STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155341	A. BUILDING 00 B. WING	10/17/2013

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EASTGATE MANOR NURSING & REHABILITATION CENTER	2119 E NATIONAL HWY WASHINGTON, IN 47501

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F000000	This visit was for the Investigation of Complaint IN00137499. Complaint IN00137499 Substantiated, Federal/State deficiencies related to the allegations are cited at F323 and F514. Survey dates: October 16 and 17, 2013 Facility number: 000301 Provider number: 155341 AIM number: 100289090 Survey team: Anne Marie Crays RN Census bed type: SNF/NF: 63 Total: 63 Census payor type: Medicare: 9 Medicaid: 47 Other: 7 Total: 63 Sample: 3 These deficiencies reflect state findings cited in accordance with 410	F000000	This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	IAC 16.2. Quality review on October 18, 2013 by Cheyrl Fielden, RN			

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F000323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.			
	Based on observation, interview, and record review, the facility failed to provide assistance for a dependent resident at risk for falls, resulting in a fall with a head laceration, for 1 of 3 residents reviewed for falls, in a sample of 3. Resident A Findings include: 1. On 10/16/13 at 9:15 A.M., during the initial tour, Resident A was observed lying in bed. Black and purple bruising was observed above and around her left eye, with sutures above her left eyebrow. Resident A indicated, "My head met the floor." On 10/16/13 at 9:30 A.M., the Administrator provided a list of residents, indicating those residents considered interviewable. Resident A was included as being interviewable. On 10/16/13 at 10:45 A.M., the clinical record of Resident A was reviewed. Diagnoses included, but were not limited to, chronic	F000323	DON reviewed and verified that care plan and assignment sheet for resident A were updated with current interventions. DON began in-service education with nursing staff regarding utilization of gait belts and assistive devices.Current residents' charts will be audited to identify residents with gait belts and assistive devices. Care plans and assignment sheets will be updated as needed. Nursing staff is to be in serviced regarding Accident Prevention and Supervision; regarding utilization of gait belts and assistive devices for accident prevention. DON/Designee will make compliance rounds throughout facility to validate use of assistive devices and gait belts daily (Monday thru Friday) x 2 weeks, 3 times a week x 2 weeks, weekly for 4 months, and then monthly x 6 months. Identified non-compliance will result in 1:1 re-education up to and including termination.Identified trends will be reviewed in QA monthly times 6 months and quarterly times 2 qtrs to determine further recommendations as needed.	10/28/2013

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	obstructive pulmonary disease, spinal stenosis and weakness. A Nursing Admission Assessment, dated 9/24/13, indicated the resident was alert and oriented to person, place and time. The assessment indicated the resident had weakness "all over," "cannot walk yet," and required extensive assistance of 2 for transfer and toilet use. A Minimium Data Set (MDS) assessment, dated 10/1/13, indicated the resident scored a 15 out of 15 for mental status, indicating no memory impairment. The MDS assessment indicated the resident required extensive assistance of two + staff for bed mobility, transfer, and toilet use. A test for "Balance During Transitions and Walking" indicated "Not steady, only able to stabilize with staff assistance." A Physical Therapy progress note, dated 10/8/13, included: "...Gait Tasks: Assistive Devices, The patient requires front wheeled walker and contact guard assist (contact with patient due to unsteadiness) for safe ambulation...Pt. [patient] continued to demonstrate impairment with her functional mobilities, lack of coordination, [positive] postural			

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	balance deficits, [positive] muscle strength deficits, decreased functional activity tolerance affecting pt's safety placing pt. @ risk for falls & further decline with functional mobilities...Required assistance in all mobilities with cueing for safety...Precautions: Low endurance - needs frequent rests. Visual deficits...Fall precautions; O2 [oxygen]...." A computerized progress note, dated 10/12/13 at 8:50 A.M., included: "Resident was being transferred from the BSC [bedside commode] to the bed. Resident started to slide with staff holding onto her with the gaitbelt. Staff easied [sic] resident to the floor and at that point she hit her head on the corner of the bed. Staff assisted resident back [sic] to bed after being checked out. Resident does have a laceration of 1.5 cm [centimeters] to forehead above left eye. Resident sent to ER for eval [evaluation]...Alert, Oriented to Person, Oriented to Place...Is there pain? Yes...Laceration and hematoma to left side of head...." An incident report, dated 10/12/13, included: "...Was Resident being transferred at time of incident? Yes...What type of assistance was			

