

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 05/02/2013
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NAME OF PROVIDER OR SUPPLIER STERLING HOUSE OF RICHMOND	STREET ADDRESS, CITY, STATE, ZIP CODE 3700 S A ST RICHMOND, IN 47374
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R000000	<p>This visit was for the Investigation of Complaint IN00127928.</p> <p>Complaint IN00127928 - Substantiated. State deficiencies related to the allegations are cited at R0052 and R0214.</p> <p>Survey dates: May 1 and 2, 2013</p> <p>Facility number: 010888 Provider number: 010888 AIM number: N/A</p> <p>Survey team: Penny Marlatt, RN</p> <p>Census bed type: Residential: 39 Total: 39</p> <p>Census payor type: Other: 39 Total: 39</p> <p>Sample: 5</p> <p>These state findings are cited in accordance with 410 IAC 16.2.</p> <p>Quality review 5/08/13 by Suzanne Williams, RN</p>	R000000	<p>The following is the Plan of Correction for Sterling House of Richmond in regards to the Statement of Deficiencies for the complaint survey completed on 5-2-13. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvements to satisfy that objective.</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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R000052	<p>410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion.</p> <p>Based on interview, observation and record review, the facility failed to ensure 2 of 3 residents reviewed for abuse were not subjected to mental, physical or sexual abuse by another resident in a sample of 5. (Resident #A, Resident #B, Resident #E)</p> <p>Findings include:</p> <p>1. Resident #B's clinical record was reviewed on 5-1-13 at 2:22 p.m. Her diagnoses included Alzheimer's disease, high blood pressure and degenerative joint disease. During the initial tour with the Health and Wellness Director (HWD) on 5-1-13 at 9:45 a.m., she was indicated as not being reliably interviewable. On 5-1-13 at 4:00 p.m., Resident #B was observed to enter the private dining room via a closed door, without knocking or announcing herself, and seated herself at the table with the occupant. The resident was observed to be engaged in conversation by the occupant. The</p>	R000052	<p>R_052 Resident Rights What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? The community disputes the finding of this alleged deficiency and respectfully requests it be deleted for the following reasons, and has requested a face to face IDR: ·The community immediately investigated all events related to the resident A-alleged to be the perpetrator of inappropriate statements and potentially sexual behaviors toward others, in particular Resident B and Resident E. Evidence already reviewed by the surveyor and provided at the time of survey would indicate there was no harm to Residents B and E., as a result of Resident A's actions. The community acted swiftly and within the restrictions imposed by the state regarding the transfer or discharge of Resident A, however the state hearing office rejected our request to discharge Resident A when initially attempted in October of 2012. ·The other residents (B and E)</p>	06/01/2013			

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	<p>resident was observed to not be able to identify where she was, other than "here," and could not identify the location of the city or identify names of family members. The resident's speech was observed to be halting in nature with some mix up of words. The resident remained in the private dining room, seated quietly and looking out the windows for more than 20 minutes.</p> <p>The "Interdisciplinary Progress Notes," dated 4-17-13 at 12:10 p.m., indicated Resident #B was seen by a staff member exiting from her apartment. When asked how she was doing, the resident indicated, "Not very good." Notes indicated the resident was initially reluctant to indicate the nature of the problem. She indicated, "Can't tell you." When encouraged to share her problem, the resident indicated, "A man tried to pull my hair." The resident was unable to identify the name of the person. The staff member then entered the resident's room and observed Resident #A "sitting on the bed with pants undone, shirt ruffled, tying his shoes. When asked why he was in there, the male resident stated, "Nothing.'" Resident #A left the apartment without incident when asked to do so.</p>		<p>were fully assessed for any injury, and none were noted in any of the incidents. This documentation was provided to the surveyor at the time of survey.</p> <p>·The community therefore respectfully requests deletion of this alleged deficiency. For purposes of compliance with state regulation the community response to the alleged deficiency is below:</p> <p>·Resident A was issued a 30 day discharge notice (for the second time in 6 months) prior to the complaint survey, and had already been relocated to another community at the time of the complaint survey..</p> <p>·Resident B and Resident E continue to reside in the community. Personal Service Plans have been updated to reflect any areas where personal care or services are required to meet their current needs. Follow-up evaluations have continued to reveal no evidence of any symptoms of abuse.</p> <p>·The community respectfully requests reconsideration of this alleged deficiency, as it believes it complied with all requirements of protecting its residents, to the extent possible in the assisted living environment, while respecting the privacy and dignity of all residents. It further alleges that updates and changes were made to the Care Profiles of the residents affected by the</p>				

