

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155759	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/23/2014
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NAME OF PROVIDER OR SUPPLIER GLEN OAKS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 601 W CR 200 S NEW CASTLE, IN 47362
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit included Investigation of Complaint IN00150199.</p> <p>Complaint IN00150199-Unsubstantiated due to lack of evidence.</p> <p>Survey dates: July 15, 16, 17, 18, 19, 22, and 23, 2014</p> <p>Facility number: 011187 Provider number: 155759 AIM number: 200838150</p> <p>Survey team: Barbara Gray, RN-TC Leslie Parrett, RN (July 16, 17, 18, 19, 22, and 23, 2014) Diana Sidell, RN Angel Tomlinson, RN (July 16, 17, 18, 19, and 23, 2014)</p> <p>Census bed type: SNF: 23 SNF/NF: 26 Residential: 33 Total: 82</p> <p>Census payor type: Medicare: 18</p>	F000000	<p>Preparation or execution of this plan of correction does not constitute provider admission or agreement related to the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Annual Recertification and State Licensure Survey on July 23, 2014.</p> <p>Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</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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F000279 SS=D	<p>Medicaid: 25 Other: 39 Total: 82</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1 and 16.2-5.</p> <p>Quality review completed on July 28, 2014 by Cheryl Fielden, RN.</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p>			

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	<p>Based on observation, interview, and record review, the facility failed to update and revise a care plan to prevents falls for a resident who required an assistive device of a gait belt for safe ambulation and failed to develop a care plan for a resident's Range of Motion (ROM) needs, for 2 of 19 residents reviewed for care plans. (Resident #19 and #47)</p> <p>Findings include:</p> <p>1. Review of the record of Resident #47 on 7/17/14 at 1:30 p.m., indicated the resident's diagnoses included, but were not limited to, dementia related psychosis, anxiety, depression and insomnia.</p> <p>The safety plan of care for Resident #47 dated 5/10/14 (no time), indicated the interventions included, but were not limited to, "implement enabler to assist with fall prevention" and "provide assistive devise and ensure it is accessible". The safety plan of care did not indicate what type of enabler or assistive device needed to be used to assist the resident with safety.</p> <p>The Admission Minimum Data set (MDS) assessment for Resident #47 dated 5/17/14, indicated the following: walk in room- extensive assistance of one</p>	F000279	<p>F 279 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: The care plan for resident #19 was updated August 8, 2014. The care plan for resident #47 was updated August 8, 2014. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: Director of Health Services (DHS) or designee will ensure Range of Motion (ROM) assessment is completed for each resident to determine those residents at risk for reduced Range of Motion (ROM). DHS or designee will review all residents with falls in the past 30 days to ensure the safety plan of care identifies the type of enabler or assistive device needed to assist the resident with safety. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the careplan team on Interdisciplinary Care Plan Guidelines. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: Per the campus guidelines, the Nursing Leadership Team will review the 24 hour report, circumstance forms and change in condition forms in the daily clinical meeting</p>	08/22/2014

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	<p>person, walk in corridor- limited assistance of one person and locomotion on the unit- extensive assistance of one person.</p> <p>The "profile history report" for Resident #47 dated 6/6/14, indicated the resident was at risk for falls. The interventions were "place my bed at an appropriate level for my body height to facilitate safe transfers, lock the brakes, keep my call light and frequently used items with easy reach to prevent me from overstretching, ensure my environment is appropriately lit for the time of day and my pathway are free of clutter." "My goal is to have no falls or at least no injuries from falls." The profile history report did not indicate any revision or update until 6/20/14 with the intervention to encourage to ask for help.</p> <p>The Physical therapy plan of care for Resident #47 dated 6/18/14, indicated the resident presented to therapy with a decline in Activities of Daily Living of ambulation with a front wheeled walker due to an abnormal gait pattern and poor cognition deficits. The nursing staff had noticed a decrease with the ability to ambulate, resulting in decreased safety and an increase need for assistance and risk of falls. The resident's current level of functioning was ambulated on a level</p>		<p>5 days a week, ongoing. This review is to ensure that a care plan has been developed. The Daily Clinical Meeting Report will be completed to document the review of the above stated reports/forms. The following audits and /or observations will be conducted by the DHS or designee 2 times per week times 4 weeks, then monthly times 5 months to ensure compliance: Review of 3 care plans to ensure the intervention(s) have been implemented and the careplan has been updated to prevent further falls. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>	

