

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155539	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/30/2015
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NAME OF PROVIDER OR SUPPLIER BERTHA D GARTEN KETCHAM MEMORIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 601 E RACE ST ODON, IN 47562
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F 000 Bldg. 00	<p>This visit was for the Recertification and State Licensure survey.</p> <p>Survey Dates: April 26, 27, 28, 29 and 30th, 2015.</p> <p>Facility Number: 000300 Provide Number: 155539 AIM Number: 100287240</p> <p>Census bed type: SNF: 4 SNF/NF: 49 Total: 53</p> <p>Census payor type: Medicare: 9 Medicaid: 34 Other: 10 Total: 53</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 000	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective May 22, 2015 to the state findings of the Recertification and State Licensure survey conducted on April 26, 27, 28,29 and 30th, 2015.	
F 161 SS=D Bldg. 00	<p>483.10(c)(7) SURETY BOND - SECURITY OF PERSONAL FUNDS The facility must purchase a surety bond, or</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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	<p>otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility.</p> <p>Based on record review, and interview, the facility failed to ensure resident trust accounts were sufficiently insured, in that, the amount of coverage provided by the surety bond was less than the current amount of money in the resident trust accounts. This had the potential to affect 53 of 53 residents in the facility.</p> <p>Findings include:</p> <p>The facility surety bond was reviewed on 4/30/15 at 1:15 P.M. The amount of coverage provided on the Surety bond was \$10,000.00.</p> <p>The facility statement of resident trust accounts was reviewed on 4/30/15 at 1:30 P.M. The total balance for all resident trust accounts on 4/30/15 was 15,489.09 (5,489.09 over the covered amount).</p> <p>During an interview with the Business Office Manager on 4/30/15 at 1:45 P.M., she indicated the current surety bond for 10,000.00 was not enough to cover resident trust accounts for 15,489.09 and that the amount of the surety bond would be increased to 20,000.00 right away.</p>	F 161	<p>The corrective action taken for those residents found to have been affected by the deficient practice is that a \$20,000.00 security bond has been obtained by the facility to protect the personal funds of the residents deposited in their resident trust accounts. The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that a \$20,000.00 security bond has been obtained by the facility to protect the personal funds of the residents deposited in their resident trust accounts. The measures that have been put into place to ensure that the deficient practice does not recur is that the Business Office Manager has been instructed to check the balance of the resident trust accounts monthly to ensure that the current security bond adequately covers the amount in the resident trust account. The Business Office Manager has also been instructed that at any time the resident trust account exceeds the security bond that she is to obtain a new security bond to adequately cover the amount in the residents trust account. <i>The corrective action taken to monitor to ensure the deficient practice does not recur is that a Quality Assurance tool</i></p>	05/22/2015

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F 272 SS=D Bldg. 00	<p>3.1-6(j)</p> <p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Contenance; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications;</p>		has been developed and implemented to ensure that the facility security bond exceeds the amount of monies in the residents trust account. This tool shall be completed by the Administrator and/or her designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of these tools will be reviewed at the facility Quality Assurance meetings to determine if any additional action is warranted.	

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	<p>Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the comprehensive assessment was accurate, in that, the comprehensive assessment indicated a cognitively impaired resident who required staff assistance for toileting, did not require staff assistance for toileting for 1 of 3 residents who met the criteria for review of falls. (Resident #52)</p> <p>Findings include:</p> <p>On 4/26/15 at 3:45 P.M., Resident #52 was observed sitting in a wheelchair at the nursing station with a blue cast on the left wrist.</p> <p>The clinical record of Resident #52 was reviewed on 4/30/15 at 10:47 A.M. The record indicated the diagnoses of Resident #52 included, but were not limited to, dementia and debility.</p> <p>The most recent Annual MDS (Minimum Data Set) assessment dated 12/15/14</p>	F 272	<p>The corrective action taken for those residents found to have been affected by the deficient practice is that the resident identified as resident #52 has had a new assessment completed and is now receiving assistance with transfers and ambulation. <i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that a housewide audit has been completed of all comprehensive assessments to ensure their accuracy. All other assessments were found to accurately reflect the residents' current condition and needs, including level of assistance needed with transfers and ambulation. The measures that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service has been provided for all licensed nurses on the importance of accurate resident assessments. The in-service was focused on the needs of the cognitively impaired resident and the level of supervision needed to ensure their safety during transfers and</i></p>	05/22/2015

