

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15A014	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/22/2013
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NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992
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F000000	<p>This visit was for the Investigation of Complaints #IN00127661, #IN00128225 and #IN00129202.</p> <p>Complaint #IN00127661-Substantiated. Federal deficiencies related to the allegation are cited at F323.</p> <p>Complaint #IN00128225-Substantiated. Federal deficiencies related to the allegation are cited at F312.</p> <p>Complaint #IN00129202-Substantiated. Federal deficiencies related to the allegation are cited at F225 and F226.</p> <p>Survey dates: 5/20/13-5/22/13</p> <p>Facility number: 000274 Provider number: 15A014 AIM number: 100271660</p> <p>Survey team: Shelley Reed, RN TC Betty Retherford, RN</p> <p>Census bed type: NF: 93 Total: 93</p> <p>Census payor type: Medicaid: 93</p>	F000000	<p>Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute and admission or agreement of the facts alleged or conclusions set forth in this statement of deficiencies. The facility maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. The plan of correction and specific corrective actions are prepared and/or executed in compliance with the state and federal laws. Please accept this plan of correction as it constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is June 9, 2013.</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>Total: 93</p> <p>Sample: 7</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed by Debora Barth, RN.</p>				

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F000225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record</p>	F000225	F225 Reporting alleged incident	06/09/2013			

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	<p>review, the facility failed to report an alleged incident of abuse to the appropriate agency for 1 of 7 residents who were reviewed for abuse. (Resident C)</p> <p>Findings include:</p> <p>During record review on 5/22/13 at 9:00 a.m., nursing progress notes dated 4/12/13 at 8:30 a.m., indicated Resident (C) was noted to have a bruise on his left upper arm on the outer aspect. The bruise was dark purple in color with a yellow outline. The bruise measured approximately 1.5 cm x 1.5 cm. Resident (C) stated "one of the CNA's gave it to him."</p> <p>On 4/12/13 at 9:30 a.m., nursing progress notes indicated Resident (C) stated the bruise came when the nursing staff "took him down."</p> <p>On 4/12/13 at 10:00 a.m., the DoN interviewed an unknown CNA, who indicated the bruise was not present on 4/11/13 when a shower had been given.</p> <p>The nursing progress notes, on 4/12/13 at 1:00 p.m., indicated the DoN had interviewed all staff members who worked from 4/11/13-4/12/13. She documented</p>		<p>of Abuse <u>Action taken for identified residents</u> Resident (C) no longer resides at this facility. A report pertaining to the alleged abuse was sent to the Indiana State Department of Health on May 23, 2013. <u>Identification and corrective action for other residents with the potential to be affected:</u> Skin assessments were completed on all residents and interviewable residents were interviewed with no findings indicating the need to implement corrective action. Staff interviews and staff education regarding alleged abuse recognition and reporting was conducted. (Exhibit 1, 1-A, 2, 2A, 3, 3-A-3K) <u>Measures to prevent recurrence.</u> May 23, 2013 the facility Administrator and Director of Nursing received education regarding reporting of alleged incidents of abuse to the appropriate agency which included review of the ISDH Division of Long Term Care, Reportable Unusual occurrences policy. Staff education regarding recognition and immediate reporting of potential abuse was provided May 23, 2013 and will be provided during new hire orientation and annually. (Exhibit 3,3-A-K) <u>How will the facility monitor and who is responsible:</u> The facility Administrator is responsible for monitoring and assuring timely reporting to the appropriate agency. Occurrences with the potential to be considered abuse will be reported</p>		