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	<p>surface and on carpet requiring contact guard assist, the resident required contact due to unsteadiness with the front wheeled walker.</p> <p>The fall circumstance assessment and intervention for Resident #47 dated 6/20/14, indicated the resident had a witnessed fall and hit her head. The resident had signs and symptoms of a left ankle fracture. The prevention intervention update was orient to environment, nonskid footwear, use a wheelchair and encourage to ask for help. The Interdisciplinary (IDT) review located on the bottom of the document dated 6/23/14, indicated no root cause, no intervention update appropriate or change of intervention. All areas of the review were blank. The IDT review was signed by the Assistant Director of Health services (ADHS).</p> <p>Interview with CNA #1 on 7/17/14 at 2:03 p.m., indicated she was with Resident #47 on 6/20/14 when she fell. CNA #1 indicated she was walking with the resident from the dining room to the resident's bedroom because the resident needed to use the restroom. CNA #1 indicated the resident was using a walker. CNA #1 indicated the resident was dragging her left leg while she ambulated from the dining room. CNA #1 indicated</p>			

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	<p>when they got to the resident's bedroom the resident's legs began shaking and she dropped to her knees and fell back and hit her head. CNA #1 indicated she and a nurse got the resident up and the resident did not complain of pain. CNA #1 indicated she then took the resident to the bathroom and the resident started complaining that her left ankle hurt really bad. CNA #1 indicated the resident did not have a gait belt on while she was ambulating from the dining room to her bedroom.</p> <p>Interview with Physical Therapist (PT) #4 on 7/18/14 at 11:15 a.m., indicated she did the assessment and evaluation for Resident #47 on 6/18/14. PT #4 indicated she had verbally communicated to the nursing staff that Resident #47 needed a to be held onto with a gait belt and use a walker during ambulation. PT #4 indicated the distance from the dining room to Resident #47's bedroom was between 150 to 200 feet.</p> <p>Interview with the Director of Health Services (DHS) on 7/18/14 at 1:00 p.m. indicated therapy recommendations for ambulation were communicated to the facility staff by the profile history report.</p> <p>Interview with the DHS on 7/18/14 at 2:12 p.m. indicated Resident #47 profile</p>			

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	<p>history report was not updated with therapy recommendations for ambulation on 6-18-14.</p> <p>2. On 7/15/14 at 1:11 p.m., Resident #19 was observed seated upright in a high back wheelchair watching television. Her right arm was lying limp on her lap and her fingers were turned slightly inward. At that time she indicated she could not spread her right hand fingers. She indicated she could only move her right arm by lifting it with her left arm. She had a Ankle/Foot/Orthotic (AFO) boot on her right foot. She indicated she had a diagnosis of Multiple Sclerosis (MS).</p> <p>Resident #19's record was reviewed on 7/17/14 at 1:06 p.m. Her diagnosis included but was not limited to MS.</p> <p>Resident #19's Admission Minimum Data Set (MDS) Assessment dated 5/5/14, indicated she understood and was able to understand others. She scored 15 on her Brief Interview for Mental Status (BIMS) Exam, indicating she was cognitively intact for daily decision making. She required extensive assistance of 2 persons for bed mobility, transfer, dressing, and toileting. She required extensive assistance of 1 person for eating and personal hygiene. She did</p>			

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	<p>not walk. She had limitations in her functional ROM in her upper and lower extremities on one side of her body.</p> <p>A Range Of Motion Assessment available in Resident #19's record without a date indicated she had ROM limitations in her right shoulder, elbow, wrist, fingers, hip, knee, ankle, and toes.</p> <p>On 7/17/14 at 2:04 p.m., Occupational Therapist #5 indicated Resident #19 wore the AFO boot daily for her right foot drop and it was removed at night.</p> <p>No Care Plan was available for review in Resident #19's record. On 7/18/14 at 2:46 p.m., the Director of Health Services (DHS) indicated Resident #19 did not have a Care Plan specific for her ROM needs.</p> <p>The Interdisciplinary Team Care Plan Guideline provided by LPN #6 on 7/22/14 at 10:41 a.m., indicated the following: " Purpose: To ensure appropriateness of services and communication that will meet the resident's needs, severity/stability of conditions, impairment, disability, or disease in accordance with state and federal guidelines. Procedure: a. The initial plan of care included on the Admission Nursing Assessment will be</p>			

