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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155149 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 01/29/2015 |
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| NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION | STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260 |
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| F000000 | <p>This visit was for the Investigation of Complaint IN00163279.</p> <p>This visit was in conjunction with a Recertification and State Licensure Survey and the Investigation of Complaint IN00162422 completed on January 29, 2015.</p> <p>Complaint IN00163279-Substantiated. Federal/State deficiencies related to the allegations are cited at F-282, F-309, and F-323.</p> <p>Survey dates: January 21, 22, 23, 26, 27, 28 & 29, 2015</p> <p>Facility number: 000070 Provider number: 155149 AIM number: 100266190</p> <p>Survey team: Sandra Nolder, RN- TC Michelle Carter, RN Michelle Hosteter, RN Gloria Bond, RN (January 26, 27, 28 & 29, 2015) Tammy Alley, RN (January 21, 2015)</p> <p>Census bed type: SNF- 10 SNF/NF- 88</p> | F000000 | <p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p> <p>This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Survey Review on or after February 18, 2015.</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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| F000282 SS=E | <p>Total- 98</p> <p>Census payor type: Medicare- 15 Medicaid- 67 Other- 16 Total- 98</p> <p>Sample- 15</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review was completed by Tammy Alley RN on February 4, 2015.</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. Based on interviews, record reviews, and observations, the facility failed to ensure plans for care, nursing guidelines, and physicians orders were followed, appropriately, for 5 of 13 residents, in a sample of 13, reviewed for care plans. (Residents F, R, B, C, S)</p> <p>Findings include:</p> <p>1. The clinical record for Resident F was</p> | F000282 | <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> · Resident F no longer resides in this facility. · Resident R is receiving wound dressing changes, incontinence care and transfers | 02/18/2015 | | | |

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| | <p>reviewed on 1/26/15. Diagnoses for Resident F included, but were not limited to, frontal lobe dementia and insomnia.</p> <p>Reportable incident documentation submitted to the Indiana State Department of Health, Long Term Care Division, on 1/27/15 at 10:03 a.m., and nursing progress notes, dated 1/27/15 at 12:42 a.m., indicated Resident F eloped on 1/27/15, shortly after midnight. Using her body weight, Resident F broke through an exit door that led outdoors. The alarm sounded and Resident F was in the staff's sight the entire episode.</p> <p>"Immediate Action Taken" documentation indicated staff were able to take the resident back into the building and the resident was put on 1:1 (one on one supervision).</p> <p>IDT (Interdisciplinary Team) notes, dated 1/27/15 at 9:07 a.m., indicated Resident F was receiving 1:1 supervision. A discontinue time was not evidenced during documentation and physician orders reviews.</p> <p>Resident F was observed in her room, laying down in bed, with her eyes closed, during an observation at 12:15 p.m., on 1/28/15. Resident F was the only person in the room.</p> | | <p>per physician's order/ plan of care, is assessed, and is kept pain free as possible.</p> <ul style="list-style-type: none"> · Resident B is checked every 2 hours and receives routine incontinence care per care plan. · Resident C receives as needed pain medication with complaints of pain, scheduled pain medication, scheduled pain medication 30 minutes prior to dressing change, and now has a new order for a local anesthetic to use as needed during dressing changes. Care plan has been updated accordingly · Resident S has urinary output documented in ccs per facility policy. · LPN #4-No longer employed with facility. · CNA#1 and CNA#2 are no longer employed with this facility. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All residents who receive 1:1 supervision, wound dressing changes, routine incontinent care, hoyer lift transfers, and have suprapubic catheters have the potential to be affected by the | |

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| | <p>LPN #1 indicated, during an interview 12:15 p.m., on 1/28/15, Resident F was no longer under 1:1 supervision, so, there was not a staff member with her, in her room, to provide 1:1 supervision. The 1:1 was only for yesterday, 1/27/15.</p> <p>The Director of Nursing Services (DNS) indicated, during an interview on 1/28/15 at 12:21 p.m., she would have to check the orders, but was pretty sure Resident F should have 1:1 supervision, at that time. The DNS did not know why Resident F was unattended.</p> <p>During an interview with the Executive Director (ED), on 1/28/15 at 12:24 p.m., she indicated Resident F should have 1:1 supervision, at all times, and was unaware Resident F was left unattended.</p> <p>At 12:45 p.m., on 1/28/15, during an observation, CNA #7 arrived to provide 1:1 supervision for Resident F.</p> <p>The ED indicated, during an interview on 1/28/15 at 12:50 p.m., there was a communication error; apparently, there was an aide in the room with Resident F, earlier, and the aide took a break. Therefore, Resident F was left unattended, during the aide's break. The aide did not communicate with staff,</p> | | <p>alleged deficient practice.</p> <ul style="list-style-type: none"> Care Plans for all residents identified have been reviewed and updated if needed by the Interdisciplinary Team according to physician orders and facility policy for all residents who receive 1:1 supervision, wound dressing changes, routine incontinent care, hooyer lift transfers, and have suprapubic catheters. Staff will be in-serviced by Director of Nursing Services (DNS) or designee by February 18, 2015 on following residents care plans and resident profiles, 1:1 supervision procedure, Skin Management Program, Pain Management Policy, and Bladder Program. <p>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> Staff will be in-serviced by Director of Nursing Services (DNS)/designee by February 18, 2015 on following residents care plans and resident profiles, 1:1 supervision procedure, Skin Management Program, Pain Management Policy, and Bladder Program. | | |

