STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155290	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ELIZABETH HEALTHCARE CENTER	701 ARMORY RD DELPHI, IN 46923

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F000000	This visit was for the Investigation of Complaint #IN00157616. Complaint #IN00157616- Substantiated. State deficiencies related to the allegations are cited at F279 & F323. Survey dates: November 17 & 18, 2014 Facility number: 000187 Provider number: 155290 AIM number: 100267300 Survey team: Michelle Carter, RN Census bed type: SNF- 23 SNF/NF- 40 Total- 63 Census payor type: Medicare- 9 Medicaid- 30 Other- 24 Total- 63 Sample- 5 This deficiency reflects state findings cited in accordance with 410 IAC	F000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	16.2-3.1. Quality Review was completed by Tammy Alley RN on November 24, 2014.			
F000279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).			
	Based on record review and interview, the facility failed to ensure comprehensive care plans were revised to reflect the resident's needs and ensure interventions to prevent injuries were put into place. This deficient practice resulted in injury for 2 of 5 residents reviewed for care plan development and revision. (Residents B & E)	F000279	**Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice:** **Resident B careplan has been**	12/16/2014

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	Findings include: 1. The clinical record for Resident B was reviewed on 11/17/14 at 1:00 p.m. Diagnoses for Resident B included, but were not limited to, senile dementia, muscle weakness, osteoarthritis, macular degeneration, and a personal fall history. An ADL (Activities of Daily Living) care plan, dated 8/11/14, indicated the following: "I have had a general decline, weak and tired. ....At present I require assist with transfers. I am currently non-ambulatory. I rely on a wheelchair and staff for my locomotive needs." Nursing notes indicated the following: 9/29/14 nursing notes indicated, "Resident has a poor appetite, showing a decline in health. Res [resident] requires extensive assist of 2 with transfers, can bear weight with 2 persons but unstable. Leans to the left in her wheelchair and needs repositioned frequently. ...." Nursing notes indicated Resident B had a history, as well as a preference, of leaning forward while she was in a sitting position. 10/5/14 at 7:15 p.m., "Res [resident] tipped forward falling out of w/c		**reviewed and updated with current fall interventions.** **Resident E is discharged.** **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:** **Current residents have had their careplans reviewed to ensure fall interventions are in place.** **Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur:** **Nursing staff have been re-inserviced on fall prevention and interventions.** **DHS/designee will review three**	

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	[wheelchair] as CNA was pushing her down the hall. As smooth surface floor changed to carpet, the bump caused her feet to jerk the w/c forward throwing her out. She fell on her head. Several involuntary body movements with 2 episodes of vomiting...." 10/6/14 at 3:00 a.m. "[name of hospital] contacted facility. Informed writer Res has C1 cervical fracture ...." During an interview with the Assistant Director of Health Services (ADHS) on 11/17/14 at 1:20 p.m., she indicated prior to her fall on 10/5/14, Resident B used a standard wheelchair, without foot pedals, to get around. She moved her feet to propel herself. Care plans did not indicate this manner to which Resident B was transported. The Director of Health Services (DHS) indicated on 11/18/14 at 10:15 a.m., during an interview, she discussed the health decline of Resident B with family members on 9/29/14. Resident B was, increasingly, leaning forward while sitting. The discussion included the possibility of using a high back wheelchair with foot pedals to prevent an accident. The DHS indicated before staff put the new interventions/preventions in place, Resident B fell and fractured her		**times per week admission/readmission charts and any current falls to ensure fall interventions are in place and careplan updated.** **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** **ED/designee will review results of audits monthly in Quality Assurance for 6 months or until 100% compliance is achieved.**	

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	neck. Resident B was a known fall risk and facility staff did not act on their own recommendations, fast enough. She indicated the discussed fall prevention intervention was not added to Resident B's care plan. 2. The clinical record for Resident E was reviewed on 11/18/14 at 12:30 p.m. Diagnoses for Resident E included, but were not limited to, osteoarthritis, deconditioning/weight loss, atrial fibrillation, and anorexia. A care plan, facility review dated 5/20/14, indicated Resident E was at risk for a fall with injury. Prevention interventions included: - Provide/monitor the use of adaptive devices: walker, wheelchair. A Self-Care Deficit care plan, facility review dated 5/20/14, indicated Resident E required assistance with transfer, walking, locomotion, and toilet use, related to weakness. Interventions included: - Assess and record self-care status changes. Nurses notes, dated 9/1/14 at 5:50 a.m., indicated Resident E was found on the floor, at the foot of her bed. She stated she was "going after my walker so I can			

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	go to the bathroom." Resident E was not able to move her right hip and right leg and yelled out in pain when the nurse attempted to move her right leg for assessment. Nurses notes indicated her right foot was slightly rotated, outward. A fall circumstance report, dated 9/1/14, indicated Resident E was found on the floor in her room, secondary to a fall, at 5:50 a.m. She was attempting to transfer without the use of an assistive device. "Walker was out of reach." Additionally, nursing assessment and fall report documentation, dated 9/1/14, indicated "Resident was attempting to take herself to the bathroom without assistance and fell reaching for her walker." On 9/1/14 at 9:30 p.m., nurses notes indicated the hospital reported Resident E had a right hip fracture. During an interview on 11/18/14 at 3:30 p.m., the ADHS indicated at the time of Resident E's fall on 9/1/14, she was using her wheelchair for mobility. However, she had shown improvement during therapy sessions with the use of a walker. The wheelchair was at her bedside, but she preferred to use the walker, at that time.			

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	At 3:55 p.m. on 11/18/14, the ADHS indicated documentation did not indicate the wheelchair was at Resident E's bedside and documentation/care plans were not updated to reflect a walker preference. At 4:00 p.m. on 11/18/14, the DHS indicated the latter was true, during an interview. This Federal tag relates to Complaint #IN00157616. 3.1-35(b)(1)			
F000323 SS=G	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 record review and interview, the facility failed to ensure appropriate interventions were put in place to prevent a fall and a fall related injury for 2 of 5 residents reviewed for a fall related injury. Resident B had a fall that resulted in a Cervical fracture. (Residents B & E) Findings include: 1. The clinical record for Resident B was	F000323	**Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice:** **Resident B careplan has been reviewed and updated with current fall interventions.**	12/16/2014

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	able to move her right hip and right leg and yelled out in pain when the nurse attempted to move her right leg for assessment. Nurses notes indicated her right foot was slightly rotated, outward. A fall circumstance report, dated 9/1/14, indicated Resident E was found on the floor in her room, secondary to a fall, at 5:50 a.m. She was attempting to transfer without the use of an assistive device. "Walker was out of reach." Additionally, nursing assessment and fall report documentation, dated 9/1/14, indicated "Resident was attempting to take herself to the bathroom without assistance and fell reaching for her walker." On 9/1/14 at 9:30 p.m., nurses notes indicated the hospital reported Resident E had a right hip fracture. A care plan, facility review dated 5/20/14, indicated Resident E was at risk for a fall with injury. Prevention interventions included: - Provide/monitor the use of adaptive devices: walker, wheelchair. At 4:00 p.m., on 11/18/14, during an interview, the DHS and ADHS indicated staff failed to ensure Resident E's walker			

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	was within her reach. This Federal tag relates to Complaint #IN00157616. 3.1-45(a)(2)			