

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155688	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/12/2016
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NAME OF PROVIDER OR SUPPLIER  FREELANDVILLE COMMUNITY HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 310 W CARLISLE ST, PO BOX 288 FREELANDVILLE, IN 47535
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F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: February 8, 9, 10, 11, and 12, 2016.</p> <p>Facility number: 000355 Provider number: 155688 AIM number: 100273640</p> <p>Census bed type: SNF/NF: 27 Total: 27</p> <p>Census payor type: Medicare: 6 Medicaid: 16 Other: 5 Total: 27</p> <p>These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by #02748 on February 19, 2016.</p>	F 0000	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective March 13, 2016 to the annual licensure survey completed on 2-12-16.	
F 0323 SS=G Bldg. 00	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review the facility failed to ensure adequate supervision was provided to prevent falls for 2 of 3 resident reviewed for falls who had a high risk for falls. This resulted in Resident #16 experiencing a left hip fracture. (Resident #16, Resident #23)</p> <p>Findings include:</p> <p>1. On 2/8/16 at 11:20 A.M., Resident #16 was observed lying in a low bed with no distress noted. One side of Resident #16's bed was against the wall and the other side had a mat on the floor.</p> <p>On 2/11/16 at 12:25 P.M., Resident #16 was observed sitting in a Broda chair in the main dining room.</p> <p>On 2/8/16 at 12:13 P.M., Resident #16's clinical record was reviewed. Resident #16 had been admitted to facility on 5/19/14. Admission diagnoses included but were not limited to, fracture of other parts of pelvis, unspecified psychosis, and type 2 diabetes mellitus without complications. A 9/28/15 Significant Change Minimum Data Set assessment</p>	F 0323	<p><b>F323 It is the practice of this facility to assure that interventions are in place to assist with the prevention of falls. The correction action taken for those residents found to be affected by the deficient practice include:</b> Resident #16 has been reviewed and has a care plan in place related to implemented fall interventions to assist with the prevention of future falls including supervision. Resident #28 has been reviewed and a care plan is in place related to fall interventions including supervision. <b>Other residents that have the potential to be affected have been identified by:</b> All residents have been reviewed and those that have been identified as at risk for falls or who have had a fall in the past 3 months has been reviewed to assure that appropriate interventions are in place. <b>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</b> The nursing staff has been in-serviced related to providing services to our residents in a manner that promotes safety. Fall intervention implementation was included in the in-service to be provided in</p>	03/13/2016

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	<p>(MDS) indicated extensive assistance of 2 or more staff needed for bed mobility and walking in corridor with a total dependence of 2 or more staff needed for transfers. The MDS lacked a resident interview regarding mental status. A short and long term memory problem was noted with severe impaired cognition for decision making . A Quarterly MDS dated 12/16/15, indicated extensive assistance of 2 or more staff for bed mobility, transfers and walking in the corridor. The 12/16/15 Quarterly MDS indicated Resident #16 had a severely impaired cognition score of 3.</p> <p>His current care plan with latest revision on 2/2/16 indicated, Resident #16 was at a high risk for falls:"... triggers high risk for falls r/t [related to] hx [history of] multiple falls at home and fall with compression fx [fracture] to back, fx to pelvis while at home, weakness, decreased mobility, unsteady gait, poor safety awareness and confusion r/t poor cognition r/t Alzheimer's, Orthostatic Hypotension hx and hx spontaneous syncope and collapse at home, Seizure disorder. Hx of falls. Attempts to get up without assist at times..." Goal was no further injury and to accept assist with transfers. Interventions included but was not limited to, 15 minute checks initiated 9/14/15 and resolved on 11/12/15, body</p>		<p>accordance with the plan of care based on the resident's individual needs. In addition, the IDT team will review any resident who is identified as having a fall to assure that new interventions are implemented to assist with the prevention of future falls including increased supervision. There will be routine monitoring via rounds by Administrator, nursing administration, and nurses to assure that the environment is free from hazards, interventions are in place for fall prevention in accordance with the plan of care, and that level of direct supervision is appropriate based on the resident's individual needs. <b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b> In addition to routine rounds, a Performance Improvement Tool has been initiated that will be utilized to randomly review 5 residents who have had falls or are at high risk for falls to assure that appropriate interventions to assist with the prevention of falls has been implemented. This tool will review the resident to assure that proper supervision is in place. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, then quarterly x3 in the areas related to nursing. Any areas identified via the audit will be immediately corrected. The Quality Assurance Committee will review the tool at the scheduled</p>	