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F000318 SS=D	<p>initiated within 24 hours and completed within 72 hours of admission to address pertinent areas of care, treatment and risk. i. Care plan interventions should be reflective of the impact the risk area(s), disease process(es) have on the individual resident. b. Discipline specific admission assessments will be completed within 72 hours of admission. c. A comprehensive care plan will be developed within 7 days of completion of the admission comprehensive assessment (MDS 2.0). i. Problems should identify the relative concerns. ii. Goals should be measurable and attainable. iii. Interventions should be reflective of the individual's needs and risk influence... j. New problem areas should be printed and added to the existing care plans...."</p> <p>3.1-35(a) 3.1-35(a)(1) 483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Based on observation, interview, and record review, the facility failed to provide Range of Motion (ROM) services for a resident who had limited</p>	F000318	F318 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #19	08/22/2014

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	<p>ROM, for 1 of 3 residents who met the criteria for ROM. (Resident #19)</p> <p>Findings include:</p> <p>On 7/15/14 at 12:38 p.m., LPN #7 indicated Resident #19 did not receive ROM services.</p> <p>On 7/15/14 at 1:11 p.m., Resident #19 was observed seated upright in a high back wheelchair watching television. Her right arm was lying limp on her lap and her fingers were turned slightly inward. At that time she indicated she could not spread her right hand fingers. She indicated she could only move her right arm by lifting it with her left arm. She had a Ankle/Foot/Orthotic (AFO) boot on her right foot. She indicated she had a diagnosis of Multiple Sclerosis (MS).</p> <p>On 7/17/14 at 10:39 a.m., Resident #19 was observed seated upright in a high back wheelchair in her bedroom. Her right hand was lying limp on her abdomen. She had an AFO boot on her right foot. Her right hand fingers were turned slightly in and more prominent on her last 2 fingers. She indicated she could not extend her fingers on her right hand. She indicated staff had never exercised her right hand.</p>		<p>careplan was updated to reflect that resident was at risk for reduced Range of Motion (ROM). Employees are cued each shift via electronic communication to complete ROM documentation.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</p> <p>Director of Health Services (DHS) or designee will ensure Range of Motion (ROM) assessment is completed for each resident to determine those residents at risk for reduced Range of Motion (ROM). Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Licensed Nurses on the following guideline: Range of Motion assessment and ROM documentation in the Caretracker. The DHS or designee will educate certified nursing assistants on documentation of ROM in Caretracker. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: Per the campus guidelines, the Clinical Care Meeting team will review the medical record compliance percentage during each meeting. This review is to ensure that ROM completion is properly documented. The Daily Clinical</p>	

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	<p>Resident #19's record was reviewed on 7/17/14 at 1:06 p.m. She was admitted to the facility on 4/23/14. Her diagnosis included but was not limited to MS.</p> <p>Resident #19's Admission Minimum Data Set (MDS) Assessment dated 5/5/14, indicated she understood and was able to understand others. She scored 15 on her Brief Interview for Mental Status (BIMS) Exam, indicating she was cognitively intact for daily decision making. She required extensive assistance of 2 persons for bed mobility, transfer, dressing and toileting. She required extensive assistance of 1 person for eating and personal hygiene. She did not walk. She had limitations in her functional ROM in her upper and lower extremities on one side of her body.</p> <p>A Range Of Motion Assessment available in Resident #19's record without a date indicated she had ROM limitation in her right shoulder, elbow, wrist, fingers, hip, knee, ankle, and toes.</p> <p>A Physical Therapy Evaluation for Resident #19 dated 4/25/14, indicated she was dependent on staff for activities of daily living (ADL), bed mobility, and transfers at her prior living facility. She was unable to bear weight on her bilateral</p>		<p>Meeting Report will be completed to document the review of the above stated reports/forms. The following audits and /or observations will be conducted by the DHS or designee 2 times per week times 4 weeks, then monthly times 5 months to ensure compliance: Review of the compliance percentage ensure the intervention(s) have been implemented. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>		