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	<p>staff had observed Resident (C) with an unsteady gait and bumping into walls during ambulation.</p> <p>The Minimum Data Set (MDS) assessment, dated 5/8/13, indicated Resident (C) scored a 1 of 15 for the Brief Interview Mental Status (BIMS). A BIMS score of 1 indicated Resident (C) had severe impairment. Resident (C)'s diagnoses included, but were not limited to, seizure disorder, asthma, dementia, ataxia gait, intermittent impulse control and constipation.</p> <p>During an interview on 5/22/13 at 10:30 a.m., the Executive Director (ED) indicated the alleged abuse on 4/12/13 was not reported to the Indiana State Department of Health.</p> <p>Review of a current facility policy, dated 3/13/2012 titled "Abuse, Neglect, and Misappropriation of Property" which was provided by the Nurse Consultant on 5/20/13 at 10:00 a.m., indicated the following:</p> <p>"Investigation: 1. The facility will conduct an internal investigation and report the results of the investigation to the enforcement agency in accordance with state law including the state survey and</p>		<p>immediately to the facility administrator. The administrator will assure the allegation of abuse occurrence is reported to the Indiana State Department of Health Long Term Care Division and will maintain a log of incidents reported. Additionally, the Social Service department manager will participate in the investigation of allegations of abuse and will review to confirm reporting of alleged abuse in accordance with the Indiana State department of Health Long Term Care Division policy and facility policy. Results of monitoring will be reviewed by facility QA committee times 6 months, with reporting to the regional Quality Assurance Committee for review and recommendations. (Exhibit 4)</p>				

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	<p>certification agency within five working days of the incident or according to state law....</p> <p>Reporting and Response: 1. The facility will report all alleged violations and substantiated incidents to the state agency and to all other agencies as required and will take all necessary corrective actions depending on the results of the investigation."</p> <p>This Federal tag relates to Complaint #IN00129202.</p> <p>3.1-28(c)</p>			
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F000226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interview and record review, the facility failed to implement their policy related to an alleged incident of abuse for 1 of 93 residents who reside in the facility. (Resident C)</p> <p>Findings include:</p> <p>During record review on 5/22/13 at 9:00 a.m., nursing progress notes dated 4/12/13 at 8:30 a.m., indicated Resident (C) was noted to have a bruise on his left upper arm on the outer aspect. The bruise was dark purple in color with a yellow outline. The bruise measured approximately 1.5 cm x 1.5 cm. Resident (C) stated "one of the CNA's gave it to him."</p> <p>On 4/12/13 at 9:30 a.m., nursing progress notes indicated Resident (C) stated the bruise came when the nursing staff "took him down."</p> <p>On 4/12/13 at 10:00 a.m., the DoN interviewed an unknown CNA, who indicated the bruise was not present</p>	F000226	<p>F226 Abuse Policy Action taken for identified resident</p> <p>Resident (C) no longer resides at this facility. A report was sent to the Indiana State Department of Health on May 23, 2013. <u>Identification and corrective action for other residents with the potential to be affected:</u> Residents were assessed via skin assessments and interviewable residents interviewed to determine other potentially reportable occurrences of alleged abuse with no findings indicating corrective action was applicable. (Exhibits 1, 1-A, 2, 2-A.) <u>Measures to prevent recurrence.</u> May 23, 2013 the facility Administrator and Director of nursing received education regarding reporting of alleged incidents of abuse to the appropriate agency which included review of the ISDH Division of Long Term Care, Reportable Unusual occurrences policy. Staff education regarding recognition of abuse or allegation of abuse and immediate reporting of allegation of abuse was provided May 23 and will be provided during new hire orientation and annually. (Exhibit</p>	06/09/2013			

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	<p>on 4/11/13 when a shower had been given.</p> <p>The nursing progress notes on 4/12/13 at 1:00 p.m., indicated the DoN had interviewed all staff members who worked from 4/11/13-4/12/13. She documented staff had observed Resident (C) with an unsteady gait and bumping into walls during ambulation.</p> <p>The Minimum Data Set (MDS) assessment, dated 5/8/13, indicated Resident (C) scored a 1 of 15 for the Brief Interview Mental Status (BIMS). A BIMS score of 1 indicated Resident (C) had severe impairment. Resident (C)'s diagnoses included, but were not limited to, seizure disorder, asthma, dementia, ataxia gait, intermittent impulse control and constipation.</p> <p>During an interview on 5/22/13 at 10:30 a.m., the Executive Director (ED) indicated the alleged abuse on 4/12/13 was not reported to the Indiana State Department of Health.</p> <p>Review of a current facility policy, dated 3/13/2012, titled "Abuse, Neglect, and Misappropriation of Property" which was provided by the Nurse Consultant on 5/20/13 at 10:00</p>		<p>3, 3-A-3-K)<u>How will the facility monitor and who is responsible:</u> The facility Administrator is responsible for monitoring and assuring timely reporting to the appropriate agency. Occurrences with the potential to be considered abuse will be reported immediately to the facility administrator. The administrator will assure the allegation of abuse occurrence is reported to the Indiana State Department of Health Long Term Care Division and will maintain a log of incidents reported. Additionally, the Social Service department manager will participate in the investigation of allegations of abuse and will review to confirm reporting of alleged abuse in accordance with the Indiana State department of Health Long Term Care Division policy and facility policy. Results of monitoring will be reviewed by facility QA committee times 6 months, with reporting to the regional Quality Assurance Committee for review and recommendations. (Exhibit 4)</p>		

