

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155736	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/29/2016
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NAME OF PROVIDER OR SUPPLIER MILL POND HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1014 MILL POND LN GREENCASTLE, IN 46135
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R 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00195922.</p> <p>Complaint IN00195922 - Substantiated. State Residential Rule is cited at R0036.</p> <p>Dates of survey: March 28 and 29, 2016</p> <p>Facility number: 004550 Provider number: 155736 AIM number: 200526450</p> <p>Census bed type: SNF: 17 SNF/NF: 35 Residential: 28 Total: 80</p> <p>Census payor type: Medicare: 11 Medicaid: 33 Other: 8 Total: 52</p> <p>Sample: 4</p> <p>This state finding is cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed 3/31/16 by 29479.</p>	R 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the deficiency cited during a Compliant Survey on March 29th, 2016. Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	

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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R 0036 Bldg. 00	<p>410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency</p> <p>(k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed:</p> <p>(1) a significant decline in the resident ' s physical, mental, or psychosocial status; or</p> <p>(2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment.</p> <p>Based on interview and record review the facility failed to adequately assess and identify changes in health condition following an unwitnessed fall and failed to immediately notify a resident's physician of a significant decline in mental status following a fall with a head injury resulting in a resident being admitted to the hospital with a condition incompatible with life for 1 of 3 residents reviewed for physician notification of decline in health status. (Resident E).</p> <p>Finding includes:</p> <p>Resident E's closed clinical record was reviewed on 3/28/16 at 10:23 a.m. A nurse's note dated 3/11/16 at 3:30 p.m. included, "Resident found on the floor by the foot of the bed. Resident tearful and anxious. Bruise on left temple. Bruise on temple is 4 cm [centimeters] X [by] 4 cm, raised and tender. Bruise on left side</p>	R 0036	<p>1. Resident E was affected. Resident E has been discharged from the campus.</p> <p>2. All residents have the potential to be affected. The DHS or designee will re-educate the nursing staff on guidelines for fall management neurological assessments, and physician and responsible party notification. This includes Fall Management Guidelines: The staff member attending to the resident at the time of the incident should notify the attending physician or medical director in the absence of the attending physician and the responsible party. Neurological checks will be completed per the Guidelines For Neurological Checks: Neurological checks should be initiated for a resident having an unwitnessed fall or fall known to have hit their head. Neurological checks should be continued per the physicians order or for 48 hours as follows: every 15 minutes for one</p>	04/26/2016

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	<p>of her body 6 cm X 8 cm. Bruise is on left lower back. Attempted to give tylenol."</p> <p>Nurses' notes on 3/11/16 at 4:50 p.m. documented, "Dr. [physician's name] paged." At 4:55 p.m., "order obtained for Ativan [anti-anxiety] 0.5 one time dose, Ativan order increased to 1-2 tabs [tablets] qid [four times daily] prn [as needed]. MD [medical doctor] ordered for a ua [urinalysis] to be obtained." The record did not indicate the physician had been made aware the resident was previously found on the floor and had a large bruise at the temple of her head.</p> <p>A nurse's note, identified as a late entry, dated 3/11/16 at 3:30 p.m., indicated the neuro checks and vital signs were assessed four times, then the resident refused additional assessments.</p> <p>The "Neurological Assessment Flow Sheet," provided by the Director of Health Services (DHS) on 3/28/16 at 3:00 p.m., indicated "normal range" assessments every 15 minutes from 3:30 p.m. - 4:30 p.m. on 3/11/16. The flow sheet indicated the resident refused assessments every 30 minutes and was combative from 4:45 p.m. - 6:15 p.m. on 3/11/16. The flow sheet indicated hourly checks from 7:15 p.m. - 10:15 p.m. were</p>		<p>hour, every hour for the next four hours, every four hours for the next 48 hours. Should neurological checks be initiated, this will be entered into the Matrix system. The Matrix system then will alert staff to complete the neurological checks per the guidelines. The staff will be instructed to notify the DHS or designee of all incidents and condition changes. A post fall change in condition tool (attached) will be completed after each fall that occurs to ensure immediate recognition and response to any changes.</p> <p>3. As a measure for ongoing compliance the nursing management team will review each incident/change in condition report including neurological checks in the clinical meeting daily on regularly scheduled days ongoing to ensure interventions are implemented, completed, documented, and communicated appropriately. Additionally the DHS or designee will audit three charts of residents with falls/change in condition weekly for 8 weeks, then three charts monthly ongoing to ensure appropriate interventions are in place. The ED or designee will review the post fall/change in condition tool daily for 5 days weekly for 8 weeks, then monthly ongoing.</p> <p>4. As a measure of quality assurance the DHS or designee will review any findings and subsequent corrective action in the campus</p>	

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	<p>not completed on 3/11/16 and indicated the resident was "sleeping." The record indicated the resident was out of the facility at 11:15 p.m. on 3/11/16. The record did not indicate the physician was notified of changes in the resident's behavior and level of consciousness.</p> <p>An ambulance "run sheet," dated 3/11/16, was reviewed on 3/28/16 at 12:00 p.m. The document indicated the ambulance was dispatched at 11:14 p.m. to the facility for the "chief complaint" of combativeness and indicated Resident E was to be transported to a geri-psychiatric unit. The run sheet indicated a "secondary complaint" of a fall where resident struck head 14 hours earlier. Description of the resident's condition included, but was not limited to, "...2. staff members advised Medic 1 that the pt [patient] has been sleeping a lot during the past several hours, but when she becomes awake, she is striking out at the staff members. The staff believed that the pt was not going to be able to be controlled and when they contacted the pt's PCP [primary care physician], he directed that the pt be transported to [health facility named] for further behavioral health work-up. When approaching the pt, attempts were made to gently arouse the patient. This was unsuccessful. It was noted immediately</p>		Quality Assurance meetings. The plan will be revised, as warranted.	