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	<p>pillow each side of bed initiated on 9/14/15, broda chair when up initiated on 9/28/15 and revision on 2/2/16, call light in reach initiated on 5/20/14 and revision on 10/14/14, check and change every hour during night hours- initiated on 9/14/15 and revision on 2/2/16, dysom to wheelchair initiated 5/26/15 and resolved on 11/3/15, lay down after all meals initiated on 1/22/16, low bed with padded mat beside bed initiated on 5/19/14, mattress with bolsters to bed every shift initiated on 10/6/15, sensor alarm to bed and chair initiated on 5/20/14 and canceled on 3/27/15, snap alarm seat belt while in wheelchair initiated on 3/9/15 and canceled on 9/3/15.</p> <p>Review of the clinical record on 2/11/16 at 9:11 A.M., indicated the following falls had occurred:</p> <p>1st fall-A progress note dated 3/8/15 at 9:30 P.M., indicated, " This nurse found resident sitting on floor in C-Hall hallway. It appears resident has fallen but resident denies remembering how got on the floor. Resident is A [Alert] &amp; O [Oriented] x 1 with confusion and forgetfulness which is normal for resident d/t [due to] impaired cognition. Upon assessment, neuro checks WNL [with-in normal limits]. Speech clear. Hand</p>		meeting following the completion of the tool with recommendations as needed based on the outcome of the tool. <b>The date the systemic changes will becompleted:</b> March 13, 2016				

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	<p>grasps strong and equal bilaterally. Pupil size 2 mm [millimeters] bilateral with brisk reaction. VS [vital signs]:B/p: 137/78, P [pulse] 88, R [respirations]: 20, T [temperature] 98.0, O 2 [oxygen] Sat [saturation]: 95 % RA [room air]. MAE [Moving All Extremities]. No bruising or swelling noted. No external rotation noted. Denies pain or discomfort. Resident stated, 'I am just fine.' Full ROM [range of motion] and was able to be assisted up and to bathroom by staff x 2. Family notified. Neurochecks and vital sign checks will continue."</p> <p>2nd fall- A progress note dated 5/20/15 at 7:15 P.M., indicated, " Resident slipped out of wheelchair onto floor while in the lobby watching television. No injuries noted. V/S [vital signs] 97.7-80-20-150/78. Interventions: 1) dysom mat to wheelchair at all times; buckle type seat belt to wheelchair at all times. Family, Dr. [physician's name], Administrator, and DON [Director of Nursing] notified."</p> <p>A progress note dated 5/21/15 at 5:30 A.M., indicated, "Nurse and CNA went to Resident's room to get Resident up for the day. Bruising noted to Resident's right eye. Bruising reported to family, Dr. [physician's name], Administrator, and DON [Director of Nursing].</p>			

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	<p>Resident apparently bruised eye when he slipped out of wheelchair on 5/20/15..."</p> <p>3rd fall- A progress note dated 9/14/15 at 6:18 A.M., indicated, "CNA [CNA's name] alerted this nurse to residents room. Upon entering room, this nurse observed res. [resident] sitting on floor on mat next to room mates [sic] foot of bed. Res is conscious, disoriented x 4, his normal before said incident. No bruises, bumps, swelling, or open areas observed. MAE [Moves All Extremities], no c/o [complaints] pain. Res [Resident] is incont [incontinent] of B/B [bowel and bladder], kept CD [clean and dry] per staff. Res had been checked 30 min [minutes] prior to incident. Assisted res to his feet, able to stand with assistance x 2, and transferred to W/C [wheelchair]. VS [Vital Signs] 128/72-88-20-97.7 O 2 [oxygen] sat [saturation] 95% on RA [Room Air]. Res was toileted, bathed, dressed, and brought to lobby by nurses station. 15 min [minute] checks started. MD [physician] and family notified of incident." Documentation was lacking resident was provided with supervision at time of fall.</p> <p>A progress note dated 9/14/15 at 9:00 A.M., indicated,"Reported to Dr. [physician's name] resident c/o</p>			