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	<p>indicated Resident #52 experienced moderate to severe cognitive impairment, was able to transfer independently to the toilet without oversight or assistance of staff, and was not at risk to experience falls.</p> <p>A Restorative program note dated 9/18/14 at 4:22 P.M. indicated, "...standby assist daily with 1 staff... [Name of Resident #52] is markedly confused...and up ad lib in room..."</p> <p>A Restorative Task List Report provided by RN #10 on 4/30/15 at 12:45 P.M. indicated Resident #52 was discharged from the restorative caseload on 9/22/14 and required standby assistance of one staff for ambulation.</p> <p>A Progress note dated 3/6/15 at 6:48 A.M. indicated, "...res heard to be yelling out from shower room 'im [sic] on the floor' apon [sic] inspection res found on floor in front of door. rom [range of motion] and prom performed with out difficulty except to L [left] wrist witch [sic] is reported to be painful with swelling occurring at this time..."</p> <p>A Resident/Visitor Incident Report dated 3/6/15 at 6:40 A.M., provided by the DON [Director of Nursing] on 4/28/15 at 10:00 A.M. indicated, Resident #52</p>		<p>ambulation. <i>The corrective action taken to monitor to ensure the deficient practice does not recur is that a Quality Assurance tool has been developed and implemented to monitor the accuracy of the comprehensive assessments related to the level of assistance needed for the cognitively impaired residents. This tool will be completed by the Director of Nursing and/or her designee weekly for four weeks, then monthly for three months, then quarterly for three quarters. The outcome of these tools will be reviewed at the facility Quality Assurance meetings to determine if any additional action is warranted.</i></p>	

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F 282 SS=D Bldg. 00	<p>experienced an unwitnessed fall while independently transferring to the toilet in the common shower room.</p> <p>An X-ray report dated 3/6/15 at 8:40 A.M. indicated, "...current history: left wrist pain, fall this am [A.M.] injuring [sic], swelling and bruising...Impression: Soft tissue swelling around the wrist and radius ulnar styloid fracture..."</p> <p>During an interview on 4/30/15 at 11:30 A.M., RN #10 indicated, Resident #52 should have been supervised during transfers.</p> <p>During an interview on 4/30/15 at 11:35 A.M., RN #11 indicated, the MDS of Resident #52 was incorrect related to fall history and assistance required.</p> <p>3.1-31(d)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to ensure, physician's orders were followed,</p>	F 282	The corrective action takenfor those residents found to have been affected by the deficient practice isthat the	05/22/2015

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	<p>in that, the clinical record lacked documentation that an immobilizer had been removed and skin assessed for impairment as ordered for 1 of 3 residents reviewed for pressure areas. (Resident #20)</p> <p>Findings Include:</p> <p>On 4/26/15 at 5:44 PM Resident #20 was observed in her room lying in bed in no apparent distress.</p> <p>The clinical record for Resident #20 was reviewed on 4/28/15 at 10:02 A.M. The diagnoses included, but were not limited to, bipolar disorder, abnormal posture, congestive heart failure.</p> <p>The admission nursing assessment dated 2/19/15 included: patient alert, unable to determine orientation, paralysis, hemiplegia/quadruplegia "don't walk", right leg normal color, temp and can bear weight. The assessment continued and included totally dependent for bed mobility, toileting and personal hygiene. Resident #20 was listed as utilizing a wheel chair.</p> <p>A Braden scale dated 2/19/15 indicated Resident #20 was at high risk for the development of pressure areas.</p>		<p>resident identified as resident #20 is now wearing the immobilizer only when up in the wheelchair. The resident's skin integrity is being checked by nursing each shift.</p> <p><i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that a housewide audit has been conducted on all residents to ensure that any resident with any type of brace, splint, immobilizer, casts, or Ted Hose, etc. is having skin checks completed each shift to ensure the integrity of their skin has not been compromised. The measures that have been put into place to ensure that the deficient practice does not recur is that the facility has adopted a policy that any resident with any type of medical device such as a brace, immobilizer, splint or Ted Hose, etc. will have the device removed each shift for skin checks to ensure that the integrity of the skin has not been compromised. Any resident with a cast will have the skin checked every shift as well. A mandatory in-service has been provided for all nursing staff on the new policy related to use of medical devices that could impair skin integrity. The corrective action taken to monitor to ensure the deficient practice does not recur is that a Quality Assurance tool has been developed and implemented to monitor residents</i></p>	