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	<p>a.m., indicated the following:</p> <p>"Identification: ...2. The facility will report the allegation to the State Agency in accordance with the state law....</p> <p>Investigation: 1. The facility will conduct an internal investigation and report the results of the investigation to the enforcement agency in accordance with state law including the state survey and certification agency within five working days of the incident or according to state law.</p> <p>3. Investigations will be prompt...not limited to the following; a. Notification of physician and family; b. Identification and removal of the alleged person or persons responsible for the incident;... g. Follow-up resolution;....</p> <p>Reporting and Response: 1. The facility will report all alleged violations and substantiated incidents the the state agency and to all other agencies as required and will take all necessary corrective actions depending on the results of the investigation."</p>				

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	This Federal tag relates to Complaint #IN00129202. 3.1-28(a)				

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F000312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on observation, record review, and interview, the facility failed to ensure each resident received oral care in accordance with their plan of care for 1 of 4 residents reviewed for provision of oral care. (Resident #J)</p> <p>Findings include:</p> <p>1.) During an observation on 5/21/13 at 8:35 a.m., Resident #J was resting in his bed. His mouth was open and he was breathing partially through his mouth. He had an accumulation of a dried crusty yellow substance on both his upper and lower lips. His tongue was coated with a thick accumulation of a yellow substance. A portion of the yellow substance appeared to be adhered to the roof of his mouth and extended down to the top of the tongue.</p> <p>During an observation and interview with LPN #6 on 5/21/13 at 8:37 a.m., she indicated Resident #J did need mouth care. LPN #6 talked with an unidentified CNA who entered the</p>	F000312	<p>F312 ADL Care for Dependent residents <u>Action taken for identified resident</u> Resident J is receiving oral care @ 7am, 11am, 3pm, 7pm, and 11 pm during waking hours and at least one time during the night and additionally as needed . Oral care is monitored and documented by licensed nurse. (Exhibit 5) <u>Identification and corrective action for other residents with the potential to be affected:</u> Residents with potential to be affected include any resident unable to perform oral care independently. Residents with potential to be affected are monitored daily to assure oral care is performed per the residents plan of care. May 23, 2013 nursing staff education was provided regarding oral care and will be provided to nursing staff during new hire orientation and annually.(Exhibit 6) <u>Measures to prevent recurrence.</u> Residents unable to perform oral care independently are monitored daily to assure oral care is performed per the residents plan of care. May 23, 2013 nursing staff education was provided regarding oral care and will be provided</p>	06/09/2013	

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	<p>room during the observation and indicated mouth care would be given.</p> <p>The clinical record for Resident #J was reviewed on 5/20/13 at 10:30 a.m.</p> <p>Diagnoses for the resident included, but were not limited to, hydrocephalus, infantile cerebral palsy, dysphagia, spastic quadriplegia, blind, mentally retarded and developmentally disabled, and gastrostomy tube placement.</p> <p>An annual Minimum Data Set (MDS) assessment, dated 2/21/13, indicated Resident #J was severely cognitively impaired, unable to speak, rarely/never understood others, and was rarely/never understood by others. The assessment indicated the resident was fed by a gastrostomy tube and was totally dependent on the staff for all activities of daily living.</p> <p>A current health care plan problem, dated 2/26/10, and reviewed on 2/25/13, indicated the resident needed the assistance of the staff for daily life situations due to cerebral palsy. One of the approaches for this problem was for the staff to "Provide oral care two times daily and as needed."</p>		<p>during new hire orientation and annually(Exhibit 7, 7-A-7C) <u>How will the facility monitor and who is responsible</u>. The Director of Nursing /Designee is responsible and will monitor to assure resident's oral care is provided to meet the needs of residents who cannot provide oral care independently. This monitor will be done daily times 2 weeks, then 3 times a week times 2 weeks, then weekly times x 8 weeks, and monthly for 3 months. Results of monitoring will be presented to facility QA Committee times 6 months for review and further recommendation with reporting to the regional Quality Assurance Committee for review and recommendation</p>		