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	<p>In interview with CNA #1 on 5-1-13 at 3:17 p.m., she indicated on 4-17-13 around 11:00 a.m., she saw Resident #B in the hallway. She indicated when she inquired as to how she was doing, she was told by Resident #B, "Not good." CNA #1 indicated, "She said some man in her room tried to pull her hair. Because of her dementia, initially I wasn't sure what to think. But I went and checked in her room and found [name of Resident #A] sitting on her bed, putting his shoes on and tying them. His shirt was twisted to the front, his pants unzipped and his belt undone. I asked him what he was doing in her room and he said, 'Nothing.' The sheet was pulled down. I told him to wait right there and I called my nurse. [Name of Resident #B] was still in the hall. After that, I left him to the nurse and walked [name of Resident #B] to a different part of the building."</p> <p>Review of Resident #A's clinical record on 5-1-13 at 10:15 a.m. indicated his diagnoses included, but were not limited to, senile dementia and high blood pressure. Physician progress notes, dated 3-19-13, indicated he was alert and oriented "x3" (to person, place, time.)</p>		<p>behaviors of Resident A, and these interventions were evident from the extensive documentation in the clinical record, reviewed by the surveyor.</p> <p>How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> ·Other residents who live in our AL community may be affected by a behavior of another resident and have the potential to be affected by the alleged deficient practice. ·The Health and Wellness Director, in collaboration with other associates at the community, will utilize the Collaborative Care Review meeting/process to determine, based on staff observation and resident reports, if any other residents have had a change in orders or in condition, which would warrant the development or augmentation of their current Personal Service Plans. <p>What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?</p> <ul style="list-style-type: none"> ·The Health and Wellness Director (who is responsible for updates to the Personal Service Plan) was re-educated by the Regional Director of Healthcare Services on 5-16-13 on the appropriate process to follow when updating Personal Service 				

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	<p>The "Interdisciplinary Progress Notes," dated 4-17-13 at 11:00 a.m., indicated Resident #A was found sitting on another female resident's bed in her room with pants unbuttoned, unzipped, shirt ruffled, tying his shoes. when asked what, why [sic] he was in this room, he stated, "Nothing." Resident #A left the apartment without incident when asked to do so. The notes indicated when he was questioned privately by the HWD as to why he was in Resident #B's room, he indicated, "I thought she was agreeable, but she wasn't."</p> <p>In interview with the HWD on 5-2-13 at 2:20 p.m., she indicated Resident #A did not explicitly indicate he had planned to have sexual relations with Resident #B, but due to the manner in which he was found (partially undressed with the bed linens turned down), she indicated, "It was a toss up" between physical and sexual abuse concerns.</p> <p>Resident #A's progress notes indicated he was placed immediately on one on one supervision "indefinitely until we [are] able to prove he was safe around the other residents." He remained on 1:1 supervision until he left the facility on</p>		<p>Plans.</p> <ul style="list-style-type: none"> ·The Health and Wellness Director will attend additional training on the Collaborative Care review process on 5-29-13, also to be provided by the Regional Director of Healthcare Services. ·Residents will continue to be assessed by the licensed prior to move-in, within 14-30 days of move-in, every 6 months, and with condition change, as per existing policy. ·At the time of each assessment, the resident, designated responsible parties, and physician will continue to be notified if there is a change in condition noted. ·A Collaborative Care meeting will take place twice monthly with members of the interdisciplinary team to review residents for changes in condition, including cognitive impairment, which may warrant a change to the Personal Service Plan. <p>How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place?</p> <ul style="list-style-type: none"> ·The Executive Director, and other members of the interdisciplinary team, will meet twice monthly in an ongoing manner to review residents for changes in condition and to determine the most appropriate interventions to the Personal Service Plan to meet the needs of the individual resident. 				

