

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155775	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/31/2013
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NAME OF PROVIDER OR SUPPLIER CUMBERLAND POINTE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1051 CUMBERLAND AVE WEST LAFAYETTE, IN 47906
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F000000	<p>This visit was for the Investigation of Complaint #IN00140648.</p> <p>Complaint #IN00140648-Substantiated. Federal/state deficiencies related to the allegations are cited at F282 and F323.</p> <p>Survey dates: December 30 & 31, 2013</p> <p>Facility number: 000547 Provider number: 155775 AIM number: 100267440</p> <p>Survey team: Michelle Carter, RN- TC Maria Pantaleo, RN Holly Duckworth, RN</p> <p>Census bed type: SNF: 30 SNF/NF: 37 Residential: 66 Total: 133</p> <p>Census Payor type: Medicare: 10 Medicaid: 22 Private: 101 Total: 133</p>	F000000	<p>Survey Event ID QY1011The submission of this POC does not indicate an admission by Cumberland Pointe Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Cumberland Pointe Health Campus. This facility recognized its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities (for Title 18/19 programs). To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</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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	<p>Sample: 6</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review was completed by Tammy Alley RN on January 3, 2014.</p>			
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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on interview and record review, the facility failed to ensure the care plan was followed in accordance to the required assistance needed for 1 of 6 residents reviewed, in a sample of 6, for following the written plan of care. (Resident C)</p> <p>Findings include:</p> <p>The clinical record for Resident C was reviewed on 12/30/13 at 1:00 p.m.</p> <p>Diagnoses for Resident C included, but were not limited to, Alzheimer's dementia, chronic obstructive pulmonary disease, mitral valve prolapse, depression disorder, anxiety disorder, psychosis, generalized weakness, history of transient ischemic attack(s) (TIA's), history of cerebral vascular accident, diverticulosis, and gastritis.</p> <p>A Fall Circumstance, Assessment and Intervention form, dated 12/1/13, at 8:45 p.m., indicated the</p>	F000282	<p>CORRECTIVE ACTION: The staff member involved in the incident was provided one-on-one in-service education on 12-01-13 by the nursing unit manager to ensure she understood that the resident's care plan had been updated to require two staff assist for turning and repositioning because the resident was on a sapphire mattress. IDENTIFY OTHER RESIDENTS: All health center resident's care plans/resident profiles are being reviewed to identify any other residents on sapphire mattresses that would have the same potential to be affected. If any residents are identified with the same risk, the care plan/resident profile will be reviewed to ensure the resident's need for two staff assistance is clearly noted.</p> <p>MEASURES/SYSTEMIC CHANGES: An in-service related to "Resident Safety During Bed Positioning" is being completed with all nursing staff. Also, an in-service related to "Reviewing for Updates in the Resident's Care Plan/Resident Profile" is being completed to ensure staff accessibility on the Care Tracker kiosk. To ensure</p>	01/29/2014	

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	<p>resident was assisted to the floor by a staff member, while the staff member was turning Resident C, in bed. "Staff member turning res [resident] - Res rolled out of bed".</p> <p>A Change in Condition form, dated 12/1/13, at 8:45 p.m., indicated the following: "Staff member providing care-repositioned Res in bed- Res rolled over edge of bed. Staff member attempted to stop fall. Res slid to floor. Landed on matt (sic) beside bed. Hit left side of head on base of tube feeding stand. No red or open areas noted. No bruising noted. ROM [range of motion] within Res normal limits. Neuro checks with in Res normal limits. Res denies pain or discomfort. No signs/symptoms pain or discomfort noted."</p> <p>Resident C's Activities of Daily Living (ADL's) care plan indicated, "2 person assist when providing any type of care such as bathing, changing, repositioning, transferring, etc." The date of this intervention was not noted, clearly.</p> <p>During an interview, on 12/30/13, at 3:00 p.m., the Assistant Director of Health Services (ADHS) indicated Resident C's care plan was updated</p>		<p>prompt and clear staff understanding of the resident's need for assistance, a level of assistance for bed mobility and transfers is being entered on the first line of the ADL section for each resident's care plan/resident profile. All newly hired nursing staff members will continue to receive training on the Care Tracker kiosk and accessing the care plan/resident profile during new hire orientation.</p> <p>MONITORING CORRECTIVE ACTION: The percent of new nursing employees that complete the new hire orientation training on the Care Tracker kiosk and accessing the care plan/resident profile will be reported to the QA committee monthly for 4 months. Bi-weekly for 30 days the Director of Health Services (DHS) or designee will audit 10% of nursing staff on the health center on each shift for return demonstration on accessing the care plan/resident profile on the Care Tracker kiosk. Then the audits will be completed weekly for 60 days with 10% of nursing staff on each shift followed by audits every other week for 30 days with 10% of the nursing staff on each shift. In the event the staff member being audited does not display competency then retraining will occur immediately with return demonstration required. The DHS will provide a report of the percent of audits</p>		

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F000323 SS=D	<p>on 11/30/13, to include "2 person assist". The ADHS indicated only one staff member was repositioning Resident C, at the time of the fall, on 12/1/13. The ADHS continued to indicate, "Two staff members should have been working together, during repositioning, with Resident C."</p> <p>This Federal tag relates to complaint #IN00140648.</p> <p>3.1-35(g)(2)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to ensure resident safety, resulting in a fall, for 1 of 6 residents reviewed, in a sample of 6 for resident safety. (Resident C)</p> <p>Findings include:</p> <p>The clinical record for Resident C was reviewed on 12/30/13 at 1:00 p.m.</p>	F000323	<p>completed accurately to the QA Committee monthly for 4 months.</p> <p>CORRECTIVE ACTION: The staff member involved in the incident was provided one-on-one in-service education on 12-01-13 by the nursing unit manager to ensure she understood that the resident's care plan had been updated to require two staff assist for turning and repositioning because the resident was on a sapphire mattress. IDENTIFY OTHER RESIDENTS: All health center resident's care plans/resident profiles are being reviewed to identify any other residents on</p>	01/29/2014	

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