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	<p>During an interview on 5/22/13 at 12:50 p.m., Family Member Z indicated she visited the resident frequently. She indicated she had concerns with the resident's mouth care. She indicated at least once weekly the resident would be noted to have a heavy accumulation of yellow matter on his tongue and dried yellow substance on his lips.</p> <p>Review of the current facility policy, dated 1/23/12, provided by the Assistant Director of Nursing on 5/22/13 at 1:35 p.m., titled "Oral Hygiene" included, but was not limited to the following:</p> <p>"Purpose: Promote oral hygiene, prevent oral infection, prevent gum disease and tooth decay.</p> <p>Procedure:</p> <p>Independent Resident:</p> <p>1. Encourage resident to complete oral care every morning and at bedtime.</p> <p>...Assist or Dependent Resident:</p> <p>...3. assist resident in brushing</p>						

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	teeth...." This federal tag relates to Complaint #IN00128225. 3.1-38(a)(3)(c)				

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F000323 SS=G	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure that a resident with osteoporosis and a history of multiple fractures of the lower extremities was transferred in the safest manner possible and in accordance with his plan of care resulting in additional musculoskeletal stress and a spontaneous fracture of the left femur for 1 of 3 residents reviewed for injuries of unknown origin. (Resident #J)</p> <p>Findings include:</p> <p>1.) During an observation of a resident transfer on 5/20/13 at 10:20 a.m., conducted by CNA #'s 17, 18, 7, 20, and LPN #19, the following was noted:</p> <p>The staff were preparing to transfer Resident #J from his bed to a special adaptive wagon which had a formed insert to comfortably support his body. The head of the wagon had been placed at the end of the</p>	F000323	<p>F323 Accident Hazards/Supervision Action taken for resident's #. Resident (J) was screened by therapy and is being transferred by 4 staff using a lift pad and a person supporting his casted leg. Resident (J) will be re-screened by therapy when the cast is removed to assure the safest method of transfer. Nursing staff education was provided April 29 and continues with any new staff assigned to care for this resident with the transfer process communicated in the resident information in the CNA book and CNA information sheet. CNA #23 and #21 were re-educated on following resident's plan of care (Exhibit 8, 8A, 9) <u>Identification and corrective action for other residents with the potential to be affected</u>: Residents requiring staff assist or mechanical lift were reviewed to assure a safe appropriate method of transfer is in use and care planned. May 1, the CNA information sheets were reviewed and updated to assure communication of the appropriate method of transfer for each resident. Staff education was provided on using the CNA</p>	06/09/2013			

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	<p>resident's bed.</p> <p>The resident had a cast on his left leg which extended from his thigh to his foot.</p> <p>The staff had placed a denim like lift pad under the resident which extended the full length of his body.</p> <p>Two staff were on each side of the resident and one staff was near the end to support the leg. The staff grasped the lift pad on each side, raised the resident off of the bed, moved him down the length of the bed, and placed him into the wagon.</p> <p>The lift was completed easily and the resident did not appear to be uncomfortable during the transfer. His entire body was supported by the lift pad and his weight was distributed the full length of the lift pad.</p> <p>During an interview with the four CNA's at this time, they indicated this was always the manner in which the resident was transferred, but prior to his fracture, it had been completed by only two people. When asked if they had been able to transfer the resident easily in this manner by only two people, they all indicated it could be done, but the ease of the transfer</p>		<p>information sheet and following the residents designated transfer method. Monitoring of the transfer process was initiated May 1, to assure staff are following the individual resident's care plan for transfer as communicated on the CNA information sheet. (Exhibit 10, 10-A, 10-B) <u>Measures to prevent recurrence</u>. Staff education, regarding the CNA information sheet and following the resident's designated transfer method, was provided to current staff and will be provided annually and during new hire orientation. Monitoring to assure staff are following the individual resident's care plan for transfer as communicated on the CNA information sheet will continue as a monthly audit due to the high volume of totally dependent resident transfers. (Exhibit 9, 11, 11-B) <u>How will the facility monitor and who is responsible</u> The Director of Nursing /designee is responsible for monitoring to assure transfers are in accordance with each resident's individual plan of care. Monitoring to assure resident transfer is completed in accordance with the individual resident's care plan was initiated May 1, with daily monitoring times 2 weeks, then 3 days a week times 2 weeks, then weekly resident times 2 months Monthly audits of transfers per plan of care will</p>		