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| | <p>appropriately.</p> <p>During an interview on 1/28/15 at 2:50 p.m., CNA #7 indicated she was the aide scheduled for 1:1 supervision with Resident F that day (1/28/15), and was with Resident F at 8:30 a.m. to 11:55 a.m., when she took a lunch break. The MCF (memory care facilitator) was supposed to relieve her (CNA #7) until she returned. CNA #7 indicated 1:1 supervision was to be provided, continuously, and did not know why Resident F was left unattended.</p> <p>Resident F was not provided 1:1 supervision, as expected, secondary to an elopement on 1/27/15, from 11:55 a.m. to 12:45 p.m., on 1/28/15.</p> <p>2. On 1/27/15 at 2:55 p.m., the record review for Resident R was completed. Diagnoses included, but were not limited to, multiple sclerosis, adult failure to thrive, pressure ulcer and chronic pain.</p> <p>The physician order dated 1/19/15, for Resident R's right gluteal wound indicated: discontinue Dakins to buttocks wound (2) Buttock wound sterile water cleanse, moisten fluffed gauze with Silvasorb gel (a gel that contains a antimicrobial medication to prevent infection to the wound) and loosely pack</p> | | <ul style="list-style-type: none"> Director of Nursing and/or designee will conduct rounds on all shifts to ensure care plans and physician orders are followed related to 1:1 supervision, wound dressing changes, pain management, routine incontinence care, and catheters are emptied each shift and documented in cc's. The Interdisciplinary Team will review all physicians orders, vital signs report, facility activity report in clinical meeting to ensure that services are provided according to physician orders and plan of care including: urine output of catheters are documented in ccs, resident complaints of pain are addressed, dressing changes are done per physician's order, and resident's are receiving 1:1 supervision Monday-Friday and Saturday and Sunday by the Weekend Supervisor. <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> Elopement Risk, Skin Management, Pain Management, Mechanical Lift, and Resident Care Rounds CQI tools will be completed weekly x 4 weeks, monthly x 6 months, and then quarterly for one year with results reported to the Continuous | |

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| | <p>wound swab periwound (around the wound) with skin prep (a skin barrier wipe to protect the skin). Cover with ABD (a type of wound dressing) and Medifix tape. Change daily and as needed if soiled or dislodged. This was the last wound order found in the chart.</p> <p>On 1/28/2015 10:52 a.m., LPN #4 removed the old undated and unmarked dressing. The dressing was a small square of adhesive with a pink color to outside and non adhesive bandage on the other side.</p> <p>On 1/28/15 at 1:00 p.m., the final dressing change was completed. LPN #4 used sterile water to clean the wound. She used Silvasorb soaked gauze, soaked with sterile water and fluffed the gauze and placed it into the wound. She used skin prep around the peri wound and covered the wound with a large white ABD pad, then secured the pad with a large piece of Medifix tape. She indicated at that time these were the current orders. The dressing she placed was different than the one removed earlier in the shift.</p> <p>The care plan dated 7/13/11, indicated the resident was at risk for pain related to chronic pain, knee pain, Gout (inflammatory condition of the joints),</p> | | <p>Quality Improvement Committee overseen by the Executive Director.</p> <p>If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.</p> | | | | |

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| | <p>H/O (history of) pain related to Multiple Sclerosis. Administer meds as ordered, assist/encourage to reposition frequently, document effectiveness of prn medications, notify MD if pain is unrelieved, worsening or having break thru pain as needed, observe for changes in day to activities, observe for changes in sleep pattern, observe for changes in sleep pattern. Observe for non verbal signs of pain, changes in breathing, vocalizations, mood/behavior changes, eyes change expression, sad/worried face, crying, teeth clenched, changes in posture, offer non pharmacological interventions such as quiet environment, rest, shower, back rub, reposition.</p> <p>On 1/27/15 at 2:00 p.m., CNA #1 and CNA #2 were observed transferring Resident R with a Hoyer lift from her Broda chair into her bed. The CNA's placed the Hoyer pad underneath the resident, transferred her and positioned her in bed. The resident had facial grimacing and a furrowed brow while the CNA's were transferring her. CNA #2 told the resident they were going to remove her pants and clean her up. CNA #1 and CNA #2 moved the resident to her left side and to the other while removing her pants. The resident yelled out as CNA #1 pulled on the left side of pants and CNA #2 pulled on the right side of</p> | | | |

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| | <p>the pants and pulled them down underneath of the resident's knees. Then CNA #1 and CNA #2 continued care by pulling off the resident's brief, unfastening it on the left side and pulled the brief down without taking the seam off of the right side. As they turned to reposition her on her right side the resident indicated "that hurts." She was yelling, had facial grimacing and her eyebrows were furrowed.</p> <p>On 1/28/15 at 11:20 a.m., LPN # 4 indicated during interview, the CNA's completing the transfer and care should have reported the complaints of pain to her. LPN # 4 indicated she had not been notified of the resident's complaints of pain.</p> <p>A document titled "Pain Management" dated 1/03, with revision dates of 12/03, 1/06, 1/08, 3/10 and 9/2013 was provided by the Assistant Director of Nursing on 1/29/15 at 11:15 a.m. The policy indicated, "...It is the responsibility of the facility to ensure that each resident is assessed for pain, and the efficacy of pain medication, while keep the resident as comfortable and pain free as possible...."</p> <p>3. Resident B's record was reviewed on 1/26/15 at 10:05 a.m. Diagnoses included, but were not limited to, acute</p> | | | |