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	<p>An untimed emergency department discharge note dated 2/25/15, included but was not limited to "...keep immobilizer on at all time, may loosen the immobilizer to give skin care and to check for pressure ulcers at rt [right] thigh and rt leg...".</p> <p>A weekly wound sheet dated 3/11/15 included, but was not limited to, unstageable pressure area identified on right Achilles measuring 2 x 2.4 centimeters, white in color, no drainage or odor. The treatment applied was a foam bordered dressing. The area was healed on 4/1/15.</p> <p>A weekly wound sheet dated 3/30/15 included, stage 1 pressure ulcer measuring 6.2 by 1.2 cm was found on right lower leg, maroon in color, no odor or drainage present. The treatment applied was to skin prep area BID [twice a day] then reeval.</p> <p>A weekly wound sheet dated 3/25/15 included, but was not limited to, unstageable pressure ulcer to right lower leg, measuring 6.5 by 1.6, overall condition worsening, and dark necrotic tissue present in 10% of wound bed.</p> <p>The care plans were reviewed and included, but were not limited to, pain</p>		<p>with medical devices that could impair skin integrity to ensure that skin checks are being completed every shift to monitor skin integrity. This tool will be completed by the Director of Nursing and/or her designee weekly for four weeks, then monthly for three months, then quarterly for The corrective action taken for those residents found to have been affected by the deficient practice is that the resident identified as resident #20 is now wearing the immobilizer only when up in the wheelchair. The resident's skin integrity is being checked by nursing each shift. three quarters. The outcome of these tools will be reviewed at the facility Quality Assurance meetings to determine if any additional action is warranted.</p>	

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	<p>initiated on 2/23/15. The interventions included, keep knee immobilizer on right leg at all times may loosen the immobilizer to give skin care and check for pressure ulcers of right leg and right thigh initiated 2/25/15.</p> <p>A care plan for impaired skin related to a pressure ulcer on right lower leg initiated 3/20/15 included, loosen straps on immobilizer every 2 hours for 15 minutes.</p> <p>A basic metabolic panel dated 3/7/15 included total protein 6.2 (low) with reference range of 6.4-8.2 and Albumin 2.4 with a reference range of 3.0-4.0.</p> <p>The facility treatment administration records for February and March 2015 was reviewed and included, but was not limited to, 2/25/15 may loosen the immobilizer on right leg to give skin care and check for pressure ulcers of right leg and right thigh. Documentation was lacking that the immobilizer had been loosened to check for pressure ulcers of right leg and right thigh from 2/28/15 to 3/17/15.</p> <p>On 4/30/14 at 9:30 A.M., during an interview with the Director of Nursing (DON), she indicated, following placement of the immobilizer it was</p>			

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F 323 SS=G Bldg. 00	<p>ordered for the brace to be loosened and skin assessed at least twice a day however, she indicated documentation the order had been followed was lacking.</p> <p>On 4/20/15 at 1:30 P.M., Licensed Practical Nurse (LPN) #11 was observed doing a dressing change for Resident #20. The wound was observed to be 3 cm by 1.5 cm. The wound bed was 95% yellow slough with a scant amount of yellow drainage.</p> <p>On 4/30/15 at 3:30 P.M., the Director of Nursing provided a policy titled "Documentation of Medication Administration" It included, but was not limited to, "...2. Administration of medication & Treatments must be documented immediately after (never before) it is given... ".</p> <p>3.1-35(g)(2)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure</p>	F 323	The corrective action taken for those residents found to have	05/22/2015