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	<p>4-22-13 at 3:40 p.m. with the POA (power of attorney). The facility was notified the same date at 6:30 p.m. of Resident #A's admission to a local inpatient geriatric psychiatric unit.</p> <p>Documentation indicated the physicians and POAs of both parties were notified of the event after Resident #B was assessed and found to have no apparent injuries. The facility reported this event to the Indiana State Department of Health on 4-17-13 via electronic mail. Documentation in the days following the incident indicated Resident #B appeared to show no fear or change in usual routine.</p> <p>2. Resident #E's clinical record was reviewed on 5-1-13 at 2:50 p.m. Her diagnoses included, but were not limited to, dementia, Parkinson's disease, personality disorder, and anxiety.</p> <p>Review of the "Interdisciplinary Progress Notes," dated, 2-22-13 at 10:30 a.m. indicated the resident reported Resident #A had knocked on her apartment door the previous evening. It indicated when she opened the door, he came into her apartment and remained for over an hour. It indicated Resident #A had</p>		<p>By what date will these systemic changes be implemented? ·6-1-13</p> <p>Addendum Request: R0052: Please indicate what the facility will do in regard to the review of residents with changes in condition if issues arise prior to the twice a month meeting.</p> <p>Response: · Residents will be reviewed daily during stand-up meeting for changes in condition. · Residents with changes of condition will also be documented on the 24 hour report, so that all nurses will be aware of the current status of any new or pending orders. · The HWD / Designee will be responsible for checking the 24 hour report daily for changes indicating a need to update the Personal Service Plan.</p>				

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	<p>"said a few inappropriate things to her and would not leave when she ask him to, finally, left about an hr. [hour later.]" Documentation on the same date at 5:00 p.m., indicated the HWD spoke with Resident #E. The progress notes indicated Resident #A entered Resident #E's apartment uninvited and commented to her "about sitting on his lap." It indicated Resident #E "was very uncomfortable with the male resident." It indicated she asked Resident #A "to leave about 5x's [five times]; he kept falling asleep in recliner. Resident stated she finally got up, opened door and asked male resident to leave and this time he did." Documentation the following day, 2-23-13 at 12:45 p.m. indicated Resident #E called staff to her room because someone was knocking at her door. Resident #A was observed to be standing outside of Resident #E's apartment at that time by facility staff. Documentation indicated Resident #E "was visibly uncomfortable about the incident." In interview with Resident #E on 5-2-13 at 1:22 p.m., she indicated she feels safe at this time.</p> <p>Review of Resident #A's clinical record on 5-1-13 at 10:15 a.m. indicated his diagnoses included, but were not limited to, senile dementia</p>						

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	<p>and high blood pressure. Physician progress notes, dated 3-19-13, indicated he was alert and oriented "x3" (to person, place, time.)</p> <p>Review of the "Interdisciplinary Progress Notes, " dated 2-22-13 at 4:00 p.m. indicated the HWD and another staff member spoke to Resident #A regarding the incident the previous evening with Resident #E. Resident #A, "stated this is b-----t; you made it up." The notes indicated, "this nurse asked resident [#A] not to go to that female resident's room."</p> <p>Review of the progress notes, dated 2-23-13 at 1:30 p.m. indicated Resident #A was found knocking on Resident #E's door by staff after being notified by Resident #E of someone knocking on her door. Notes indicated, "When asked about what he needed, he stated, 'She called me.'" Resident #A left the area when requested to do so by the staff.</p> <p>No further incidents were noted in documentation between these 2 residents.</p> <p>Documentation indicated both parties' physicians and POA's were notified of the incident and the Indiana State</p>			

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	<p>Department of Health was notified by electronic mail on 2-22-13 at 6:19 p.m.</p> <p>On 5-1-13 at 2:52 p.m., the Executive Director provided a copy of policy entitled, "Preventing Resident Abuse." This policy indicated, "Our Community will not condone any form of resident abuse...Assessing, care planning, and monitoring residents with needs and behaviors that may lead to conflict or neglect; Assessing residents with signs and symptoms of behavior problems and developing and implementing care plans to address behavioral issues..."</p> <p>This state tag relates to Complaint IN00127928.</p>			