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	<p>[complaint] left leg pain, not bearing weight. New order received for x-ray left leg. Family notified."</p> <p>A progress note dated 9/15/15 at 10:35 A.M., indicated, "...Recent radiology report shows fracture to L [left ] femur..."</p> <p>4th fall- A progress note dated 9/28/15 at 11:30 A.M., indicated, "This person was coming down hall and her [sic] a noise and found resident out of wheelchair on right side with feet against pedals. V/S [Vital Signs] 136/70, 70, 18, 97.2 oxygen 96%. Noticed abrasion on right side of forehead, alert and oriented times one..." Documentation was lacking resident had been provided with supervision at time of fall.</p> <p>A progress note dated 9/28/15 at 2:25 P.M., indicated, " Follow up to resident occurrence. Upon investigation and interview with staff, resident was placed at nurses station in wheelchair to awaiting lunch. Resident fell out of w/c [wheelchair] onto floor causing abrasion to right forearm and slight redness to forehead..."</p> <p>5th fall- A progress note dated 1/22/16 at 9:05 A.M., indicated, "Heard noise in lobby from nurses station. Resident observed lying on L [left ] side on floor.</p>			

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	<p>Fall not witnessed by staff. [Resident name] alert and disoriented x 3 WNL [Within Normal Limits] for resident. Resident was reclined in broda chair, but appeared to have leaned forward and lost center of gravity and fell out of broda chair. Pink area to forehead with no bleeding observed..."</p> <p>Resident #16's clinical record in regard to falls was reviewed with the Director of Nursing (DON) on 2/11/16 at 1:35 P.M. The DON indicated since admission to the facility Resident #16 had needed assistance to ambulate. The DON indicated at the time of the first fall (3/8/15) Resident #16 utilized a sensor alarm to his wheelchair and bed. The DON indicated Resident #16 had been found sitting on the floor in C hall. The DON indicated he had fallen from his wheelchair and the immediate intervention had been to notify his physician who had ordered a Velcro alarm seat belt which the resident could not consistently remove.</p> <p>The DON indicated Resident #16 had slipped out of his wheelchair in the lobby while watching TV on 5/20/15 at 7:15 P.M. The DON indicated the intervention initiated had been to add a dycom mat to his wheelchair and an alarmed Velcro snap seatbelt which the</p>			

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	<p>resident could not consistently remove.</p> <p>The DON indicated the 3rd fall had occurred on 9/14/15 at 6:18 P.M., when the resident was found sitting on the floor next to his roommates's bed. She indicated Resident #16 stood post fall without pain but pain developed after breakfast and x-ray revealed a left hip fracture. Interventions implemented were 15 minute checks, body pillows, and check and change every hour during night (due to urinary incontinence noted). The DON indicated Resident #16 was already using a low bed with a mat. The DON also indicated Resident #16 returned to the facility on 9/21/15, after a partial hip replacement. The DON indicated on return the resident was on weight bearing as tolerated with walker, body pillows, and 15 minute checks had been resumed, low bed (no alarms), use of a wheelchair and was receiving therapy.</p> <p>The DON indicated the 4th fall had occurred on 9/28/15 at 11:30 A.M., when the resident had fallen out of his wheelchair and was found on his right side in the lobby. The DON indicated staff had just assisted Resident #16 up for lunch. The intervention implemented after the fall was to utilize a Broda chair.</p> <p>The DON indicated the next fall had</p>						