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	<p>that there was a prominent bruise on the pt's face located over the left temporal and left forehead area of her head/face. When the staff was asked how long the bruise had been present, they replied that the pt had fallen at least once the previous day and again once earlier today, at approximately 0900 hrs [hours] (Approximately 14 1/2 hrs earlier). They noted that as the day passed, the pt's behaviors became increasingly more erratic and was sleeping more during her episodes of belligerence. When asked about the appearance of the blood noted on the pt's lips and teeth, they could not offer an explanation as to how it got there or how long it had been there. When asked specifically if there had been any body movements that could associated [sic] with typical seizure activity, they could not state one way or the other. The pt does have a past hx [history] of dementia and Alzheimer's Disease, and has had previous treatment at the behavioral health unit at [name] Health Care." Documentation on the report included, but was not limited to, "Neurological Exam", Level of consciousness: Unresponsive. Loss of Consciousness: Yes. "Neuro Comments: Pt is unresponsive to verbal and tactile noxious stimuli....Pupils Left size 6 mm [millimeters], Right 3 mm. React: left: non-reactive, Right: Sluggish. An</p>			

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	<p>assessment of the motor skills for the extremities indicated the resident was comatose and flaccid...." The record indicated the resident was transported to the local hospital Emergency Department.</p> <p>A hospital report, dated 3/12/16, reviewed on 3/28/16 at 1:30 p.m., included, but was not limited to, "...EMS [emergency medical service] called for behavioral disturbance. Patient found to be obtunded and unresponsive. The patient was found unresponsive...."</p> <p>The hospital "Physical Exam" included but was not limited to: "...Vital Signs: 03/12/2016 00:05 BP [blood pressure] 228/145. HR [heart rate] 130...Appearance: (contusion to left parietal area of skull) (sic)...Neuro: Severely altered mental status: comatose. Eyes do not open. Best verbal response: none. Best motor response: decerebrate (suffering from the effects of loss of cerebral activity, such as thought, consciousness, sensation and the power of voluntary movement)...."</p> <p>A radiology report from an emergency room location, included, but was not limited to, "...No definite fracture is identified. Incidental inflammatory changes of the sinuses are noted. No</p>			

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	<p>obvious features of acute CVA [cerebral vascular accident] IMPRESSION; Large left-sided acute subdural hematoma with significant mass effect..."</p> <p>A "Course of Care" hospital note included, but was not limited to, "...Condition is incompatible with life. Family arriving. Plan is to medicate the patient into comfort and terminally wean." The Clinical Impression included, but was not limited to, "Cardiac arrest secondary to intracerebral (cortical and subcortical) hemorrhage...."</p> <p>Licensed Practical Nurse (LPN) #1 was interviewed on 3/29/16 at 1:15 p.m. The nurse indicated she contacted the resident's physician on 3/11/16 after the fall. She indicated she reported to the physician the resident had fallen and hit her head, but the main reason he was contacted was due to the resident's behaviors. She indicated the physician had not been made aware of the resident's refusal to have neuro checks and assessments done.</p> <p>The resident's physician was interviewed (by way of his nurse) on 3/29/16 at 3:20 p.m. The nurse indicated the physician recalled the staff had phoned him and had mentioned she had fallen and had been agitated. The nurse indicated the</p>			

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	<p>physician had indicated the same thing had happened a month previously. He did not remember the focus being on anything other than the agitation.</p> <p>The facility's policy titled "Guidelines for Neurological, Checks," most recent update of 11/2010, provided by the Campus Support RN on 3/29/16 at 11:45 a.m., included, but was not limited to, "Purpose: To evaluate the level of consciousness, evaluate pupil response, motor function, pain and vital signs that may alert staff for potential for head injury or seizure activity. PROCEDURE:</p> <ol style="list-style-type: none"> 1. Residents having an unwitnessed fall or fall known to have hit their head should be evaluated for injury. 2. The head of the resident should be examined for injury: hematomas, abrasions, lacerations, bleeding, etc. 3. If the resident has a change in consciousness neurological checks should be initiated to determine level of consciousness and neurological levels of responsiveness. Unwitnessed falls should have neuro-checks completed....18. Obtain vital signs with each assessment. 19. Neurological checks should be continued per the physician order or for 48 hours: 20. Every 15 minutes for one hour, 21. Every hour thereafter for four hours. 22. Every four hours times 48 hours. 23. Physician and responsible party 			

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	notification a. Notify physician after fall and evaluation has been completed for further orders for treating resident....c. Continue to notify the physician and responsible party if changes persist." This State Residential Rule finding relates to Complaint IN00195922.				