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	<p>services were provided to prevent falls, in that, a cognitively impaired resident (Resident #52) and a cognitively impaired dependent resident (Resident #20) identified as being at risk to fall, were not provided assistance, supervision, and/or the proper use of equipment and experienced falls for 2 of 3 residents who met the criteria for review of falls. This deficient practice resulted in Resident #52 experiencing a left wrist fracture.</p> <p>Findings include:</p> <p>1. On 4/26/15 at 3:45 P.M., Resident #52 was observed sitting in a wheelchair at the nursing station with a blue cast on the left wrist.</p> <p>During an interview on 4/27/15 at 10:00 A.M., LPN #11 indicated Resident #52 experienced a left wrist fracture after a fall in March 2015.</p> <p>The clinical record of Resident #52 was reviewed on 4/30/15 at 10:47 A.M. The record indicated the diagnoses of Resident #52 included, but were not limited to, dementia and debility.</p> <p>The most recent Annual MDS (Minimum Data Set) assessment dated 12/15/14 indicated Resident #52 experienced</p>		<p>been affected by the deficient practice is that the resident identified as resident #52 has had a new fall risk assessment completed and the care plan has been revised to include new interventions including supervision, in an effort to prevent future falls.</p> <p>The corrective action taken for those residents found to have been affected by the deficient practice is that the resident identified as resident #20 has had a new fall risk assessment completed and the care plan has been revised to include two person assist for all transfers and repositioning of resident while in wheelchair in accordance with the wheelchair and Hoyer lift manufacturer guidelines.</p> <p><i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that a housewide audit has been completed on all residents related to fall risks. New fall risk assessments have been completed and care plans</i></p>	

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	<p>moderate to severe cognitive impairment, was able to transfer independently to the toilet without oversight or assistance of staff, and was not at risk to experience falls.</p> <p>The most recent Physician's Order Recap dated 3/2/15 included, but was not limited to, "...Up ad lib [at liberty]-staff assist [sic] as needed (res) [resident] will [sic] allow)..."</p> <p>A Care Plan for "Resident has severely impaired cognition" dated 11/26/14 indicated, "...offer choices within res ability..."</p> <p>A Care Plan for "At high risk for fall, balance issues..." dated 1/1/15 included, but was not limited to, interventions of, "...Light cord within reach, visible and resident informed of location and use...make sure resident is wearing non-slip footwear...remind resident to lock brakes prior to transfers..." The plan lacked any intervention related to supervision.</p> <p>A Fall Risk Assessment dated 12/21/14 indicated Resident #52 experienced disorientation to self, had a history of falls, and/or was at risk to experience falls.</p>		<p>up-dated as warranted based on the residents current safety needs.</p> <p>The measures that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service has been provided for all nursing staff. The in-service included a review on the proper completion of the fall risk assessment, the facility policy on following the manufacturer guidelines for equipment such as the Hoyer lift and specialty chairs with a focus on providing adequate assistance during transfers and ambulation.</p> <p><i>The corrective action taken to monitor to ensure the deficient practice does not recur is that a Quality Assurance tool has been developed and implemented to monitor resident transfers and ambulation to ensure that proper assistance, supervision and/or proper use of equipment is being followed</i></p>	

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	<p>A Physical Therapy Discharge Summary dated 1/20/14 indicated, "...Safety education, staff aware the pt [patient] needs assistance for all mobility tasks, proper gait technique with RW [rolling walker], transfer training...Prognosis to maintain CLOF [Current Level of Function]= Good with consistent staff follow-through...Transfers=SBA [Standby assist]..."</p> <p>An Occupational Therapy Discharge Summary dated 1/20/14 indicated Resident #52 required supervision during the toileting activity.</p> <p>A Therapy to Restorative Nursing Program Communication Form dated 1/20/14 indicated, "...SBA/CGA [Contact Guard Assist] all self care and transfers..."</p> <p>A Restorative program note dated 9/18/14 at 4:22 P.M. indicated, "...standby assist daily with 1 staff... [name of Resident #52] is markedly confused...and up ad lib in room..."</p> <p>A Restorative Task List Report provided by RN #10 on 4/30/15 at 12:45 P.M. indicated Resident #52 was discharged from the restorative caseload on 9/22/14 and required standby assistance of one staff for ambulation.</p>		<p>in accordance with the residents plan of care. The tool also monitors to ensure that the manufacturer guidelines are being followed in the use of equipment such as Hoyer lifts and specialty chairs. This tool will be completed by the Director of Nursing and/or her designee weekly for four weeks, then monthly for three months, then quarterly for three quarters. The outcome of these tools will be reviewed at the facility Quality Assurance meetings to determine if any additional action is warranted.</p>	