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	<p>occurred on 1/22/16 at 9:05 A.M., after breakfast, when Resident #16 was sitting slightly reclined in his Broda chair watching television in the lobby. Resident #16 had been found on the floor by staff. The intervention implemented had been to lay Resident #16 down after meals.</p> <p>On 2/12/16 at 10:36 A.M., during interview with the DON, she indicated Fall Risk Assessments were completed after a fall had occurred. The DON provided an admission Fall Risk Assessment (5/19/14 score of 20-High Risk )and a Fall Risk Assessment dated (2/14/15 score of 13- High Risk ) before the 3/8/15 fall. The DON also indicated at that time that a Post Fall Assessment was completed by nurses after residents had fallen. The Post Fall Assessment was completed each shift for 3 days following each fall. The DON was made aware the 3 Post Fall Assessments for the 9/14/15 fall indicated the fall had occurred on 9/14/15 (fracture date) at 4:50 A.M., not 6:18 A.M., as was documented in the progress notes. The Neurological Flow sheet initiated 9/14/15 (fracture date) first time was illegible and the next times documented were 5:15 A.M., 5:30 A.M., 5:45 A.M., 6:00 A.M., before the fall was documented as occurring on 6:18 A.M. on the 9/14/15</p>			

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	<p>progress note. The Fall Risk Assessment completed after the 9/14/15 fall was dated 9/14/15 and time completed was documented at 5:29 A.M. The DON indicated at that time she was unaware of a second fall occurring on 9/14/15 and could not explain the discrepancies in the documentation of the time of the fall at 4:50 A.M., and 6:18 A.M., on the 9/14/15 fall.</p> <p>On 2/12/16 at 11:21 A.M., the DON was made aware documentation was lacking of evidence that Resident #16 had received adequate supervision to prevent falls. The DON indicated at that time she understood the concern and would provide the facility fall policy.</p> <p>2. Resident #26 was observed in his/her room on 2/8/16 at 1:38 P.M. exiting the bathroom, walking across the room towards a personal chair. Resident #26 was observed, at that time, to have an unsteady gait and to not be using an assistive device.</p> <p>The clinical record of Resident #26 was reviewed on 2/12/16 at 2:00 P.M. The record indicated the diagnoses of Resident #26 included, but were not limited to, dementia.</p> <p>The Annual MDS (Minimum Data Set)</p>			

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	<p>assessment dated 8/26/15 indicated Resident #26 experienced severe cognitive impairment, had no history of falls, required the limited assist of two staff and a walker for transfers, toileting, and walking in the room. The assessment further indicated Resident #26 experienced unsteady balance during transitions and walking.</p> <p>The Quarterly MDS dated 11/18/15 indicated Resident #26 experienced severe cognitive impairment, had not experienced a fall since the previous assessment, required the limited assist of two staff and a walker for transfers, toileting, and walking in the room. The assessment further indicated Resident #26 experienced unsteady balance during transitions and walking.</p> <p>The February 2016 Physician's Order Recap included, but was not limited to, an order for, "up ad lib [at liberty] with roller walker"</p> <p>An IDT (Interdisciplinary Team) note dated 10/13/15 indicated Resident #26 experienced a fall and further indicated, "root cause analysis...fell in rm [room]...up with assist of 1, got dizzy and lost balance..."</p> <p>A Care Plan for ADL's [Activities of</p>			