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| | <p>cerebrovascular disease (stroke), hemiplegia (paralysis to half of the body), convulsions, and iron deficiency anemia.</p> <p>An IDT (Interdisciplinary Team) "Bladder Continence Review" dated 1/8/15, indicated the recent bladder assessment without a catheter was concluded on 1/12/15. The review indicated the resident was always incontinent (no episodes of continent voiding). She was not mentally and physically aware of the need to void and able to use a toilet, commode, urinal or bedpan. She was not appropriate for a scheduled toileting program. The review indicated routine incontinent care would be provided for the resident.</p> <p>Resident B had a Care Plan dated 7/13/11, which addressed the problem of incontinence due to a cerebrovascular accident and hemiplegia. The approaches included, but were not limited to, "8/14/14--toilet resident prior to activities...7/13/14--Assist with incontinent care as needed. Check every 2 hours for incontinence...."</p> <p>A continuous observation of Resident B occurred on 1/26/15 from 9:50 a.m., to 1/26/15 at 1:57 p.m.</p> <p>On 1/26/15 at 9:50 a.m., Resident B was</p> | | | |

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| | <p>sitting in her wheelchair, in the activity room. She had just finished doing an exercise activity.</p> <p>On 1/26/15 at 10:00 a.m., Resident B was transported to the main dining room and was left in front of the TV, to wait for the next activity to start.</p> <p>On 1/26/15 at 10:25 a.m., Resident B was taken to therapy by a therapist.</p> <p>On 1/26/15 at 11:00 a.m., Resident B was transported to the main dining room, by the therapist, to join the activity, which was already in progress.</p> <p>On 1/26/15 at 11:26 a.m., Resident B remained in the main dining room. The activity was finished. Resident B was sitting in her wheelchair with the TV playing.</p> <p>On 1/26/15 at 11:35 a.m., an activity person transported Resident B to the nurse on her hallway and told the resident's nurse she had requested a pain pill.</p> <p>On 1/26/15 at 11:39 a.m., Resident B received a pain pill by the nurse who was responsible for her care and she remained sitting in the hallway near the nurses cart. At that time, no staff member had asked</p> | | | |

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| | <p>Resident B if she needed to be checked, changed or use the toilet.</p> <p>On 1/26/15 at 11:47 a.m., The SSD (Social Service Director) transported Resident B to the main dining room.</p> <p>On 1/26/15 at 12:45 p.m., Resident B received her lunch tray and was eating.</p> <p>On 1/26/15 at 1:23 p.m., a therapist transported and returned Resident B to her room.</p> <p>On 1/26/15 at 1:25 p.m., LPN #4 and CNA #10 transferred the Resident B to bed with a mechanical lift.</p> <p>On 1/26/15 at 1:50 p.m., CNA #10 and CNA #12 provided pericare to Resident B and changed her brief. Resident B's brief was moderately saturated with yellow urine and had a concentrated urine odor.</p> <p>During an interview on 1/26/15 at 2:00 p.m., CNA #10 indicated that she had not worked on Resident B's unit for awhile, but, the last time she worked on the unit, the Resident B came and told the CNA's when she had to use the bathroom. She indicated the CNA's used the stand up lift to toilet the resident, but since she broke her leg she had to be placed on the toilet</p> | | | |

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| | <p>with the mechanical lift. CNA #10 indicated Resident B usually told the staff she had to be toileted, 2-3 times a shift. She indicated it had been over 2 hours since she had checked or changed the Resident B.</p> <p>On 1/27/15 5:35 p.m., the DNS (Director of Nursing Services) indicated she would have expected the CNA caring for Resident B to have checked, changed or toileted the resident every 2 hours.</p> <p>4. Resident C's record was reviewed on 1/27/15 at 10:51 a.m. Diagnoses included, but were not limited to, great toe amputation, dementia with behavioral disturbances, Alzheimer's disease, flaccid hemiplegia (paralysis on one half of the body), hypertension, chronic ischemic heart disease, cerebrovascular disease, and peripheral vascular disease (poor circulation to the lower extremities).</p> <p>Resident C had a Care Plan dated 6/25/13, that addressed the problem she was at risk for pain related to decreased mobility due to diagnosis of osteoporosis and wound. The approaches included, but were not limited to, "6/25/13-Administer meds as ordered...6/25/13--Document effective of prn medications, Notify MD if pain is unrelieved and/or worsening...6/25/13--Observe for non</p> | | | |

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| | <p>verbal signs of pain: changes in breathing, vocalizations, mood/behavior changes, eyes change expression, sad/worried face, crying, teeth clenched, changes in posture...."</p> <p>On 1/27/15 at 10:55 a.m., LPN #1 was observed changing Resident C's right, lower extremity (RLE) wound dressing. She placed the resident's RLE onto a clean incontinence pad on the edge of the bed. At that time, Resident C indicated to LPN #1 her RLE was tender. LPN #1 removed the old dressing by cutting it with a pair of scissors. The old 4 x4 gauze dressings were stuck to the edges of the Resident C's wound. Resident C said to the nurse, at that time, when she removed the dressings, "Ouch, that hurts!" The dressings were dried along the edges of the resident's wound. LPN #1 indicated to Resident C she was being as gentle as she could be and would be done in a minute. The resident had a furrowed brow and grimaced when she removed the dressings from the resident's RLE.</p> <p>LPN #1 irrigated the wound with normal saline. The resident indicated to LPN #1 the wound was tender and LPN #1 indicated, again, she was being as gentle as she could be. LPN #1 indicated, at that time, she had medicated the resident at</p> | | | |