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	<p>depended on who the "two people" were.</p> <p>The clinical record for Resident #J was reviewed on 5/20/13 at 10:30 a.m.</p> <p>Diagnoses for the resident included, but were not limited to, hydrocephalus, infantile cerebral palsy, dysphagia, spastic quadriplegia, blind, mentally retarded and developmentally disabled, osteoporosis, gastrostomy, aphasia, history of bilateral chronic hip dislocations and diffuse bony demineralization, history of fracture of the distal left femur January 2005, and history of fractured right femur 2002.</p> <p>An annual Minimum Data Set (MDS) assessment, dated 2/21/13, indicated Resident #J was severely cognitively impaired, unable to speak, rarely/never understood others, and was rarely/never understood by others. The assessment indicated the resident was fed by a gastrostomy tube and was totally dependent on the staff for all activities of daily living. The assessment indicated the resident required the assistance of two for transfers and bathing. The MDS indicated the resident was 48</p>		continue monthly. Results of monitoring will be reviewed by facility QA committee times 6 months, with reporting to the regional Quality Assurance Committee for review and recommendations. (Exhibit 12)		

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	<p>inches tall and weighed 104 pounds.</p> <p>A health care plan problem, dated 2/26/10, and reviewed on 2/26/13, indicated the resident had an alteration in mobility due to being non weight bearing. The problem indicated the resident had a history of fractures due to cerebral palsy and osteoporosis. One of the approaches for this problem indicated the resident needed the "assistance of two when transferring."</p> <p>A review of a Federally required "Entity Self Reported" incident, received 5/1/13, indicated Resident #J was noted to have a slightly swollen/warm to touch left knee on 4/29/13 at 7:50 a.m. The physician was contacted and family notified. The resident was transferred to the emergency room and an x-ray determined the resident had a new fracture of his left femur.</p> <p>A nursing note, dated 4/28/13 at 9 p.m. (the first entry on 4/28/13), indicated a CNA reported to the nurse that Resident #J was agitated and not acting "right". The nurse assessed the resident and noted that the resident was crying. An as needed pain medication was given due to the resident's symptoms of discomfort.</p>			

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	<p>At 10:30 p.m., the resident was noted to be resting quietly in bed without signs or symptoms of pain and/or discomfort.</p> <p>A nursing note, dated 4/29/13 at 2 a.m., indicated the resident was agitated and crying. Pain medication was repeated at that time. Vital signs were taken and an abdominal assessment was done. No concerns were noted related to the lower extremities.</p> <p>A nursing note, dated 4/29/13 at 7:30 a.m., indicated the staff had noted that the resident's left knee appeared swollen and warm to touch. The resident "grimaced" when the leg was touched. The physician was contacted and the resident was sent to the emergency room for treatment.</p> <p>A fracture of the left femur was noted on an x-ray, dated 4/29/13, taken during the emergency room visit. The resident returned to the facility on 4/29/13 at 3:50 p.m. with a cast on his left leg extending from his thigh to his toes.</p> <p>During a review of the 200 hall (the hall on which Resident #J resided) assignment sheets for 4/28/13, provided by the DoN on 5/21/13 at</p>			