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	<p>upper and lower extremities. She had completed up to 50% of normal range in her right upper and lower extremity.</p> <p>An Occupational Therapy Evaluation for Resident #19 dated 4/28/14, indicated she was able to follow routines and had been dependent on staff for all self care tasks, transfers, and wheelchair mobility at her previous living facility. She was flaccid on her right upper and lower extremities and was unable to bear weight.</p> <p>On 7/17/14 at 2:04 p.m., Occupational Therapist #5 indicated Resident #19 wore the AFO boot daily for her right foot drop and it was removed at night. She indicated Resident #19 should have ROM of her extremities with daily care.</p> <p>No ROM care documentation was available for review in Resident #19's record.</p> <p>On 7/18/14 at 9:34 a.m., The Director of Health Services (DHS) indicated the CNA's provide residents with ROM during care. She indicated the CNA's did not document a residents specific ROM care but they documented ADL care.</p> <p>No Care Plan was available for review in Resident #19's record related to ROM.</p> <p>On 7/18/14 at 2:46 p.m., the DHS indicated Resident #19 did not have a</p>			

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	<p>Care Plan specific for her ROM needs.</p> <p>On 7/21/14 at 9:14 a.m., Resident #19 was observed seated upright in her high back wheelchair.. Her feet were on the wheelchair rests and she had a AFO boot on her right foot. Her right hand was lying limp on her right leg and her fingers were turned slightly in. She indicated the staff did not do any ROM exercises with her when they provided her care.</p> <p>On 7/21/14 at 1:27 p.m., CNA #8 indicated she had provided Resident #19 with her a.m., care that morning and she had requested help from another CNA to get Resident #19 out of bed and into her wheelchair using a stand up lift. She indicated she did not do ROM exercises with Resident #19. She indicated she believed Restorative provided residents with ROM care. She indicated there was an area in the Care Tracker to documented Restorative and she personally had never charted in the Restorative area.</p> <p>The Contracture Prevention and Management Program provided by LPN #6 on 7/22/14 at 10:41 a.m., indicated the following: "Purpose: To prevent or reduce contractures and deformity, and/or preserve range of motion of residual limb to allow for use of prosthesis if needed</p>			

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	<p>through the provision of range of motion, stimulation of circulation, and muscle strengthening exercises. Procedure: 1. Analyze Interdisciplinary assessments that may include but not be limited to: >MDS >Nursing Assessments >Therapy screen and/or evaluation >Mobility RAP >Current use of orthotic appliances/prosthetic devices. 2. Complete the Initial Restorative Assessment to establish a baseline for residents with potential or actual range of motion limitations. 3. Review and analyze assessments. 4. Determine the need for therapy interventions or nursing restorative/functional maintenance program. 5. Determine the type of exercises required based on the analysis of the assessments and residents abilities. Types of exercises include: a. Passive Range of Motion (PROM): No active involvement of the moving of the joint. b. Active Range of Motion (AROM): Performed by the resident with cueing or supervision by staff. c. Strengthening and conditioning of muscles. 6. Determine the goal of the range of motion activities. 7. Evaluate the need for splint/brace/prosthetic device use and assistance and refer to therapy as indicated. 8. Include the resident/responsible party in the goal setting process. 9. Enter the resident specific interventions and goals on the</p>			

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F000323 SS=G	<p>Restorative/Functional Maintenance Program Plan Interventions and goals and approaches will include but not be limited to: >Frequency > Duration > Special instructions >Precautions. 10. Initiate documentation of the resident program in the Care Tracker (Restorative field) or the Restorative Documentation log and/or the Resident Care Record for residents requiring documentation of daily participation and/or number of minutes that interventions are provided. 11. Inform care giving team of plan. Assist to implementing strategies during care giving activities. 12. Complete the Restorative/Functional Maintenance Program Summary which documents progress towards goals on a quarterly basis or as required by state regulations, as indicated by the specific program. 13. Ensure restorative program minutes are communicated to the MDS Coordinator for inclusion in the MDS Assessment."</p> <p>3.1-42(a)(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 observation, interview and</p>	F000323		08/22/2014

