

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155319	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
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NAME OF PROVIDER OR SUPPLIER CLINTON GARDENS	STREET ADDRESS, CITY, STATE, ZIP CODE 375 S 11TH ST CLINTON, IN 47842
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F000000	<p>This visit was for the Investigation of Complaint IN00142840 and Complaint IN00143788.</p> <p>Complaint IN00142840 Substantiated. No deficiencies related to the allegation are cited.</p> <p>Complaint IN00143788 Substantiated. Federal/state deficiencies related to the allegations are cited at F157 and F323.</p> <p>Survey dates: February 13 & 14, 2014</p> <p>Facility number: 000212 Provider number: 155319 AIM number: 100285040</p> <p>Survey team: Joyce Hofmann, RN</p> <p>Census bed type: SNF/NF: 100 Total: 100</p> <p>Census payor type: Medicare: 23 Medicaid: 57 Other: 20 Total: 100</p>	F000000	Requesting paper review IDR to reduce severity for F-323.	
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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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F000157 SS=D	<p>Sample: 4</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p>			
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	<p>Based on an interview and record review, the facility failed to immediately inform a resident's physician, and family member of significant health changes and falls for 1 of 4 sampled residents reviewed for significant health changes/falls (Resident B).</p> <p>Findings include:</p> <p>Review of Resident B's closed clinical record, on 02/13/14 at 1:45 p.m., indicated the resident was admitted to the facility on 01/02/14 at 6:15 p.m. with diagnoses which included, but were not limited to, urinary tract infection, altered mental status, chronic obstructive pulmonary disease, transient cerebral ischemia, arthritis, venous thrombosis, pain, and Alzheimer's disease.</p> <p>Progress Notes, dated 01/03/14 at 6:20 p.m., indicated Resident B was found on the floor next to his bed. Resident B stated he slid out of bed. Progress Notes, approximately 8 hours later, dated 01/04/14 at 2:55 a.m., indicated the resident was found with large discoloration to left hip/lower back, left inner upper thigh, left back by shoulder. The resident stated he did not fall. Left</p>	F000157	<p>F 157 (S/S= D) Notify of Changes (Injury/Decline/Room, ETC)--- it is the policy of the facility that the resident, physician, and if known the resident's legal representative or an interested family member is notified of resident injury, decline, room change, etc. 1. Corrective action(s) which will be accomplished with those residents found to have been affected by the deficient practice: R8 no longer resides at this facility. 2. How the facility will identify the Residents having the potential to be affected by the deficient practice: All residents are at risk and have the potential to be affected. DNS/ Designee conducted a chart audit to ensure any Resident that experience a change in condition that the physician and family were notified. 3. The measures the facility will take or systems the facility will alter to assure that the problem will be corrected and not reoccur: Nursing staff have been re-educated by DON or nursing designee on Physician, Resident, POA, and family notification on 02/24/14. DNS/ Designee will audit medical records to ensure family and physician is notified when a change of condition occurs. 4. Quality assurance plans to monitor facilities performance to make sure that the corrections are achieved and are permanent: To ensure compliance, the DNS/Designee is responsible for the completion</p>	02/25/2014			

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	<p>arm and leg slightly weaker than right. The record lacked documentation to indicate these findings were reported to the physician or family.</p> <p>Progress Notes, dated 01/08/14 at 12:26 p.m., indicated, "IDT Note: On 1/7/14 at 6:30P, DNS (Director of Nursing Services) notified that resident fell on 1/4/14 on day shift. Upon investigation, CNA's stated that resident had unwitnessed fall. When CNA asked what had happened, resident's roommate stated that resident attempted to get out of w/c (wheelchair) and fell. CNA's stated that resident was assisted up x 2 staff to w/c with no c/o (complaint of) pain/discomfort noted. Family was made aware of fall later in shift. Physician was notified of fall on 1/8/14 during investigation. On 1/5/14, resident exhibited a decline in condition as evidenced by vital signs, nail beds blue, cool and clammy skin. Physician and family were notified of condition change and resident was sent to hospital for eval. DNS and 2 EMT's transferred resident x 2 assist pivot transfer to gurney which resident was able to do without difficulty. No s/s (signs/symptoms) pain/discomfort noted with transfer.</p>		<p>of the Change of Condition CQI tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. Dates when corrective action will be completed: 02/25/14</p>	