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| | <p>10:00 a.m., with her routine Tramadol. The resident indicated the pain medicine helped a little bit, but her leg was still hurting.</p> <p>LPN #1 smeared the Santyl around in a circular motion four times, while crossing over the inside of the wound. The resident indicated at that time, the wound bed was hurting and LPN #1 indicated she was being as gentle as she could be and she was almost finished. Resident C was observed with furrowed brows and facial grimacing. LPN #1 using a sterile cotton tipped applicator, and applied a Hydrogel gauze dressing to Resident C's wound. The resident indicated at that time, her wound bed was hurting. LPN #1 indicated to Resident C, she was being as gentle as she could. Resident C was observed with facial grimacing and furrowed brows while LPN #1 was packing the wound with the Hydrogel gauze.</p> <p>Resident C indicated as LPN #1 was applying the Calazime to the edges of the wound and wrapping the RLE with the Kerlix gauze, her leg was hurting. LPN #1 indicated that she was just about done with the dressing change. Resident C was observed with facial grimacing and furrowed brows throughout these two steps of the dressing change. LPN #1 did</p> | | | |

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| | <p>not stop during the wound dressing change to medicate the resident with any as needed medication. After the dressing change was completed, while LPN #1 was disposing of trash, Resident C indicated to LPN #1 her RLE continued to hurt.</p> <p>During an interview on 1/27/15 at 11:29 a.m., LPN #1 indicated Resident C had not normally had that much pain during wound dressing changes. But, the old dressing was dried around the wound edges and it stuck to her wound when she tried to remove it. She indicated she normally would have stopped and medicated the resident having pain during a dressing change, then finished the dressing, but she had pre-medicated Resident C, so she thought she would be okay throughout the dressing change. LPN #1 indicated Resident C was having more pain during that dressing change than she normally had with the dressing changes.</p> <p>On 1/27/15 at 11:30 a.m., LPN #1 was observed asking Resident C at the nurses station if she was still having RLE pain and the resident indicated at that time she was having pain. At that time, LPN #1 medicated the resident with her as needed Acetaminophen pain medication.</p> | | | |

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| | <p>During an interview on 1/28/15 5:45 p.m., the DNS indicated LPN #1 should have stopped doing the dressing change, medicated the resident, waited for the medication to take effect, and then resumed with the dressing change.</p> <p>5. Resident S record was reviewed on 1/26/2015 at 11:25 a.m. Diagnoses included, but were not limited to, diabetes, history of frequent urinary tract infections and chronic use of a suprapubic urinary catheter.</p> <p>On 1/26/2015 at 11:35 a.m., the resident's urinary catheter bag was observed hanging down below the bed and being 3/4 full of dark yellow to amber colored urine.</p> <p>The resident's record indicated on 1/26/2015 at 11:57 p.m., the resident's fluids were equal to, "360mL [milliliter]" and the resident's urine was equal to "large."</p> <p>The resident's care plan indicated the resident required a suprapubic catheter and, "will have catheter care managed appropriately...."</p> <p>The facility's policy and procedure titled, "Bladder Program" and last dated 11/2014 indicated under residents with</p> | | | |

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| F000309 SS=G | <p>Foley catheters, "...Urinary output from Foley catheters will be documented in cc's [cubic centimeters]..."</p> <p>During an interview on 1/28/2015 at 1:15 p.m., LPN #5 indicated she did not know the facility's policy and procedure with urinary catheters and urinary output documentation.</p> <p>This Federal tag relates to Complaint IN00163279.</p> <p>3.1-35(g)(1)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, interview and record review, the facility failed to ensure a dressing change was completed without potential for infection for 1 of 2 residents observed for a dressing change (Resident C) and failed to ensure effective pain management was provided for 2 of 2 residents reviewed for pain management resulting in Resident C complaining of pain throughout and after a wound</p> | F000309 | <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> · Resident C has wound dressing change completed per "Dressing Change" policy without potential for infection. · Resident C has an effective | 02/18/2015 |

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| | <p>dressing change. (Resident C and R)</p> <p>Findings include:</p> <p>1. Resident C's record was reviewed on 1/27/15 at 10:51 a.m. Diagnoses included, but were not limited to, hypertension, chronic ischemic heart disease, and peripheral vascular disease (poor circulation to the lower extremities).</p> <p>The resident's recapitulation (recap) orders dated January 2015, included, but were not limited to, the following:</p> <p>6/13/13--Acetaminophen (a non-narcotic pain medication) 325 mg (milligrams) Take two tablets (650 mg) by mouth every six hours as needed for moderate pain</p> <p>12/9/14--Tramadol (a pain medication) 50 mg take one tablet by mouth twice daily as needed.</p> <p>12/10/14--Keflex (An antibiotic medication) 500 mg (milligrams) by mouth three times a day for 10 days for right lower extremity (RLE) wound.</p> <p>12/12/14--Tramadol 50 mg take one tablet by mouth three times a day.</p> <p>1/19/15--RLE wound--Cleanse the wound with normal saline (wound cleanser). Apply Santyl (an ointment medication that removes the dead tissue from the wound) to the wound bed. Top</p> | | <p>pain management plan in place and it is followed when wound care is provided.</p> <ul style="list-style-type: none"> · Resident R has been reviewed and has an effective pain management plan in place for when resident transfers per hoyer lift and during incontinence care · LPN #1-has been educated on the "Dressing Change" policy. · CNA#1 and CNA#2 are no longer employed with the facility. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All residents that receive wound dressing changes, are transferred per hoyer lift, require assistance with repositioning, and incontinence care have the potential to be affected by the alleged deficient practice. · All residents with wounds will be reviewed by Wound Nurse/Designee to ensure that an effective pain management plan is in place and care plan is updated accordingly. · Nursing staff will be in-serviced by February 18, 2015 by the DNS/designee on the Dressing Change (Incision or | |