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	<p>record review the facility failed to thoroughly investigate the root cause analysis of a fall and failed to use a gait belt during ambulation with a resident who was at high risk for falls resulting in a fall with a left ankle fracture, causing pain for 1 of 3 residents reviewed for falls of 3 who met the criteria for accidents (Resident #47).</p> <p>Finding include:</p> <p>Interview with Resident #47 on 7/16/14 at 10:01 a.m., indicated she had discomfort and pain without relief. Resident #47 indicated she had fell and messed up her left ankle. Resident #47 indicated the facility gave her pain medicine for her left ankle pain and sometimes it helped and sometimes it did not help. Resident #47 was sitting in a wheelchair with a pink cast on her left leg and foot.</p> <p>Interview with LPN #9 on 7/16/14 at 11:41 a.m., indicated Resident #47 had fell and sustained a left ankle fracture in last 30 days.</p> <p>Review of the record of Resident #47 on 7/17/14 at 1:30 p.m., indicated the resident's diagnoses included, but were not limited to, dementia related psychosis, anxiety, depression and</p>		<p>F 323</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</p> <p>The care plan for resident #47 was updated August 8, 2014.</p> <p>A gait belt is used for resident #47 during ambulation.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</p> <p>DHS or designee will review all residents with falls in the past 30 days to ensure the safety plan of care identifies the type of enabler or assistive device needed to assist the resident with safety.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</p>		

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	<p>insomnia.</p> <p>The "assessment review and considerations" for Resident #47 dated 5/10/14 (no time), indicated the resident was at risk for falls due to cognitive impairment.</p> <p>The nursing safety assessment for Resident #47 dated 5/10/14 (no time), indicated the resident required an assistive device of a walker and a wheelchair.</p> <p>The safety plan of care for Resident #47 dated 5/10/14 (no time), indicated the interventions included, but were not limited to, "implement enabler to assist with fall prevention" and "provide assistive devise and ensure it is accessible". The safety plan of care did not indicate what type of enabler or assistive device needed to be used to assist the resident with safety.</p> <p>The Admission Minimum Data set (MDS) assessment for Resident #47 dated 5/17/14, indicated the following: walk in room- extensive assistance of one person, walk in corridor- limited assistance of one person, locomotion on the unit- extensive assistance of one person, toilet use-extensive assistance of one person, walking- not steady, only</p>		<p>DHS or designee will re-educate the Licensed Nurses on the following guideline: Falls Management Program and Gait Belt Policy. DHS or designee will re-educate the Certified Nursing Assistants on Gait Belt Policy. Therapy Designee will re-educate the Physical Therapy staff on guidelines for documenting / updating plan of care to reflect fall prevention of a resident on caseload who has experienced a fall. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</p> <p>Per the campus guidelines, the Nursing Leadership Team will review the 24 hour report, circumstance forms and change in condition forms in the daily clinical meeting 5 days a week, ongoing. This review is to ensure that a root cause has been established post fall and the careplan has been updated. The Daily Clinical Meeting Report will be completed to document the review of the above stated reports/forms. In addition, Nursing will complete a Nursing to Therapy Communication form to notify therapy of a residents fall.</p>	

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	<p>able to stabilize with staff assistance, functional range of motion-no impairment of the upper or lower extremities, pain or hurting in the last five days-no and received scheduled, as needed or non medication interventions for pain in the past five days-no.</p> <p>The "profile history report" for Resident #47 dated 6/6/14, indicated the resident was at risk for falls. The interventions were "place my bed at an appropriate level for my body height to facilitate safe transfers, lock the brakes, keep my call light and frequently used items with easy reach to prevent me from overstretching, ensure my environment is appropriately lit for the time of day and my pathway are free of clutter." "My goal is to have no falls or at least no injuries from falls." The profile history report did not indicate any revision or update until 6/20/14 with the intervention to encourage to ask for help.</p> <p>The "Rehabilitation screening" for Resident #47 dated 6/16/14, indicated the resident staff reported the resident was ambulating with a front wheeled walker from the dining room with an abnormal gait. The resident was observed during this screen to have poor posture, rigidity in bilateral leg extremities and ambulating with a wider base of support</p>		<p>The following audits and /or observations will be conducted by the DHS or designee 2 times per week times 4 weeks, then monthly times 5 months to ensure compliance: Observation of resident ambulation and transfer to ensure gait belts are used per resident plan of care.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>	