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	<p>Staff education provided regarding notification and charting r/t (related/to) falls, discipline given...."</p> <p>Review of a written statement by CNA #4, dated 01/04/14 at 9:00 a.m., indicated, "... the resident stood up out of his chair and tried to push his breakfast tray in the hall. His alarm was sounding, but was not heard by me because I was in the shower room with another resident. The statement indicated, "I also over heard the nurse [LPN #7] state to not start anymore paperwork on resident since he had fallen less than 24 hrs. (hours) ago."</p> <p>Review of a written statement by CNA #6, dated 01/04/14 at "around 9:00 AM," indicated, "... I overheard [LPN #7] telling [LPN #8] not to fill out the paperwork because they were still completing the forms from his previous fall....."</p> <p>There was no documentation in the clinical record to indicate the second fall had been immediately reported to the physician and investigated, and there was no new fall prevention interventions to prevent additional falls.</p> <p>Interview with the DON, on 02/13/14</p>						

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	<p>at 3:45 p.m., the DON indicated she was first made aware of the second fall on 01/07/14 at 6:30 p.m. when she got a phone call from the hospital telling her, the resident had 2 fractures of the pelvis, 3 fractured ribs, and sepsis. The DON indicated she started an investigation immediately and found the resident had fallen on 01/04/14 during day shift and the fall was not reported to the physician. The DON indicated the nurse assessed Resident B who denied pain and no injuries were found. The DON indicated the record lacked documentation to indicate the physician and/or family were notified of the second fall.</p> <p>Review of the facility's Fall Management Program, with last revised date of 09/2013, indicated, "POLICY It is the policy ... 2. If the resident experienced an injury from the fall, contact facility DNS/ED (Director of Nursing Services/Executive Director) per facility policy. 2. The physician will be contacted immediately, if there are injuries, and orders will be obtained. * If there are no injuries, notify the physician during normal business hours 3. The family will be notified immediately by the charge nurse of falls with injury. * If</p>			

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F000323 SS=G	<p>there are no injuries, notify the family during the day or evening hours (if a fall occurred during the middle of the night, wait until morning)...."</p> <p>This federal finding is related to Complaint IN00143788.</p> <p>3.1-5(a)(1) 3.1-5(a)(2)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to ensure a resident received adequate supervision and assistive devices to prevent bruising and fractures from falls for 1 of 4 sampled residents reviewed for falls (Resident B).</p> <p>Findings include:</p> <p>Resident B's closed clinical record was reviewed, on 02/13/14 at 1:45 p.m., and indicated the resident was admitted to the nursing facility on 01/02/14 at 6:15 p.m. Resident B's diagnoses included, but were not</p>	F000323	<p>Requesting paper IDR to reduce severity.F 323 (S/S= G) Free of Accidents Hazards/Supervision/Devices--- it is the policy of the facility that the resident environment remains is free of accident hazards as it is possible; and each resident received adequate supervision and assistance devices to prevent accidents: 1. Corrective action(s) which will be accomplished with those residents found to have been affected by the deficient practice:RB no longer resides at this facility. 2. How the facility will identify the Residents having the potential to be affected by the deficient practice: All</p>	02/25/2014