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| | <p>the wound with hydrogel (a gel medication applied to the wound to aid in the prevention of the wound drying out) gauze. Apply Calazime (an ointment applied around the wound as a skin protector) to periwound. Cover the wound with an ABD (abdominal) pad and Kerlix (gauze wrapping). Change daily and as needed if soiled or dislodged.</p> <p>1/27/15--Hydrocodone/APAP (a narcotic pain medication) 5/325 mg one tablet by mouth 30 minutes prior to wound treatment daily for pain.</p> <p>An "Infection Control Individual Report" dated 12/10/14 at 10:52 a.m., indicated the resident had redness and swelling to the RLE. She was ordered Keflex 500 mg by mouth for 10 days on 12/10/14.</p> <p>A "Non-Pressure Wound Skin Evaluation Report" dated 1/20/15 at 2:00 p.m., indicated the resident had a full thickness wound to her RLE caused by trauma, which was not present on admission to the facility. The wound origination date was 12/9/14. The wound measured 7.5 cm (centimeters) x 5.5 cm x 0.3 cm. The wound bed color was 100% red granulation (the pink/red, moist tissue, which fills the open wound when it begins to heal). The wound had a small amount of serosanguineous (light red to</p> | | <p>Wound) Policy, Pain Management Programs, and appropriate mechanical lift transfers.</p> <ul style="list-style-type: none"> The IDT will review Facility Activity Report and progress notes daily and weekend supervisor on Saturday and Sunday to identify residents with complaints of pain when the wound is touched, when the wound is packed, when the dressing is removed, and for general pain during the dressing change to make sure that pain was assessed and addressed during wound dressing changes. The DNS/designee will audit medication administration records for corresponding administration of pain medication. DNS/designee will review as needed pain medication usage by reviewing the medication administration record and narcotic count record daily to contact physician for evaluation of routine use by February 18, 2015 All residents will be asked QIS questions regarding pain by Customer Care Representatives weekly. If pain is identified, physician will be notified, care plans updated, and followed as needed. <p>What measures will be put into place or what systemic changes you will make to</p> | |

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| | <p>pink, thin, watery and normal during the inflammatory stage of healing) drainage.</p> <p>A Wound Physician progress note dated 1/19/15, indicated "Chief Complaint: RLE hematoma... HPI (History Physical Information):... Duration: First noted 10/29/14... Integumentary:... Wound #1 Right, Anterior Lower Leg is a Full Thickness Trauma Wound and has received a status of Not Healed. Subsequent wound encounter measurements are 7.5cm length x 5.5cm width x 0.3cm depth... The patient reports a wound pain of level 3. The wound is deteriorating... Wound Orders: Wound #1 right, Anterior Lower Leg... Cleanse wound bed with NS [normal saline]. Pat dry. Apply skin prep or barrier cream to periwound. Santyl to wound bed followed by hydrogel moistened, fluffed gauze, then cover with dry gauze and secure daily and PRN [as needed], soiled-Cover with ABDS & Kerlix. Change daily & PRN... Ulcer of lower limbs, except pressure ulcer, Ulcer of calf--Deteriorated with slightly larger dimensions but no slough or odor today. change to Santyl for chemical maintenance [sic] debridement, hydrogel for moist wound healing & to decrease pain when dressing removed...."</p> <p>A Wound Physician progress note dated</p> | | <p>ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> Licensed Nurses will be in-serviced by February 18, 2015 by the DNS/designee on the Dressing Change Policy, Pain Management Policy, and Mechanical Lift policy. The IDT will review Facility Activity Report and progress notes daily and weekend supervisor on Saturday and Sunday to identify residents with complaints of pain when the wound is touched, when the wound is packed, when the dressing is removed, and for general pain during the dressing change to make sure that pain was assessed and addressed during wound dressing changes. The DNS/designee will audit medication administration records for corresponding administration of pain medication. DNS/designee will review as needed pain medication usage by reviewing the medication administration record and narcotic count record daily to contact physician for evaluation of routine use by February 18, 2015. All residents will be asked QIS questions regarding pain by Customer Care Representatives weekly. If pain is identified, physician will be notified, and care plans updated as | |

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| | <p>1/19/15, indicated "Chief Complaint: RLE hematoma [a blister filled with bloody drainage]... HPI (History Physical Information):... Duration: First noted 10/29/14...Integumentary:... Wound #1 Right, Anterior Lower Leg is a Full Thickness Trauma Wound and has received a status of Not Healed. Subsequent wound encounter measurements are 7.5cm length x 5.5cm width x 0.3cm depth...The patient reports a wound pain of level 3. The wound is deteriorating [getting worse]... Ulcer of lower limbs, except pressure ulcer, Ulcer of calf--Deteriorated with slightly larger dimensions but no slough or odor today...."</p> <p>A Physician progress note dated 1/12/15, indicated "...History of present illness:.. Resident has wound to RLE-recent I & D [Incision and Drainage]... Review of Systems:.. Symptom Management:.. Pain Location: RLE... Pain description: Intermittent Pain Triggers: Dressing changes Pain Treatments: Medications Pain Duration: Three weeks up to two months... Opioid Use for Pain: No...."</p> <p>Nursing progress notes reviewed for RLE wound dressing changes from 12/9/14 to 1/27/15, and the resident had 35 dressing changes completed. She complained of pain during the dressing changes at the</p> | | <p>appropriate.</p> <ul style="list-style-type: none"> · CNAs will be skills validated on mechanical lift transfers by February 18, 2015 by the Clinical Education Coordinator or designee · Licensed nurses will have Dressing Change skills validation completed by February 18, 2015 by the Clinical Education Coordinator or designee. · All residents with wounds will be reviewed by Wound Nurse/Designee to ensure that an effective pain management plan is in place and followed. Orders and Care Plans will be updated as needed. <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> · Skin Management Program CQI and Pain Management CQI tool will be completed weekly x 4 weeks, monthly x 6 months, and then quarterly for one year with results reported to the Continuous Quality Improvement Committee overseen by the Executive Director · If a threshold of 95% is not achieved, an action plan will be | |

