p>...Follow-up</p> <p>...Staff should check on a resident who has fallen as described below and monitor the resident for sign/symptoms of pain. Checks should also include resident complaints of nausea, vomiting, lethargy, headaches, visual disturbances, difficulty moving extremities or any other unusual symptoms or complaints. These observations should be documented in the Resident's Service Notes....</p> <p>It is recommended that a resident be checked:</p> <p>every hour for the first 4 hours after the fall</p> <p>then, at least 2 x [times] on the next shift</p> <p>and 1 x on the following shift....</p>			

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R0217	<p>410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows:</p> <p>(1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident.</p> <p>(2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review.</p> <p>(3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request.</p> <p>(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.</p> <p>(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.</p> <p>Based on interview and record review, the facility failed to ensure Service Plans were accurately updated to reflect the current needs of residents for 1 of 6 residents review in a sample of 8.</p> <p>Findings includes:</p>	R0217	R217 – Evaluation - Deficiency Resident #13 Negotiated Service Plan has been updated. Residents Negotiated Service Plans that were due for 90 day review, or change in condition, have been updated. Residence Director and/or Wellness Director will update Negotiated Service Plans every 90 days and when	07/21/2012			

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	<p>Resident #13's clinical record was reviewed on 7/2/12 at 9:20 a.m. The resident's diagnoses included, but were not limited to, dementia, cerebral vascular disease, and history of right knee replacement.</p> <p>Review of the resident's Service Plan for 3/31/12, indicated the facility's standard was for bathing was two times per week. There was an 'X' in the box for "Do you need assistance to bathe or shower?" There was nothing marked on the Service Plan indicating if the resident required assistance and/or type of assistance needed. The Service Plan indicated the resident needed reminders to independently use the bathroom or change protective garments. The Service Plan indicated the resident required staff present while dressing or grooming or needed physical assist with to dress or groom.</p> <p>The Service Plan indicated the resident did not use any assistive devices for mobility, transfer or transport. The Service Plan indicated the resident had fallen in the past week. It did not reflect falls in the last month or last three months. It had a note indicating the resident had fallen in the past. The resident was to be monitored for safe ambulation and wear proper footwear.</p>		<p>residents change in condition last more than 4 days. A calendaring system will be implemented and reviewed to ensure compliance. . The Regional Director of Operations will audit the Negotiated Service Plans monthly for 4 months, then quarterly thereafter to ensure compliance.</p>	

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	<p>There was a note to encourage the resident to use a wheelchair when she is unsteady.</p> <p>Review of the Resident Services Notes indicated the resident had fallen three times in January, 2012, one time in February, 2012, three times in April, 2012, four times in May, 2012, and three times in June, 2012.</p> <p>A 4/16/12, 10:45 a.m., Resident Service Note by the Director of Nursing, indicated the resident was willing to stay in a wheelchair as preferred by the residents daughter.</p> <p>A 4/18/12, undated Resident Services Notes indicated the resident has declined in the last month and has had increased falls and hitting her head. She is in a wheelchair. She needs cueing for eating and assist with other activities of daily living.</p> <p>Review of the CNA Task Sheets indicated Resident #16 required assistance with brushing her teeth, brushing her hair, dressing, making her bed, toileting and her brief changed every two hours, and she needed assistance with showers on Wednesday and Fridays, and assistance to the dining room at meals.</p>						

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	<p>During an interview with the Director of Nursing on 7/5/12 at 10:25 a.m., she indicated the resident had a significant change and it was not reflected on her Service Plan. She indicated at the time of the Service plan review she thought the resident would be picked up for Hospice services , but Hospice indicated the resident was not a candidate for their services at this time. She indicated she had not completed the Service Plan accurately to reflect the resident's needs.</p> <p>The 6/2008, "Resident Care Services Resource Guide" related to "Negotiated Service Plans" was provided by the Director of Nursing on 7/3/12 at 9:40 a.m. It indicated the Administrator was responsible for ensuring all residents have accurate, current, and signed negotiated Service Plans. The Administrator was to consult with the Director of Nursing for health related information that should be incorporated into the Service Plan. Tasks needing to be performed for the resident were to be listed under the Planned Services column. The Service Assessment and Negotiated Service Plan must be reviewed and updated every 90 days or whenever significant changes in service needs occur. Changes which are expected to last more that 14 days signal the need for a re-assessment and new Negotiated Service Plan.</p>						