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	<p>limited to, urinary tract infection, altered mental status, venous thrombosis, transient cerebral ischemia, chronic obstructive pulmonary disease, peripheral vertigo, arthritis, pain, and Alzheimer's disease.</p> <p>Resident B's Admission assessment, dated 01/02/14, indicated the resident had not fallen in the last month, had not fallen in the last 2 to 6 months, and expressed no fear of falling.</p> <p>Resident B's Progress Notes, dated 01/03/14 at 6:20 p.m., indicated the resident was found on the floor next to his bed. Resident B had indicated he slid out of bed. The resident was assessed and found with not injuries except for older bruising to left inner thigh. A Progress Note, dated 01/03/14 at 7:20 p.m., indicated the family informed the nurse the resident had fallen at home prior to admission to the nursing facility. The resident's bed was moved against the wall and an alarm monitor was applied to the bed after the resident fell.</p> <p>Progress Notes, dated 01/04/14 at 2:55 a.m., indicated the resident was found with large discoloration to left</p>		<p>residents at risk for falls have the potential to be affected. DNS/ Designee conducted a chart audit to ensure of the Residents medical records that are at risk for falls to ensure all Residents fall interventions are in place. 3. The measures the facility will take or systems the facility will alter to assure that the problem will be corrected and not reoccur: Nursing staff have been re-educated by DON or nursing designee on the facility fall management policy and procedure which includes the implementation of individualized interventions, conducting thorough fall investigations to determine root cause and assuring all assistive devices and injury prevention devices are in place at all times at all times according to the individualized care plans, fall documentation requirements, ensuring that fall prevention interventions are working appropriately and applied correctly on 02/24/14. DNS/Designee will conduct rounds on each shift daily to ensure Resident fall interventions are in place per plan of care. 4. Quality assurance plans to monitor facilities performance to make sure that the corrections are achieved and are permanent: To ensure compliance, the DNS/Designee is responsible for the completion of the Fall Intervention CQI tool weekly times 4 weeks, bi-monthly</p>				

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	<p>hip/lower back, left inner upper thigh, left back by shoulder. The resident stated he did not fall. Left arm and leg slightly weaker than right.</p> <p>Progress Notes, dated 01/05/14 at 9:19 p.m., indicated Resident B was admitted to the hospital with sepsis.</p> <p>Interview with the Director of Nursing Services (DNS), on 02/13/14 at 3:45 p.m., indicated she got a phone call from the hospital telling her, the resident was admitted with to the hospital with 2 fractures of the pelvis, 3 fractured ribs, and sepsis. The DNS indicated she started an investigation immediately in efforts to determine the cause of the fractures. The DNS indicated she found the resident had fallen on 01/04/14 during day shift and the fall was not reported to the physician. The DNS indicated the nurse assessed Resident B who denied pain and no injuries were found. The DNS indicated there was no documentation in the clinical record regarding any other falls.</p> <p>Progress Notes, dated 01/08/14 at 12:26 p.m., indicated, "IDT Note: On 1/7/14 at 6:30P, DNS (Director of Nursing Services) notified that</p>		<p>times 2 months, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. Dates when corrective action will be completed: 02/25/14</p>				

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	<p>resident fell on 1/4/14 on day shift. Upon investigation, CNA's stated that resident had unwitnessed fall. When CNA asked what had happened, resident's roommate stated that resident attempted to get out of w/c (wheelchair) and fell. CNA's stated that resident was assisted up x (by) 2 staff to w/c with no c/o (complaint of) pain/discomfort noted. Family was made aware of fall later in shift. Physician was notified of fall on 1/8/14 during investigation. On 1/5/14, resident exhibited a decline in condition as evidenced by vital signs, nail beds blue, cool and clammy skin. Physician and family were notified of condition change and resident was sent to hospital for eval. DNS and 2 EMT's transferred resident x 2 assist pivot transfer to gurney which resident was able to do without difficulty. No s/s (signs/symptoms) pain/discomfort noted with transfer. Staff education provided regarding notification and charting r/t (related/to) falls, discipline given...."</p> <p>Review of a written statement by CNA #4, dated 01/04/14 at 9:00 a.m., indicated, "I was in the shower room, [name of Resident B's roommate] came and knocked on the door told me his roommate was</p>			