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| | <p>following times these number of times: Whenever the wound area was touched- -1 time Packing of the wound--7 times Removal of the dressing--5 times General pain during the dressing change- -10 times</p> <p>The resident's MAR's (Medication Administration Records) were reviewed from 12/9/14 to 1/27/15, for pain medication administration. The resident's MAR dated December 2014, indicated the resident received as needed doses of pain medications these number of times: Tramadol 50 mg--5 times Acetaminophen-0 times</p> <p>The resident's MAR dated January 2015, indicated the resident received as needed doses of pain medications these number of times: Tramadol--0 times Acetaminophen--1 time, which was 1/27/15, after her wound dressing was changed.</p> <p>On 1/27/15 at 10:55 a.m., LPN #1 was observed changing Resident C's RLE wound dressing. She placed her clean supplies on a towel barrier on the resident's bed. She washed her hands. She placed the resident's RLE onto a</p> | | developed to ensure compliance | | | | |

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| | <p>clean incontinence pad edge of the bed. At that time, Resident C indicated to LPN #1 her RLE was tender. LPN #1 opened her dressing supplies on the clean towel barrier and got her supplies ready for the dressing change. She tore two pieces of tape and placed them on the resident's nightstand, then dated and initialed them. She got her empty trash bag ready on the nightstand and took a pair of scissors out of the plastic bag, which she had used to bring the dressing supplies down to the resident's room. She placed the pair of scissors on the clean towel barrier with the clean supplies without wiping them off. She donned clean gloves at that time.</p> <p>LPN #1 removed the old dressing by cutting it off with the pair of scissors then she laid the scissors back on the clean towel barrier field without cleaning the scissors. The old 4 x4 gauze dressings were lying on top of the wound and the dressings were stuck to the edges of the resident's wound due to being dried along the edges of the resident's wound. The resident indicated to the nurse at that time when she removed the dressings "Ouch, that hurts." LPN #1 indicated to the resident at that time she was being as gentle as she could be and she would be done in a minute. The resident had a furrowed brow and grimaced when LPN</p> | | | |

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| | <p>#1 removed the dressings from the resident's RLE. She threw the old dressing in the trash. The old 4 x 4 gauze pads covering the wound had a moderate amount of brownish red drainage on them. She irrigated the wound with normal saline in a syringe without changing her gloves. The resident indicated to LPN #1 at that time the wound was tender and LPN #1 indicated at that time to the resident, she was being as gentle as she could be. LPN #1 indicated at that time, she had medicated the resident at 10:00 a.m., with her routine Tramadol. The resident indicated at that time, the pain medicine helped a little bit, but her leg was still hurting. The wound was approximately the size of an orange. The wound bed was red with white slough along the lateral outside edge of the wound. LPN #1 removed her gloves and washed her hands, then donned clean gloves.</p> <p>LPN #1 applied Hydrogel onto one 4 x 4 gauze dressing, then laid it back on the open package. LPN #1 squeezed Santyl ointment into the middle of the wound, then used one sterile cotton tipped applicator and smeared it around the entire wound. She started in the middle where the glob of ointment was and continued to smear the Santyl around in a circular motion four times, while crossing</p> | | | |

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| | <p>over the inside of the wound. The resident indicated at that time, the wound bed was hurting and LPN #1 indicated at that time, she was being as gentle as she could be and she was almost finished with the dressing. The resident was observed with furrowed brows and facial grimacing during that time She pulled the 4 x 4 gauze smeared with Hydrogel gauze apart into a flat circle and used a sterile cotton tipped applicator and applied it to Resident C's wound. The resident indicated at that time, her wound bed was hurting. LPN #1 indicated at that time to the resident, she was being as gentle as she could. The resident was observed with facial grimacing and furrowed brows while LPN #1 was packing the wound with the Hydrogel gauze.</p> <p>LPN #1 applied Calazime ointment around the periwound with a sterile tipped applicator, then covered the wound with an ABD pad. She wrapped the Kerlix gauze around the ABD pad and secured it with tape. The resident indicated at that time, as the LPN #1 was applying the Calazime to the edges of the wound and wrapping the RLE with the Kerlix gauze that her leg was hurting. LPN #1 indicated that she was just about done with the dressing change. The resident was observed with facial</p> | | | |

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| | <p>grimacing and furrowed brows throughout these two steps of the dressing change. LPN #1 did not stop during the wound dressing change to medicate the resident with any as needed pain medication. She cleaned up her trash and removed her gloves. Resident C indicated to LPN #1 while she was cleaning her trash up after the dressing change that her RLE continued to hurt. She washed the pair of scissors with soap and water, then washed her hands.</p> <p>During an interview on 1/27/15 at 11:29 a.m., LPN #1 indicated she should have removed her gloves, then irrigated resident C's RLE with normal saline. She indicated she had cleansed her scissors with alcohol before she went into the room. She indicated she should have applied the Santyl by starting in the middle of the wound and worked her way out towards the outside of the wound. She indicated she should not have placed the pair of scissors on the clean towel barrier next to her clean supplies after she cut the old dressing off the resident's RLE. LPN #1 indicated the 4 x 4 gauze dressings that she removed from the wound should not have been laid on top of the resident's wound. She indicated the resident had not normally had that much pain when her wound dressing was changed, but the old dressing was dried</p> | | | |