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	<p>A Progress note dated 3/6/15 at 6:48 A.M. indicated, "...res heard to be yelling out from shower room 'im [sic] on the floor' apon [sic] inspection res found on floor in front of door. rom [range of motion] and prom performed with out difficulty except to L [left] wrist witch [sic] is reported to be painful with swelling occurring at this time..."</p> <p>A Resident/Visitor Incident Report dated 3/6/15 at 6:40 A.M., provided by the DON [Director of Nursing] on 4/28/15 at 10:00 A.M. indicated, Resident #52 experienced an unwitnessed fall while independently transferring to the toilet in the common shower room.</p> <p>An X-ray report dated 3/6/15 at 8:40 A.M. indicated, "...current history: left wrist pain, fall this am [A.M.] injuring [sic], swelling and bruising...Impression: Soft tissue swelling around the wrist and radius ulnar styloid fracture..."</p> <p>During an interview on 4/28/15 at 9:00 A.M. the DON indicated, supervision had not been provided to Resident #52 at the time of the fall on the morning of 3/6/15.</p> <p>During an interview on 4/30/15 at 11:30 A.M. RN #10 indicated, Resident #52 should have been supervised during</p>			

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	<p>transfers.</p> <p>The Policy and Procedure for "Fall Prevention Program" provided by the DON on 4/30/15 at 2:00 P.M., lacked any interventions related to providing adequate supervision for a resident not identified as at high risk to experience a fall.</p> <p>2. On 4/28/15 at 10:02 A.M., Resident #20 was observed sitting in a high back wheelchair reclined with her legs extended in front of her on elevated leg rests. No complaints of discomfort or non verbal signs of pain were observed.</p> <p>On 4/28/15 at 10:10 A.M., Resident #20's clinical record was reviewed. Resident #20 had been admitted to the facility on 2/19/15. Her admission Minimum Data Set assessment (MDS) dated 2/26/15 indicated, a severely impaired cognition (rarely or never makes decisions), and was totally dependent and needed the assistance of 2 or more staff for bed mobility and transfers. Diagnoses included but were not limited to, bipolar 11 currently depression, history of seizures, and morbid obesity.</p> <p>A care plan dated 2/19/15 indicated a problem of, "...At risk for physical injury from falls related to: ... position in</p>			

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	<p>w/c/chair, Dementia..." Interventions included, the assistance of 2 staff for transfers, a mechanical lift for transfers, use of a low bed, and assistance needed for check and change/ toileting.</p> <p>A report entitled "Resident/Visitor Incident Report dated 2/24/15 was received and reviewed on 4/28/15 at 1:50 P.M. The report indicated the fall had been witnessed in the resident's room on 2/24/15 at 10:15 A.M. The report indicated the incident was "equipment failure." The report indicated, "...CNA positioning, Hoyer pad under legs. Chair fell over backwards on the push rail of the chair. [Zero] injuries noted..."</p> <p>A Late Entry Health Status Note dated 2/24/15 at 10:25 A.M., indicated, "Physical exam performed on bil [bilateral] arms have normal ROM [Range of Motion]. Eyes bright and PEARL [Pupils Equal And React to Light]. No knot or redness to back of head noted. No change in LOC [Level of Consciousness]. Pt [patient] slightly jumpy to touch. Bil [bilateral] feet and legs warm to touch no redness or swelling noted. No change in ROM to bil lower extremities noted. Will cont [continue] to monitor for any change."</p> <p>A Health Status Note dated 2/24/15 at</p>			