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	<p>on the floor. I immediately ran to see what happened. I saw [Resident B] on the floor in his doorway and called for the nurse. [CNA #5] came down to help along with [LPN #8], the nurse. We rolled him on his back and resident had no marks (sic) bruises or bleeding. Stated that he had to use the bathroom. So me and [CNA #5] picked him up and put him in his wheelchair and I took him to the bathroom. Resident remained in his wheelchair in Activity room until his daughter came and asked us to lay him down and was in bed until lunch and then layed (sic) back down after lunch until our shift ended." The statement indicated the resident stood up out of his chair and tried to push his breakfast tray in the hall. The statement indicated, "...His alarm was sounding, but was not heard by me because I was in the shower room with another resident...I also over heard the nurse [LPN #7] state to not start anymore paperwork on resident since he had fallen less than 24 hrs. (hours) ago."</p> <p>Review of a written statement by CNA #6, dated 01/04/14 at "around 9:00 AM," indicated, "... I overheard [LPN #7] telling [LPN #8] not to fill out the paperwork because they</p>						

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	<p>were still completing the forms from his previous fall....."</p> <p>Interview with LPN #3, on 02/13/14 at 11:15 p.m., indicated she did not know about the second fall, but noted the purple bruising on the upper shoulder, hip, and groin areas. LPN #3 indicated she was told Resident B was on neuro checks every hour.</p> <p>Interview with the DON and Administrator, on 02/14/14 at 9:20 a.m., indicated Resident B's alarm had sounded on the second fall, and the roommate had notified the CNA, who was in the spa area with another resident, that Resident B fell.</p> <p>Interview with Resident B's roommate, on 02/14/14 at 11:45 a.m., who had a BIM's score of "13", indicated Resident B was pushing his over the bed table out the door of their room, stumbled at the threshold of the room door, pushed the table out away from him, and fell rolling to right side.</p> <p>Interview with CNA #4, on 02/14/14 at 12:15 p.m., indicated Resident B's roommate came down the hall and called for help. CNA #4 indicated</p>						

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	<p>the resident's bed alarm was sounding, the resident was lying on his left side in the bedroom doorway with his head into the hallway. CNA #4 indicated she saw a bruise on his right side and on his lower back by his hip area.</p> <p>Review of the facility's Fall Management Program, with last revised date of 09/2013, indicated, "POLICY It is the policy ... to ensure residents residing within the facility will maintain maximum physical functioning through the establishment of physical, environmental, and psychosocial guidelines to prevent injury related to falls. ... A care plan will be developed at time of admission specific to each resident based upon the results of the fall risk assessment. ... Post Fall 1. Any resident experiencing a fall will be assessed immediately by the charge nurse for possible injuries and provide necessary treatment. * A neurological assessment will be initiated on all un-witnessed falls * A neurological assessment will be initiated on all residents hitting their head. 2. If the resident experienced an injury from the fall, contact facility DNS/ED (Director of Nursing Services/Executive Director) per</p>			

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	<p>facility policy. 2. The physician will be contacted immediately, if there are injuries, and orders will be obtained. * If there are no injuries, notify the physician during normal business hours 3. The family will be notified immediately by the charge nurse of falls with injury. * If there are no injuries, notify the family during the day or evening hours (if a fall occurred during the middle of the night, wait until morning) 4. A fall circumstance report will be initiated as soon as the resident has been assessed and cared for. * The report must be completed in full in order to identify possible root causes of the fall and provide immediate interventions. * An entry will be completed in the nurses' (sic) notes addressing the fall, any injuries, physician and family notification, and interventions initiated. 5. All falls will be discussed by the interdisciplinary team at the 1st IDT meeting after the fall to determine root cause and other possible interventions to prevent future falls. * The fall circumstance report will be reviewed by the team * A CQI form will be completed for necessary follow-up * The care plan will be reviewed and updated, as necessary."</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155319	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/14/2014
NAME OF PROVIDER OR SUPPLIER CLINTON GARDENS			STREET ADDRESS, CITY, STATE, ZIP CODE 375 S 11TH ST CLINTON, IN 47842		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>This federal finding is related to Complaint IN00143788.</p> <p>3.1-45(a)(2)</p>				