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	<p>increasing the risk for falls. The resident may benefit from physical therapy skilled services for abnormal gait pattern.</p> <p>The Physical therapy plan of care for Resident #47 dated 6/18/14, indicated the resident presented to therapy with a decline in Activities of Daily Living of ambulation with a front wheeled walker due to an abnormal gait pattern and poor cognition deficits. The nursing staff had noticed a decrease with the ability to ambulate, resulting in decreased safety and an increase need for assistance and risk of falls. The resident's current level of functioning was ambulated on a level surface and on carpet requiring contact guard assist, the resident required contact due to unsteadiness with the front wheeled walker.</p> <p>The fall circumstance assessment and intervention for Resident #47 dated 6/20/14, indicated the resident had a witnessed fall and hit her head. The resident had signs and symptoms of a left ankle fracture. The prevention intervention update was orient to environment, nonskid footwear, use a wheelchair and encourage to ask for help. The Interdisciplinary (IDT) review located on the bottom of the document dated 6/23/14, indicated no root cause, no intervention update appropriate or change</p>			

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	<p>of intervention. All areas of the review were blank. The IDT review was signed by the Assistant Director of Health services (ADHS).</p> <p>The change in condition form for Resident #47 dated 6/20/14, indicated the resident fell in her room onto her knees and then fell back and hit her head on a chair. The resident had no complaints at first and now was complaining of pain to the left ankle. The physician ordered an x-ray of the left ankle. The resident was not able to bear weight on the left ankle.</p> <p>The radiology report for Resident #47 dated 6/20/14, indicated the resident had an oblique (at an angle) fracture of the left distal fibula (the bone on the outside of the lower leg attached to the ankle) with associated soft tissue swelling.</p> <p>The pain circumstance assessment for Resident #47 dated 6/21/14, indicated the resident had acute pain from a fall with a left ankle fracture. The resident's pain was very severe. The careplan update was tramadol 50 milligrams one by mouth every four hours as needed.</p> <p>The orthopedic initial fracture care for Resident #47 dated 6/24/14, indicated the resident had a left ankle fracture as a result of a fall. The resident described her</p>			

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	<p>pain as aching, discomforting and throbbing. The symptoms occurred intermittently and was aggravated by movement. The symptoms had been acute and traumatic. The resident also was experiencing bruising, decreased mobility, joint tenderness, swelling and weakness. The resident had a splint placed to allow for swelling and will be seen in two weeks for a cast and was to be non weight bearing.</p> <p>The orthopedic note for Resident #47 dated 7/8/14, indicated the resident reported the her symptoms were intermittently and were mild to moderate. The symptoms were relieved by rest and elevation. The resident indicated she mostly sat in her chair. The resident had a short leg cast placed and was to continue to be non weight bearing.</p> <p>The physical therapy note for Resident #47 dated 6/24/14, indicated the resident had a fall on 6/20/14 resulting in a left lower leg fracture. The resident was too anxious to continue therapy services at this time.</p> <p>Interview with the ADHS on 7/17/14 at 1:35 p.m., indicated she did the investigation of Resident #47's fall on 6/20/14. The ADHS indicated the resident was with CNA #1, the resident</p>			