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	required when getting up? 2A [assistance of 2]. What action(s) were taken following the incident?...Education - Staff...." A "DCR" progress note, dated 10/14/13 and untimed, indicated, "DCR in regards to Res [resident] being transferred et [and] started to slide et staff attempted [sic] to lower her [and] she bumped her head causing a small laceration. Resdient sent to ER for tx [treatment] [and] returned. Rooms moved to give resident more room [illegible] clutter to prevent further incidents...." A care plan, initially dated 9/24/13, indicated: "Fall/Injury Risk related to: Sensory Impairment Factors visual, Pharacological Factors...pain, stiffness, unsteady, poor wt. [weight] bearing, weakness...Interventions, Ambulation 2A, changed on 9/27/13 to 1A [one assist], Transfer: 2A, changed on 9/27/13 to 1A...10/12/13 Room clutter free as possible...." On 10/16/13 at 2:00 P.M., Resident A was interviewed. Resident A indicated on 10/12/13, a CNA was assisting her to walk "from her bed toward the door." Resident A indicated the CNA did not have a gait belt on her, nor had the resident's walker to assist			

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	her. Resident A indicated, "I hit the floor." Resident A indicated she required 6 stitches, and that her head "really hurt." Resident A indicated she "didn't want to get anyone in trouble." On 10/16/13 at 3:20 P.M., LPN # 1 was interviewed. LPN # 1 indicated she was in the dining room on 10/12/13 at approximately 8:45 A.M, when she heard CNA # 1 yell for help. LPN # 1 indicated she entered the room and found Resident A on the floor and her head was bleeding. LPN # 1 indicated CNA # 1 informed her she was transferring Resident A from the bedside commode to the bed, and the resident slid down to the floor and hit the corner of the bed. LPN # 1 indicated she was not in the room at the time of the fall, and was reporting what CNA # 1 told her. On 10/17/13 at 9:10 A.M., CNA # 1 was interviewed. Regarding the fall on 10/12/13, she indicated she had already transferred Resident A from the commode to the bed. She indicated the resident was sitting on the side of the bed, and she went to the door to yell at someone else to help her position the resident up in bed. She indicated the resident "was just behind the curtain."			

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	On 10/17/13 at 10:45 A.M., during interview with the Administrator and Director of Nursing (DON), they each indicated they were told that the resident was being transferred from the commode to the bed, and the clutter in the room contributed to the fall. The DON indicated she did not think the resident had a walker in her room, because the staff did not ambulate her. The DON indicated the resident usually had a gait belt on her at all times, even while in bed. The Administrator and DON indicated they had not spoken with CNA # 1 regarding the resident's fall. 2. On 10/17/13 at 11:10 A.M., the Administrator provided the current facility policy on "Falls and Injuries," revised April 2012. The policy included: "...strives to provide an environment that is free from hazards...and provides supervision and assistance devices to each resident to prevent avoidable accidents...Centers are obligated to provide adequate supervision to prevent accidents. Adequate supervision is defined by the type and frequency of supervision, based on the individual residents assessed needs and identified hazards in the resident environment...."			