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	<p>12:32 P.M., indicated, "...Also notified him [physician] of Pt [patient] w/c [wheelchair] backwards and landing on the push bar. No injuries noted. PT [Physical Therapy] placed anti-tipper bars on the chair as soon as notified..."</p> <p>An Interdisciplinary Progress Note dated 2/25/15 at 11:00 A.M., indicated, "Review of accident 2/24/15, when resident's w/c [wheelchair] tipped over CNA was lifting resident's leg to position lift pad. Back of chair was reclined. When leg was lifted this caused chair to tip over backwards. Head didn't hit floor as the head rest was in place on w/c. Anti tippers were placed on wheelchair.</p> <p>An x-ray of the right femur dated 2/25/15 at 1:38 P.M., indicated, "...FINDINGS: Bones: There is a comminuted impacted laterally displaced fracture of the distal femoral metaphysis. Multiple tiny lucent lesions are present with distal femoral shaft..." "...IMPRESSION: 1. Distal femur fracture 2. Multiple tiny lucent lesions could represent heterogeneous bone demineralization, metastatic disease, or myeloma..." Resident #20's physician made a hand written note on the x-ray report which included but was not limited to, " pathological Fx. [fracture]..."</p> <p>On 4/29/15 at 10:15 A.M., during</p>			

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	<p>interview with Occupational Staff #1, she indicated Resident #20 on admission to the facility had been dependent on staff for all care and 2 staff members had been utilized for all care. Occupational Staff #1 indicated since admission Resident #20 had utilized a reclining high back wheelchair with elevated leg rests.</p> <p>The Director of Nursing (DON) was interviewed on 4/29/15 at 10:40 A.M., regarding Resident #20's fall on 4/24/15. The DON indicated on admission to the facility on 2/19/15, Resident #20 had been totally dependent for care. The DON indicated at the time of the fall Resident #20 had been reclined in her wheelchair. The DON was made aware of the lack of sufficient staff providing assistance with positioning when the fall had occurred, in that 1 CNA had been providing care.</p> <p>On 4/29/15 at 11:25 A.M., Physical Therapy Staff (PT) #1 was interviewed regarding PT services provided before the resident's fall on 4/24/15. PT Staff #1 indicated when therapy was initiated on 2/20/15, therapy services had addressed passive range of motion exercises and positioning in wheelchair and bed. PT Staff #1 indicated when therapy started on 2/20/15 and when the resident fell on 2/24/15, it was "preferable" to have 2</p>			

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	<p>staff to reposition Resident #20 due to her "pain and cognition."</p> <p>On 4/29/15 at 1:40 P.M., the Invacare manufactory's manual in regard to Resident #20's wheelchair (9000XT Recliner wheelchair) was reviewed. The manual included but was not limited to, "...To assure stability and proper operation of your wheelchair, you MUST maintain proper balance at all times. Your wheelchair has been designed to remain upright and stable during normal activities as long as you DO NOT move beyond the center of gravity. Virtually all activities which involve movement in the wheelchair have an effect on the center of gravity. Invacare recommends using seat/chest positioning straps for additional safety while involved in activities that shift your weight..."</p> <p>On 4/30/15 at 11:35 A.M., during interview with the DON, she was made aware of the fall risk related to the reclining wheelchair and the resident's position in regard to the above manufactory's manual information. The DON indicated at that time, nursing staff were being inserviced in regard to positioning of residents in high back wheelchairs. The DON indicated Resident #20 fall had occurred after the resident had just had a shower and had</p>			

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F 332 SS=D Bldg. 00	<p>been transferred by a mechanical lift. The DON indicated one CNA had been repositioning the resident's leg to adjust the lift pad when the fall (2/24/15) had occurred.</p> <p>3.1-45(a)(2)</p> <p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than 5%, in that, the facility had 3 medication errors out of 25 opportunities for error, resulting in a 12.0 % error rate. This affected 1 of 13 residents observed during the medication pass (Resident #6) and 1 of 5 nurses observed to pass medications. (LPN #10)</p> <p>Findings include:</p> <p>During an observation of a medication pass on 04/26/15 at 4:50 P.M., LPN #10 indicated she was preparing to administer medications through a g-tube (enteral tube), eye drops, and nasal spray for Resident #6. LPN #10 was observed to</p>	F 332	<p>The corrective action taken for those residents found to have been affected by the deficient practice is that the resident identified as resident #6 is now receiving her g-tube medications in accordance with facility policy. In addition the resident is receiving all of her medications including eye drops and nasal sprays in accordance with acceptable standards of medication administration practices.</p> <p><i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that all residents could potentially</i></p>	05/22/2015