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NAME OF PROVIDER OR SUPPLIER YORK HOUSE				STREET ADDRESS, CITY, STATE, ZIP CODE 725 W 50TH ST MARION, IN 46953			
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R0349	<p>410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.</p> <p>Based on record review and interview, the facility failed to ensure resident clinical records were complete and accurate in regards to diet orders and fall evaluation records for 2 of 6 residents reviewed for complete and accurate clinical records in a sample of 8. (Resident #'s 30 and 5)</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #30 was reviewed on 7/2/12 at 11 a.m.</p> <p>Diagnoses for Resident #30 included, but were not limited to, dementia and diabetes mellitus.</p> <p>A nursing note, written by QMA (Qualified Medication Aide) #2, dated 6/18/12 at 5:45 p.m., indicated, "Resident stood up from chair and lost balance and slid down wall to floor." The note lacked any information related to the resident's vital signs having been taken at the time</p>	R0349	<p>R349 Clinical Records - Noncompliance Resident # 30 has a current diet order and mobility planning tool. Resident #5 has a self-medication admission and diet order. Current residents' diet orders, and self-medication admission orders were reviewed and are now current. Mobility planning tools are current. Wellness Director will check physician orders for completeness when received from the physician after recapitulation. The Regional Director Quality and Care Management and/or designee, will review medical records after recapitulation for completed</p>	08/03/2012			

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	<p>of the fall.</p> <p>During an interview on 7/3/12 at 4:25 p.m., the Administrator reviewed the Incident Report completed related to the 6/18/12 fall. She indicated the resident's vital signs had been taken at the time of the fall and provided that information. The vital signs were within normal limits. The Administrator indicated the Incident Report was not part of the resident's clinical record.</p> <p>A recapitulation of physician's orders, signed by the physician on 4/15/12, lacked any diet order for Resident #30. A New Resident Order/Information form, dated 8/23/10, indicated the resident was to receive a regular, small portion diet.</p> <p>A Mobility Management Planning Tool, dated 2/28/12, indicated Resident #30 had not had any falls in the last 90 days.</p> <p>The nursing notes indicated the resident had fallen twice on 2/17/12.</p> <p>During an interview on 7/3/12 at 2:25 p.m., the Director of Nursing (DoN) indicated the resident did receive a regular diet and she had not noted the order was missing on the recapitulation of physician's orders. The DoN indicated the mobility planning tool completed on</p>		orders every 4 months, then quarterly thereafter to ensure compliance.				

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	<p>2/28/12 was incorrect and should have noted the 2 falls the resident had on 2/17/12.</p> <p>2.) The clinical record for Resident #5 was reviewed on 7/3/12 at 9 a.m.</p> <p>Diagnoses for Resident #5 included, but were not limited to, coronary artery disease, hypertension, and atrial fibrillation.</p> <p>A recapitulation of physician's orders, signed by the physician on 4/15/12, did not indicate the resident was able to self administer medications and lacked any diet order for Resident #5. All other recaps on the clinical record, signed or unsigned, lacked any information related to the resident's diet order. A Physician's Plan of Care form, dated 1/7/10, indicated the resident was to receive a regular diet.</p> <p>During an interview on 7/3/12 at 2:25 p.m., the Director of Nursing (DoN) indicated the resident did receive a regular diet and she had not noted the order was missing on the recapitulation of physician's orders. The DoN indicated the resident was able to self administer some medications and the approval for this order should have been checked "yes" on the April recap.</p>						

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