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R000214	<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 interview and record review, the facility failed to ensure the service plans were updated to reflect changes in condition related to behaviors and falls for 5 of 5 residents reviewed for service plans in a sample of 5. (Resident #A, Resident #B, Resident #C, Resident #D and Resident #E)</p> <p>Findings include:</p> <p>1. Review of Resident #A's clinical record on 5-1-13 at 10:15 a.m. indicated his diagnoses included, but were not limited to, senile dementia and high blood pressure. Physician progress notes, dated 3-19-13, indicated he was alert and oriented "x3" (to person, place, time.)</p> <p>Review of Resident #A's clinical record indicated he had been involved in 2 separate incidents involving abuse related issues, one involving Resident #E on 2-22-13 and one involving Resident #B on</p>	R000214	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?</p> <ul style="list-style-type: none"> ·Resident A was issued a 30 day discharge notice (for the second time) prior to the complaint survey, and had already been relocated to another community. ·Resident B and Resident E continue to reside in the community. Personal Service Plans have been updated by a licensed nurse to reflect any areas where personal care or services are required to meet their current needs. · How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken? ·Other residents requiring an update to their existing Personal Service Plan, due to a change of condition or change in behavioral or cognitive status have the potential to be affected by the alleged deficient practice. ·The Health and Wellness 	06/01/2013			

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	<p>4-17-13.</p> <p>Review of Resident #A's most recent service plan, dated 1-3-13, did not indicate any reference to sexual behaviors, inappropriate language, continuous one on one supervision or limited or no contact with other residents. This service plan was signed by the Health and Wellness Director on 1-9-13 and by the POA (power of attorney), but undated by the POA. Under the section identified as "Cognitive/Psychosocial," it indicated the resident had problems related to "sleep/wake" disturbances, that he was oriented to person, place and time and that he can communicate his needs and preferences, both verbally or non-verbally.</p> <p>A "CARE profile" was located in Resident #A's closed clinical record. This document indicated the resident's preferences for care. A hand-written notation, dated 2-22-13 indicated, "Resident is to stay away from [identifying information regarding Resident #E.]"</p> <p>In interview with the Health and Wellness Director (HWD) on 5-1-13 at 12:15 p.m., she indicated, "I guess I didn't take the time to write down or</p>		<p>Director, in collaboration with other associates at the community, will utilize the Collaborative Care Review meeting/process to determine if any other residents have had a change in orders or in condition, which would warrant the development or augmentation of their current Personal Service Plans.</p> <p>What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?</p> <ul style="list-style-type: none"> ·The Health and Wellness Director was re-educated by the Regional Director of Healthcare Services on 5-16-13 on the appropriate process to follow when updating Personal Service Plans. The Health and Wellness Director will attend additional training on the Collaborative Care review process on 5-29-13, also to be provided by the Regional Director of Healthcare Services. ·Residents will continue to be assessed by the licensed prior to move-in, within 14-30 days of move-in, every 6 months, and with condition change, as per existing policy. ·A Collaborative Care meeting will take place twice monthly with members of the interdisciplinary team to review residents for changes in condition, which may warrant a change to the Personal Service Plan. · How will the corrective actions 				

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	<p>update the service plan for [name of Resident #A]'s sexual behaviors. I updated the assignment sheets to make sure he wasn't around the one female and updated hers as well." In interview with the HWD on 5-2-13 at 5:27 p.m., she indicated, "The CARE Profile is more like an aide assignment type thing. When I close a chart [upon the resident's discharge from the facility], I always put the last one [CARE Profile] in the chart. It's probably not considered a part of the permanent record." In interview with the Executive Director (ED) on 5-2-13 at 5:27 p.m.. she indicated the CARE Profile is not a part of the permanent file for a resident.</p> <p>2. Resident #B's clinical record was reviewed on 5-1-13 at 2:22 p.m. Her diagnoses included Alzheimer's disease, high blood pressure and degenerative joint disease.</p> <p>Review of Resident #B's clinical record indicated she had been involved in an incident of abuse related issues, related to Resident #A on 4-17-13 towards this resident.</p> <p>Review of Resident #B's most recent service plan, dated 4-24-13, did not reflect any concerns related to the recent abuse attempted 2 days prior.</p>		<p>be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place?</p> <ul style="list-style-type: none"> · The Executive Director, and other members of the interdisciplinary team, will meet twice monthly in an ongoing manner to review residents for changes in condition and to determine the most appropriate interventions to the Personal Service Plan to meet the needs of the individual resident. · The Health and Wellness Director/Designee will review change of condition assessments every two weeks with the Executive Director, who will verify that appropriate updates have been made to the Personal Service Plan in an ongoing manner. <p>By what date will these systemic changes be implemented?</p> <ul style="list-style-type: none"> · 6-1-13 <p>Addendum Request: R0214: <i>Please indicate what the facility did for Residents #C and #D to correct the deficient practice.</i></p> <p>Response:</p> <ul style="list-style-type: none"> · Residents C and D continue to reside in the community. · Personal Service Plans have been updated by a licensed nurse to reflect any areas where personal care or services changes are required to meet their current needs. 				