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	<p>prepare the following medications for administration:</p> <p>Lactinex (a probiotic medication) given by g-tube</p> <p>Sucralfate (a gastro-intestinal medication) given by g-tube</p> <p>Colace 5 ml (a stool softener medication) given by g-tube</p> <p>Q-tussin 10 ml (a medication for cough and congestion) given by g-tube</p> <p>Zantac 10 ml (a medication to inhibit stomach acid production) given by g-tube</p> <p>Norco 5/325 (a narcotic pain medication) given by g-tube</p> <p>Refresh eye drops (a medication to relieve dry eyes)</p> <p>Saline mist (a medication to lubricate the nasal passage)</p> <p>LPN #10 was then observed to not flush the g-tube of Resident #6 with water before administering the above medications through the g-tube.</p> <p>On 4/26/15 at 4:55 P.M., LPN #10 was observed to administer one drop of</p>		<p>be affected by this deficient practice. The LPN identified as LPN # 10 has received one on one education related to the facility policy on g-tube medication administration along with education on the five R's of acceptable standards of medication administration practices.</p> <p>The measures that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service has been provided for all licensed nurses and QMAs on the facility's policy related to g-tube medication administration. The nurses and QMAs have also been instructed on the five R's of acceptable standards of medication administration practices.</p> <p><i>The corrective action taken to monitor to ensure the deficient practice does not recur is that a Quality Assurance tool has been developed and implemented to</i></p>	

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	<p>Refresh eye drops to the left eye and one drop to the right eye.</p> <p>On 4/26/15 at 5:00 P.M., LPN #10 was observed to administer two sprays of Saline Mist nasal spray to the right nares and one spray to the left nares.</p> <p>The clinical record of Resident #6 was reviewed on 4/28/15 at 5:15 P.M. The record indicated the diagnoses of Resident #6 included, but were not limited to, severe acute respiratory syndrome and conjunctivitis.</p> <p>The most recent Physician's Order Recap dated 4/9/15 included, but were not limited to, orders for, "...Flush g-tube with 60 cc [cubic centimeters] of H2O [water] before and after medications... Refresh Plus soln [solution] instill 2 drops into both eyes ... Saline Mist 0.65% nose sp [spray]...spray 1 spray into each nostril..."</p> <p>A Care Plan for "At risk for complications of gastric tube" dated 2/2/15 included, but was not limited to, interventions of, "...Administer medications as ordered..." and /or lacked any interventions related to flushing the g-tube before the administration of</p>		<p>monitormedication administration including the administration of g-tube medications toensure that acceptable standards of medication administration practices arebeing followed by all licensed nurses and QMAs. This tool will be completed bythe Director of Nursing and/or her designee weekly for four weeks, then monthlyfor three months, then quarterly for three quarters. The outcome of these tools will be reviewedat the facility Quality Assurance meetings to determine if any additionalaction is warranted.</p>	

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	<p>medication.</p> <p>The failure to flush the g-tube before administering medications and the failure to administer the ordered dose of Refresh eye drops and/or Saline mist nasal spray, resulted in 3 medication errors for that observation.</p> <p>The Policy and Procedure for medication administration by g-tube was requested to the DON (Director of Nursing) on 4/28/15 at 10:00 A.M. and was not provided.</p> <p>During an interview on 4/28/15 at 11:15 A.M., RN #10 indicated the g-tube of Resident #6 should have been flushed with 60 cc of water before medication was administered.</p> <p>The Policy and Procedure for Medication Administration-Eye Drop provided by UM (Unit Manager) #1 on 4/28/15 at 11:20 A.M. indicated, "...Purpose-To administer ophthalmic solutions...in a safe and accurate manner..."</p> <p>The Policy and Procedure for Medication Administration-Nasal Spray provided by UM (Unit Manager) #1 on 4/28/15 at 11:20 A.M. indicated, "...Purpose-To administer nasal medications in a safe and accurate manner..."</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	3.1-48(c)(1)				