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| | <p>around the wound edges and it stuck to her wound when she tried to remove it. LPN #1 indicated she normally would have stopped and medicated the resident having pain during a dressing change, then finished the dressing, but she had pre-medicated Resident C, so she thought she would be okay throughout the dressing change.</p> <p>On 1/27/15 at 11:30 a.m., LPN #1 was observed asking Resident C at the nurses station if she was still having RLE pain and the resident indicated at that time she was having pain. At that time, LPN #1 medicated the resident with her as needed Acetaminophen pain medication.</p> <p>During an interview on 1/28/15 at 1:15 p.m., the DNS (Director of Nursing Services) indicated LPN #1 should have removed her gloves and washed her hands after she removed the old dressing on 1/27/15, then cleansed Resident C's RLE wound. She indicated LPN #1 should have placed the pair of scissors on a dirty field, not the clean field after cutting the old dressing off her RLE wound. The DNS indicated LPN #1 should have applied the Santyl with a gauze from the inside of the wound to the outside of the wound and the Hydrogel gauze should have been fluffed when she applied it to the resident's RLE wound.</p> | | | |

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| | <p>During an interview on 1/28/15 at 5:45 p.m., the DNS indicated LPN #1 should have stopped doing the dressing change and medicated the resident, waited for the medication to take effect, then resumed with the dressing change.</p> <p>A current policy titled "Dressing Change (Incision or Wound)" dated 09/2012, provided by the DNS on 1/28/15 at 3:33 p.m., indicated "Procedure Steps:.. 6. Put on gloves. 7. Remove old dressing from residents and put directly in trash receptacle. 8. Remove gloves and discard. 9. Perform hand hygiene. 10. Put on gloves. 11. Initiate wound care according to the physician order:... a) cleanse away debris or drainage from the wound... 13. Remove gloves and discard. 14. Perform hand hygiene. 15. Put on gloves. 16. Apply new dressing according to the physician orders...."</p> <p>2. On 1/27/15 at 2:55 p.m., the record review for Resident R was completed. Diagnoses included, but were not limited to, multiple sclerosis, adult failure to thrive, pressure ulcer and chronic pain.</p> <p>The care plan dated 7/13/11, indicated the resident was at risk for pain related to chronic pain, knee pain, Gout (inflammatory condition of the joints),</p> | | | |

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| | <p>H/O (history of) pain related to Multiple Sclerosis. Administer meds as ordered, assist/encourage to reposition frequently, document effectiveness of prn (as needed) medications, notify MD if pain is unrelieved, worsening or having break thru pain as needed, observe for changes in day to activities, observe for changes in sleep pattern, observe for changes in sleep pattern. Observe for non verbal signs of pain, changes in breathing, vocalizations, mood/behavior changes, eyes change expression, sad/worried face, crying, teeth clenched, changes in posture, offer non pharmacological interventions such as quiet environment, rest, shower, back rub, reposition.</p> <p>On 1/27/15 at 2:00 p.m., CNA #1 and CNA # 2 were observed transferring Resident #47 with a Hoyer lift from her broda chair into her bed. The CNA's placed the Hoyer pad underneath the resident, transferred her and positioned her in bed. The resident had facial grimacing and a furrowed brow while the CNA's were transferring her. CNA #2 told the resident they were going to remove her pants and clean her up. CNA #1 and CNA #2 moved the resident to her left side and to the other while removing her pants. The resident yelled out at as CNA #1 pulled on the left side of pants, and CNA #2 pulled on the right side of</p> | | | |

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| | <p>the pants and pulled them down underneath of the resident's knees. Then CNA #1 and CNA #2 continued care by pulling off the resident's brief, unfastening it on the left side and pulling the brief down without taking the seam off of the right side. As they turned to reposition her on her right side the resident indicated "that hurts." She was yelling, had facial grimacing and her eyebrows were furrowed.</p> <p>On 1/28/15 at 11:20 a.m., LPN # 4 indicated during interview, the CNA's completing the transfer and care should have reported the complaints of pain to her. LPN # 4 indicated she had not been notified of the resident's complaints of pain</p> <p>A document titled "Pain Management" dated 1/03, with revision dates of 12/03, 1/06, 1/08, 3/10 and 9/2013 was provided by the Assistant Director of Nursing on 1/29/15 at 11:15 a.m. The policy indicated, "...It is the responsibility of the facility to ensure that each resident is assessed for pain, and the efficacy of pain medication, while keep the resident as comfortable and pain free as possible...."</p> <p>This Federal tag relates to complaint IN00163279.</p> | | | |

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| F000323 SS=D | <p>3.1-37(a)</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 interviews, record review and observations, the facility failed to ensure appropriate, accident preventative safety measures were in place for 2 of 13 residents, in a sample of 13, reviewed for accidents. (Resident F and B)</p> <p>Findings include:</p> <p>1. The clinical record for Resident F was reviewed on 1/26/15. Diagnoses included, but were not limited to, frontal lobe dementia and insomnia.</p> <p>Reportable incident documentation submitted to the Indiana State Department of Health, Long Term Care Division, on 1/27/15 at 10:03 a.m., and nursing progress notes, dated 1/27/15 at 12:42 a.m., indicated Resident F eloped on 1/27/15, shortly after midnight. Using her body weight, Resident F broke through an exit door that led outside. The alarm sounded and Resident F was in the staff's sight during the entire episode.</p> | F000323 | <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> · Resident F no longer resides in this facility · Resident B is transferred in hoist lift appropriately per policy and manufacturer's instructions. · CNA #1 and CNA #2 are no longer employed with the facility. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All residents that require 1:1 supervision and are transferred by a hoist lift have the potential to be affected by the alleged deficient practice. · CNAs will have Mechanical Lift skills validation observed by | 02/18/2015 |