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	<p>fell to her knees and then fell backward. The ADHS indicated she did not know where the resident was going at the time of the fall or if the CNA was using a gait belt or if the resident was using her walker.</p> <p>Interview with Resident #47 on 7/17/14 at 1:43 p.m., indicated she did not remember what happened the day she fell. The resident indicated she did not know if she had her walker or if staff were with her when she fell. The resident indicated she remembered she did not feel well the day she fell.</p> <p>Interview with CNA #1 on 7/17/14 at 2:03 p.m., indicated she was with Resident #47 on 6/20/14 when she fell. CNA #1 indicated she was walking with the resident from the dining room to the resident's bedroom because the resident needed to use the restroom. CNA #1 indicated the resident was using a walker. CNA #1 indicated the resident was dragging her left leg while she ambulated from the dining room. CNA #1 indicated when they got to the resident's bedroom the resident's legs began shaking and she dropped to her knees and fell back and hit her head. CNA #1 indicated she and a nurse got the resident up and the resident did not complain of pain. CNA #1 indicated she then took the resident to the</p>			

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	<p>bathroom and the resident started complaining that her left ankle hurt really bad. CNA #1 indicated the resident did not have a gait belt on while she was ambulating from the dining room to her bedroom.</p> <p>Interview with Physical Therapist (PT) #4 on 7/18/14 at 11:15 a.m., indicated she did the assessment and evaluation for Resident #47 on 6/18/14. PT #4 indicated the resident had a lot of stiffness in her legs and required contact guard assist with ambulation. PT #4 indicated the resident was at high risk for falls and required a gait belt during ambulation with the assistance of staff because the resident had a rigid spastic gait. PT #4 indicated she had verbally communicated to the nursing staff Resident #47 needed to be held onto with a gait belt and use a walker during ambulation. PT #4 indicated the distance from the dining room to Resident #47's bedroom was between 150 to 200 feet.</p> <p>Interview with the Director of Health Services (DHS) on 7/18/14 at 1:00 p.m. indicated therapy recommendations for ambulation were communicated to the facility staff by the profile history report.</p> <p>During observation on 7/18/14 at 1:20 p.m., CNA #2 and CNA #3 transferred</p>			

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	<p>Resident #47 from her wheelchair to her bed to use a bedpan, a hooyer lift was used for the transfer. CNA #2 indicated before the resident fractured her ankle she walked to the toilet. CNA #2 indicated now that the resident had to use a hooyer lift for transfers and had to use a bedpan for toileting needs because the hooyer lift would not fit in the bathroom. Resident #47 indicated it was uncomfortable for her to use a bedpan. CNA #2 left the room to look for a bedside commode. Resident #47 used the bedpan before CNA #2 returned due to the resident could not wait to use the restroom.</p> <p>Interview with the DHS on 7/18/14 at 2:12 p.m. indicated Resident #47 profile history report was not updated with therapy recommendations for ambulation on 6-18-14.</p> <p>The fall management program provided by DHS on 7/18/14 at 2:15 p.m., indicated the facility strived to maintain a hazard free environment, mitigate fall risk factors and implement preventative measures. Care plan interventions should be implemented that address the resident's risk factors. Should a resident experience a fall the attending nurse shall complete the fall circumstance form. The form includes an investigation of the circumstances surrounding the fall to</p>			

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F000441 SS=D	<p>determine the cause of the episode, a reassessment to identify possible contributing factors, interventions to reduce risk of repeat episode and a review by the IDT to evaluate thoroughness of the investigation and appropriateness of the interventions.</p> <p>3.1-45(a)(2)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p>			

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	<p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview, and record review, the facility staff failed to wear gloves when providing residents with blood glucose checks and insulin administration, and failed to disinfect a glucometer machine between residents, for 3 of 8 glucometer check observations and 6 insulin administration observations. (Resident #119, #122, and #121)</p> <p>Findings include</p> <p>On 7/16/14 at 4:04 p.m., RN #10 was observed administering 6 units of Novolg insulin subcutaneous to Resident #119. RN #10 was observed not to be wearing gloves.</p> <p>An interview with RN #10 on 7/16/14 at</p>	F000441	<p>F 441 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: LPN #11 and RN #10 were immediately coached / educated after this alleged deficient practice regarding the requirement of disinfecting the glucometer machine between each resident and the requirement of wearing gloves when checking blood glucose levels and administering insulin.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents requiring blood glucose monitoring and insulin administration have the potential to be affected by the same alleged deficient practice.</p>	08/22/2014