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	<p>Under the section for "Cognitive/Psychosocial," it indicated the resident required help to participate in community activities related to memory loss, enjoyed clerical projects and other personal interests (non-specified), required re-direction related to wandering and removing personal property of other residents and was not oriented to person, place or time. No other problem areas were identified in this category. Under the section for "Behavior Management," it indicated interventions for the problem of "exit seeking without needed supervision." No other problem areas were identified in this category.</p> <p>3. Resident #C's clinical record was reviewed on 5-2-13 at 10:02 a.m. His diagnoses included, but were not limited to, Alzheimer's disease, dementia, high blood pressure, hyperglycemia, restless leg syndrome and osteoarthritis.</p> <p>Review of Resident's #C's clinical record indicated he had an unwitnessed fall in his room on 4-5-13 which resulted in significant bruising to the face, with the left eye swollen shut and a hematoma above the left eye. He was sent to the local emergency room with no further</p>						

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	<p>injuries identified and returned to the facility on the same day.</p> <p>Review of the resident's most recent service plan, indicated it was dated 1-4-13, and signed by the HWD on 1-9-13 and by the POA on 1-15-13. Under the "Escort & Mobility" section, it indicated, "Provide attention and/or verbal prompts to and from the dining room and. or community activities as needed...Be alert to risk for falling." It indicated the resident used a walker and bed cane. Under the "Cognitive/Psychosocial" section, it indicated he was not always alert to person...place...time." An absence of specific interventions for fall prevention was not indicated. A "CARE Profile" had a hand-written, undated notation which indicated, under the Escort/Mobility section to use non-skid strips to the bathroom floor and to conduct hourly checks.</p> <p>In interview with the HWD on 5-2-13 at 2:20 p.m., she indicated Resident #C has had problems related to being found partially clothed in the hallway, but only in the evenings or late at night. She indicated he is checked on frequently related to this. She indicated, "Nothing [in regard to this] is on the service plan, but that will change. I get busy and forgot to write</p>			

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	<p>things down."</p> <p>4. Resident #D's clinical record was reviewed on 5-2-13 at 10:31 a.m. Her diagnoses included, but were not limited to, Alzheimer's disease, osteoporosis, back pain, syncope and chronic fatigue syndrome.</p> <p>Review of Resident #D's clinical record indicated she had 6 unwitnessed falls between 12-30-12 and 3-30-13. On 12-30-12 at 10:30 a.m., she had an unwitnessed fall near her apartment door with no initial injury noted; bruising appeared within several days. At the time of the fall, she was being treated for a UTI (urinary tract infection.) On 1-21-13 at 4:20 a.m., she had an unwitnessed fall and was found sitting on her bed with her walker found overturned. She received a small skin tear near her right eye. On 3-13-13 at 8:50 a.m., she experienced an unwitnessed fall in the hallway near her apartment with the walker found near her. She indicated she had "lost balance." She complained of severe left hip pain. An xray of the left hip and pelvis indicated no fracture. Nursing notes for that evening and night indicated she experienced discomfort and restlessness. On 3-15-13 at 2:00 a.m., she had an</p>			