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	<p>11:25 a.m., they indicated CNA #21 and CNA #3 had worked on the day shift and CNA #23 and #24 had worked the evening shift on 4/28/13. The assignment sheets indicated LPN #26 worked the day shift and LPN #22 worked the second shift on 4/28/13. The assignment sheets indicated day shift was from 6 a.m. to 2 p.m. and the evening shift was from 2 p.m. to 10 p.m. for the CNAs.</p> <p>An "Occurrence Investigation" report, dated 4/29/13, provided by the Executive Director on 5/20/13 at 11 a.m., indicated an investigation had been completed by the Executive Director on 4/29/13. The investigation contained the name of 4 CNAs (CNA #'s 23, 17, 21, and 25) and 2 LPNs (LPN #'s 22 and 26) who were interviewed. The names of CNA #3 and CNA #24 were not on the list of CNAs interviewed on 4/29/13 investigation noted above related to Resident #J's fractured femur.</p> <p>During an interview with the RN Consultant on 5/21/13 at 3:15 p.m., additional information was requested related to the investigation of Resident #J's care on 4/28/13. She indicated CNA #21 had been the residents primary aide on the day shift and CNA #23 had been his</p>						

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	<p>primary aide on the second shift. CNA #21 indicated no problems with the resident's left leg had been noted that day. CNA #23 indicated the resident had been "fussy" when she came on duty at 2 p.m. and she gave him his shower between 2 and 3 p.m. because that usually settled him down. When queried why CNAs #3 and #24 (the other CNAs on the day and evening shift) had not been interviewed, she indicated she did not know and would find out and talk to them. Additional information was also requested related to the resident's behavior and or skin problems noted during the shower given by CNA #23 on 4/28/13.</p> <p>During an interview with the Executive Director and RN Consultant on 5/22/13 at 9 a.m., the Executive Director indicated she had interviewed CNA #23 (the second shift CNA who gave the resident a shower) during the investigative process on 4/29/13. During the investigative interview, CNA #23 indicated she had transferred Resident #J by herself that shift using both arms and lifting him herself in a cradle like manner. CNA #23 had lifted the resident from his bed to a wheelchair, from the wheelchair to the shower bed, from the shower bed</p>			

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	<p>back to his wheelchair following the shower, and from his wheelchair back to his bed using this technique. CNA #23 indicated she was unaware of any injury to the resident during these transfers. This indicated 4 occasions on the evening shift when the resident was transferred by the assistance of one person and not in accordance with his safety needs and plan of care.</p> <p>The Executive Director indicated she had not interviewed CNA #24 related to the occurrence because she had not assisted CNA #23 during the transfers noted above. The Executive Director indicated she had contacted CNA #3 related to the occurrence, who stated she had not provided any care to the resident during her shift on 4/28/13. When queried who assisted CNA #21 with Resident #J's care during the day shift on 4/28/13 since CNA #3 had not helped her, the Executive Director indicated she did not know, but would find out.</p> <p>During an interview on 5/22/12 at 10 a.m., the Executive Director indicated she had just interviewed CNA #21 (the day shift CNA providing care to Resident #J on 4/28/13). During the interview, CNA #21 indicated she had transferred Resident #J by herself on</p>						

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	<p>that shift using the "Hoyer lift" (a mechanical device that lifts the resident on a lift pad in a curved sling like position using straps to raise the resident). CNA #21 indicated the resident had been gotten out of bed and put back into bed using the Hoyer lift. This indicates 2 occasions on the day shift on 4/28/13 when the resident was transferred by the assistance of one person and not in accordance with his safety needs and plan of care.</p> <p>This indicated at least six occasions on 4/28/13 that Resident #J was transferred by only one staff member and not in accordance with his safety needs and plan of care prior to his development of pain on 4/28/13 followed by redness and swelling of his left knee noted on the morning of 4/29/13 resulting in his transfer to the hospital for treatment of a fractured left femur.</p> <p>Review of the facility policy, dated 12/12/10, provided by the Assistant Director of Nursing on 5/22/13 at 1:20 p.m., titled "Transferring and/or Lifting," included, but was not limited to, the following:</p> <p>"Policy: To provide the resident with the safest, most comfortable mode of</p>						

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	<p>transferring to and from bed, wheelchair, or stationary chair.</p> <p>Procedure:</p> <p>1. One-Person Transfers--Should be used only if the resident can bear weight, pivot and assist with transfer, or if resident does not bear weight and the resident's weight is 50 pounds or less...."</p> <p>This federal tag relates to Complaint #IN00128225 and Complaint #IN00127661.</p> <p>3.1-45(a)(2)</p>			