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| | <p>Immediate action taken, documentation indicated staff were able to take the resident back into the building and the resident was put on 1:1 (one on one supervision).</p> <p>IDT (Interdisciplinary Team) notes, dated 1/27/15 at 9:07 a.m., indicated Resident F was receiving 1:1 supervision. A discontinue time was not evidenced during documentation and physician orders reviews.</p> <p>Resident F was observed in her room, laying down in bed, with her eyes closed, during an observation at 12:15 p.m., on 1/28/15. Resident F was the only person in the room.</p> <p>LPN #1 indicated during an interview at 12:15 p.m., on 1/28/15, Resident F was no longer under 1:1 supervision, so, there was not a staff member with her, in her room, to provide 1:1 supervision. The 1:1 was only for yesterday, 1/27/15.</p> <p>The Director of Nursing Services (DNS) indicated during an interview on 1/28/15 at 12:21 p.m., she would have to check the orders, but was pretty sure Resident F should have 1:1 supervision, at that time. The DNS did not know why Resident F was unattended.</p> | | <p>the Clinical Education Coordinator or designee by February 18, 2015.</p> <ul style="list-style-type: none"> · Staff will be in-serviced on Mechanical Lift Policy, Elopement Policy including following plan of care for continuous 1:1 supervision by the Director of Nursing Services or designee by February 18, 2015 <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> · Staff will be in-serviced on Mechanical Lift Policy, Elopement Policy including following plan of care for continuous 1:1 supervision by the Director of Nursing Services or designee by February 18, 2015 · Director of Nursing Services or designee will review all physicians orders and facility activity report daily to ensure that 1:1 resident supervision and mechanical lift transfers are added to the care plan and resident profile · Director of Nursing or designee to conduct rounds on all three shifts to ensure that continuous 1:1 supervision is being provided per plan of care and hoyer slings are applied properly during | |

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| | <p>During an interview with the Executive Director (ED) on 1/28/15 at 12:24 p.m., she indicated Resident F should have 1:1 supervision, at all times, and was unaware Resident F was left unattended.</p> <p>At 12:45 p.m., on 1/28/15, during an observation, CNA #7 arrived to provide 1:1 supervision for Resident F.</p> <p>The ED indicated during an interview on 1/28/15 at 12:50 p.m., there was a communication error. Apparently, there was an aide in the room with Resident F, earlier, and the aide took a break. Therefore, Resident F was left unattended, during the aide's break. The aide did not communicate with staff, appropriately.</p> <p>During an interview on 1/28/15 at 2:50 p.m., CNA #7 indicated she was the aide scheduled for 1:1 supervision with Resident F that day (1/28/15), and was with Resident F at 8:30 a.m. to 11:55 a.m., when she took a lunch break. The MCF (memory care facilitator) was supposed to relieve her (CNA #7) until she returned. CNA #7 indicated 1:1 supervision was to be provided, continuously, and did not know why Resident F was left unattended.</p> | | <p>transfers per manufacturer's instructions</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> ·Mechanical Lift and Elopement Risk CQI tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year. Data will be submitted to the CQI committee for follow up. ·If 95% a threshold is not achieved, an action plan will be developed | |

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| | <p>Resident F was not provided 1:1 supervision, as expected, secondary to an elopement on 1/27/15, from 11:55 a.m. to 12:45 p.m., on 1/28/15.</p> <p>2. Resident B's record was reviewed on 1/26/15 at 10:05 a.m. Diagnoses included, but were not limited to, acute cerebrovascular disease (stroke), hemiplegia (paralysis to one half of the body), convulsions, and iron deficiency anemia.</p> <p>The resident's recapitulation orders dated January 2015, included, but was not limited to, the following: 1/8/15--Hoyer lift for all transfers</p> <p>The Discharge Summary from the hospital dated 1/7/15, indicated she was admitted to the hospital on 1/3/15, after a fall at the facility and had a left femur fracture. She had an open reduction and internal fixation (repair of a fractured left femur) during her hospitalization and was readmitted back to the facility on 1/7/15.</p> <p>A "Fall Event" document dated 1/21/15 at 8:30 p.m., indicated the resident had a witnessed fall. She was sitting in her wheelchair, then being transferred to bed prior to the fall. The fall occurred in the resident's room. The resident was first observed sitting on the floor on her</p> | | | |

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| | <p>buttocks after the fall. She had clothing and non-skid socks in place. The resident did not have any injuries. Witnesses statement of the fall indicated, "2 cnas placing res [resident] to bed and as lifting res from chair res began to slip from Hoyer padding which prompted cnas to lower res to floor to prevent fall." The resident was incontinent at the time of the fall. Interventions put into place to prevent another fall was 15-minute checks and remove the mechanical lift for inspection by maintenance.</p> <p>An IDT (Intradisciplinary Team) progress note dated 1/22/15 at 9:54 a.m., indicated "Resident had witness fall on 01/21/15 evening shift. Root cause of fall identified as resident was transferring with two aids and resident began to slide from sling, two CNAs were able to cradle resident and lower her to the ground. There were no injuries during the fall... Immediate intervention was to remove Hoyer lift for maintenance to inspect for proper function. Housekeeping supervisor to inspect slings as well. IDT recommends for CNAs to be checked off by CEC [Clinical Education Coordinator] on proper lift transfers prior to working on the floor. CEC to inservice all staff on 1/27/15 on lift transfers. x-rays obtained to ensure no underlying fracture occurred..."</p> | | | |

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| | <p>During an interview on 1/27/15 at 5:35 p.m., the DNS (Director of Nursing Services) indicated the resident had an assisted fall due to the Hoyer lift pad was not crisscrossed when the CNA's were transferring her from the wheelchair to her bed and she slid out of the pad.</p> <p>This Federal tag relates to Complaint IN 00163279.</p> <p>3.1-45(2)</p> | | | | | | |