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	<p>4:58 p.m., indicated she was not sure of the facility policy related to glove use with blood glucose checks and insulin administration. She indicated she was in training and had not reviewed the policy and procedure. She indicated she was trained in nursing school to wear gloves with blood glucose checks and insulin administration. She indicated she had not worn gloves when she performed Resident #119's blood glucose check or when she administered her insulin.</p> <p>On 7/16/14 at 4:07 p.m., LPN #11 was observed providing Resident #122 with a blood glucose check and administering 8 units of Humalog subcutaneous. She was observed not wearing gloves. She was observed not washing her hands prior to or after either procedure. The glucometer machine used was not cleaned prior to or after his blood glucose check. The glucometer machine was placed back in a box in the medication cart after use.</p> <p>On 7/16/14 at 4:36 p.m., LPN #11 was observed providing Resident #121 with a blood glucose check using the same glucometer machine she had used on Resident #122. The glucometer machine used was not cleaned prior to or after his blood glucose check. The glucometer machine was placed back in a box in the medication cart. She provided Resident</p>		<p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Licensed Nurses on the following campus guideline: Standard Precautions and Glucometer cleaning guidelines. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for 5 staff members will be conducted by the DHS or designee 2 times per week times 4 weeks, then monthly times 5 months to ensure compliance: Observation of glucometer testing and cleaning per Glucometer Cleaning Guidelines. Observation of glove use protocols per Standard Precautions. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>	

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NAME OF PROVIDER OR SUPPLIER GLEN OAKS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 601 W CR 200 S NEW CASTLE, IN 47362
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>#121 with 12 units of Humalog insulin subcutaneous and was observed not wearing gloves.</p> <p>On 7/16/14 at 4:48 p.m., LPN #11 indicated she had not worn gloves with the blood glucose check or insulin administration with Resident #122. She indicated she had forgot to wear gloves when she administered Resident #121 his insulin. She indicated she thought the facility's policy was to wear gloves with blood glucose checks but didn't realize she needed to wear gloves with insulin administration, as long as she was washing her hands. She indicated she had used the same glucometer machine for Resident #122 and #121's blood glucose check. She indicated the glucometer machine did not belong to any particular resident. She indicated she knew she should have cleaned the glucometer machine with her disinfectant wipes between each resident.</p> <p>On 7/17/14 at 11:54 a.m., the Director of Health Services (DHS) indicated if a glucometer machine is used for more than 1 resident it should be cleaned between each resident. She indicated gloves should be worn if there were any risk the staff could come in contact with a resident's body fluids. She indicated gloves should be worn by staff when</p>			

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	<p>providing a resident with a blood glucose checks and administering insulin.</p> <p>The Standard/Universal Precautions Guidelines provided by the DHS on 1/17/14 at 12:58 p.m., indicated the following: "Purpose: To prevent the transmission of infectious organisms. Procedure: 1. Assume that every person is potentially infected or colonized with an organism that could be transmitted in the healthcare setting and apply the following infection control practices during the delivery of healthcare. Elements of Standard Precautions are to be followed by personnel at all times while in the role of healthcare giver or other department providing services in the campus. 2. Standard precautions focus on keeping ALL moist body substances from being touched by personnel's hands. Standard Precautions include: a. Blood. b. Feces. c. Urine. d. Wound drainage. e. Tissues. f. Oral secretions. g. Other body fluids (except sweat). 3. Gloves: a. Wear when hand contact is reasonably anticipated with resident's mucous membrane, non-intact skin, and/or body substances or items, surfaces by them... 4. Handwashing: a. Wash hands often and well, per handwashing policy. b. Wash hands before applying and after removal of gloves...."</p>			

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	<p>The Glucometer Cleaning Guidelines provided by the DHS on 7/17/14 at 12:58 p.m., indicated the following: "</p> <p>Introduction: The CDC states that HIV can survive for at least one week in dried blood on environmental surfaces or on contaminated instruments. The following recommendations provide the guidance for cleaning and decontamination of glucometers that may be contaminated with blood and body fluids.</p> <p>Recommendations: 1. If glucometers are used from one resident to another they should be cleaned and disinfected after each use...."</p> <p>3.1-18(l)</p>			