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	This Federal tag relates to Complaint IN00137499. 3.1-45(a)(2)			

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F000514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.			
	Based on interview and record review, the facility failed to completely document an incident in which ceiling debris fell on a resident, and the transfer and return of the resident to and from the hospital, for 1 of 3 residents reviewed for documentation, in a sample of 3. Resident A Findings include: 1. On 10/16/13 at 9:30 A.M., during interview with the Administrator, she indicated on 9/26/13, following a water leak, part of the ceiling fell in on Resident A. The Administrator indicated a report was sent to the Indiana State Department of Health regarding the incident. She indicated the resident received some insulation	F000514	The local ambulance service has provided a copy of time Resident A was picked up from the facility and time returned for verification. A copy of the physician assessment from the emergency room for Resident A was present in the chart at the time of surveyor review. The physician assessment documented Resident A had no injuries from the ceiling event.Charts of other residents transferred to the emergency room will be audited to ensure documentation of time the resident was transferred, how transferred, time the resident returned and condition upon return. The Regional Director of Clinical Operations will re-inservice the Administrator and Director of Nursing regard incident reporting. Licensed nurses will be in serviced on incident reporting and	10/28/2013

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	on her and was transferred to the hospital. She indicated the resident was startled and requested a nerve pill, but sustained no injuries from the incident. The clinical record of Resident A was reviewed on 10/16/13 at 10:45 A.M. Information regarding the incident was not documented in the nursing notes. A Social Services note, dated 9/26/13 and untimed, indicated, "Assessed resident's cognitive state after ceiling collapsed in resident's room. Initial assessment resident appeared anxious [and] scared yet appeared to have no physical injuries. Resident was immediately sent to [name of hospital] for evaluation. Upon return to facility resident was placed in new room...." On 10/16/13 at 11:35 A.M., the Director of Nursing (DON) was interviewed and informed of the lack of documentation in the clinical record regarding the collapse of the ceiling on the resident, and the resident transfer to the hospital. The DON indicated the transfer sheet or incident report would be the documentation.		documentation of residents' health status, including assessments, interventions and clinical outcomes.DON/Designee will randomly audit 3 resident charts for complete documentation daily (Monday thru Friday) x 2 weeks, 3 times a week x 2 weeks, weekly for 4 months, and then monthly x 6 months. Identified non-compliance will result in 1:1 re-education up to and including termination.Identified trends will be reviewed in QA monthly times 6 months and quarterly times 2 qtrs to determine further recommendations as needed.	

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	On 10/16/13 at 11:40 A.M., the DON provided a transfer form for Resident A, dated 9/26/13. The form indicated the resident was transferred to the hospital, but did not include a time of when she was sent, nor how she was transferred. The form included: "Reason(s) for transfer: Evaluation [secondary to] debris fell from ceiling...." Documentation did not include when the resident returned from the hospital, nor her condition upon return. On 10/16/13 at 2:00 P.M., during interview with Resident A, she indicated it was her second day at the facility "when the ceiling fell on me." Resident A indicated it "scared me to death." On 10/17/13 at 9:10 A.M., during interview with the DON, she indicated an incident report had not been filled out regarding the incident. She indicated the resident was "just sent to the hospital as a precaution and returned." She indicated she thought of the problem as "more of an environmental issue." The DON indicated she filled out the transfer form, and neglected to document the time. The DON indicated the resident			

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	was transferred by ambulance. On 10/17/13 at 9:10 A.M., during interview with CNA # 1, she indicated she was working the day of 9/26/13. She indicated she heard a loud noise, and ran out into the hallway. She indicated there was insulation and drywall "all over the resident and all over the floor" of the hallway and resident room. She indicated the debris covered the resident. On 10/17/13 at 10:25 A.M., the DON indicated the facility "documents by exception," and the staff does not document unless something is wrong. 2. On 10/17/13 at 11:15 A.M., the Administrator provided the current facility policy, dated January 2004, on "Documentation." The policy included: "...will provide ongoing documentation of the resident's health status to include observations, assessments, interventions, and clinical outcomes. Documentation is designed to demonstrate the clinical picture of the resident, and to ensure the appropriate information is available to all interdisciplinary team members regarding treatment interventions and responses...Make all entries into the medical record as soon as possible after an observation, assessment, or			

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	interventions occurs...." This Federal tag relates to Complaint IN00137499. 3.1-50(a)(1)			