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	<p>unwitnessed fall and was found sitting at the entrance to her apartment. She complained of severe left hip and coccyx pain. She was sent to the local emergency room for evaluation and treatment. She returned to the facility later the same morning after xrays indicated a pelvic fracture. On 3-20-13 at 2:30 p.m., she had an unwitnessed fall and was found lying on the floor of a common area of the facility. Documentation indicated she had scooted a chair approximately 6 feet towards her wheelchair to attempt a self-transfer to the wheelchair. At that time, the resident denied any pain, but did have 3 abrasions to the mid-back area. Documentation indicated the resident was checked on hourly and experienced frequent urinary urgency and restlessness. Medication changes were made to include a prn (as needed) anti-anxiety agent. She was seen by her attending physician on 3-22-13 and by the orthopedic physician on 3-25-13 who ordered a physical therapy evaluation. On 3-29-13 at 11:45 p.m., the resident had an unwitnessed fall and was found on the floor of her apartment. She complained of severe right hip pain and her respirations were very rapid. She was sent to the local emergency room for evaluation and</p>			

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	<p>treatment. The local hospital indicated she was admitted with a left fractured hip. The resident did not return to the facility and passed away at the hospital.</p> <p>A document entitled, "Negotiated Risk Agreement," and dated 11-6-12, indicated the resident, "chooses to independently transfer and/or ambulate without assistance, placing herself at risk for falls. She has a history of numerous falls in her apartment. Resident has cut off or turned off personal alarms, which could alert staff to falls or unsupervised attempts at transfers or ambulation...Possible consequences of falls include but are not limited to skin tear, abrasions, lacerations, broken bones, head injuries, up to and including death..." This document was signed by the HWD and the POA on 11-6-12.</p> <p>Review of the service plan for Resident #D indicated it was signed by the HWD and POA on 11-21-12. Under the "Escort and Mobility" section, it indicated "Physical impairment is one of the reasons for the escort assistance," and indicated she utilized a walker and wheelchair to aide in mobility. Documentation did not indicate she was a risk for</p>			

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	<p>falls. Under the "Cognitive/Psychomotor" section, it indicated she "is oriented to person, place and time," and able to communicate her needs and preferences.</p> <p>A "CARE Profile" indicated several hand-written and undated interventions related to falls. Those interventions included non-skid strips to bathroom floor, monitor in her room, attempt to keep up front (near nurse's station), encourage oral fluids, encourage use of call cord, remind her to wear proper footwear and recliner raised to proper height. Interventions listed on 3-13-13 was xray to left hip; on 3-15-13 included adding personal alarm to the chair; on 4-1-13, was to re-assess the resident for needs prior to returning to the facility.</p> <p>In interview with the HWD on 5-2-13 at 2:20 p.m., she indicated Resident #D's service plan were similar to the other services plans with lack of updating. She indicated she had placed interventions on the CARE Profile. In interview with the HWD on 5-2-13 at 5:27 p.m., she indicated, "The CARE Profile is more like an aide assignment type thing. When I close a chart [upon the resident's</p>			

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	<p>discharge from the facility], I always put the last one [CARE Profile] in the chart. It's probably not considered a part of the permanent record." In interview with the Executive Director (ED) on 5-2-13 at 5:27 p.m.. she indicated the CARE Profile is not a part of the permanent file for a resident.</p> <p>5. Resident #E's clinical record was reviewed on 5-1-13 at 2:50 p.m. Her diagnoses included, but were not limited to, dementia, Parkinson's disease, personality disorder, and anxiety.</p> <p>Review of Resident #E's clinical record indicated she had been involved in an incident of abuse related issues, related to Resident #A on 2-22-13 towards this resident.</p> <p>Resident #E's service plan was signed by the HWD on 4-1-13, without a signature of the resident or POA. Under the "Cognitive/Psychosocial" section, it indicated the resident not always oriented to place. It did not indicate any issues related to possible or continued anxiety related to the incident of 2-22-13.</p> <p>A "CARE Profile," dated 2-22-13</p>			

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	<p>indicated to keep the resident's apartment door locked at all times, to verify who is at the door prior to opening the door, to leave the room if an unwanted visitor enters the and to seek the assistance of the staff and for staff to announce themselves prior to entering the resident's room.</p> <p>In interview with the HWD on 5-2-13 at 5:27 p.m., she indicated, "The CARE Profile is more like an aide assignment type thing. When I close a chart [upon the resident's discharge from the facility], I always put the last one [CARE Profile] in the chart. It's probably not considered a part of the permanent record." In interview with the Executive Director (ED) on 5-2-13 at 5:27 p.m.. she indicated the CARE Profile is not a part of the permanent file for a resident.</p> <p>This state tag relates to Complaint IN00127928.</p>			