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	<p>Daily Living] dated 10/14/15 indicated, "needs assist with ADL's r/t [related to] weakness, Dementia with confusion at x's [times]...I assist with transfers..."</p> <p>A PT [Physical Therapy] Evaluation &amp; Plan of Treatment dated 10/26/15 indicated "...Posture=kyphotic [excessive curvature of the upper spine]...Safety Awareness=impaired...frequently forgets to use assistive device for ambulation in room...the patient is at risk for falls..."</p> <p>A Care Plan for, "...high risk for falls..." dated 11/18/15 included interventions of, "call light in reach, instruct to utilize staff assistance when searching for things in room, keep path free of clutter, maintain bed in lowest position [sic], non skid foot wear to be worn, notify md [sic] [medical doctor] prn [as needed], provide adequate lighting"</p> <p>A Restorative Nursing Progress Note dated 12/21/15 indicated, "...while walking with restorative staff, VC's [verbal cues] provided to educate on safety awareness, proper RW [rolling walker]..."</p> <p>An IDT note dated 2/2/16 indicated, "Falls:...root cause analysis...socks-slipped-PT [Physical Therapy] will screen."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155688	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/12/2016
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NAME OF PROVIDER OR SUPPLIER  FREELANDVILLE COMMUNITY HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 310 W CARLISLE ST, PO BOX 288 FREELANDVILLE, IN 47535
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	<p>A Rehab screen dated 2/2/16 indicated, "...All transfers...mod [moderate] assist...gait...device-rolling walker...assist-mod independent...balance-good with rolling walker...safety- fair...will continue to be up ad lib at this time in the facility with her Rolling [sic] walker."</p> <p>A Fall Risk Assessment dated 2/2/16 at 12:45 P.M. indicated Resident #26 experienced a fall in the previous 3 months, had a balance problem while walking, and required the use of an assistive device.</p> <p>A Post-Fall Root Cause Analysis report dated 2/2/16 indicated Resident #26 experienced a fall with injury in the resident's room at 6:30 A.M. The report further indicated all care plan interventions were not followed..."Resident was wearing...house slippers [slick soled]...require assistance with toileting-No...last time...toileted-6:15 A [A.M.]...Conclusion: Resident was not wearing proper shoes...not using Rolling walker...New intervention...upon arising, resident is to wear proper shoes @ [at] all times..." The report contained a hand-drawn diagram of the scene at the time of incident discovery. The diagram</p>			

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NAME OF PROVIDER OR SUPPLIER  FREELANDVILLE COMMUNITY HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 310 W CARLISLE ST, PO BOX 288 FREELANDVILLE, IN 47535
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	<p>lacked any indication a walker was contained in the scene.</p> <p>A Nursing note dated 2/2/16 at 6:30 A.M. indicated, "...resident up in room in house slippers and not using walker messing with some stuff on top of bedside dresser when resident stated she lost her balance...noticed a knot on top of head, and red area on top of back..." The note lacked any documentation to indicate a new intervention to prevent falls was implemented.</p> <p>A Nursing note dated 2/2/16 at 1:53 P.M. indicated, "...found on floor by housekeeping sitting between closet and side table...resident was up ad lib in room going through...belongings when resident stated, 'I lost my balance'. Was noted resident was not using walker during ambulation. Resident then fell to floor and was found in a sitting position...noted 'bump' to top of right side of head. Small redness noted to upper back...resident wearing house slipper with slick soles. Removed slippers immediately wand [sic] was replaced with non-skid footwear...has history of not alerting staff for assist and not using walker. Staff alerts resident with constant reminders to use walker..."</p> <p>A Care Plan for Falls dated 2/2/16</p>			

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NAME OF PROVIDER OR SUPPLIER  FREELANDVILLE COMMUNITY HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 310 W CARLISLE ST, PO BOX 288 FREELANDVILLE, IN 47535
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	<p>indicated new interventions of, "Replace non skid footwear...up adlib [sic] with walker" were implemented.</p> <p>A Restorative Nursing note dated 2/3/16 at 3:27 P.M. indicated, "Resident is maintaining previous mobility level , walking over 600 feet daily with steady gait RW ad lib...no decline in functional/ADL limitations...hx [history of] preferring to walk on own without any assistive device. Responds well to verbal reminders to utilize RW and is compliant, but always insists that she is fine without it...continues to need reminders to utilize call light for staff assistance..."</p> <p>During an interview with on 2/12/16 at 11:15 A.M. the ADON (Assistant Director of Nursing) indicated no documentation could be provided to indicate a new effective intervention or supervision to prevent further falls was implemented.</p> <p>During an interview on 2/12/16 at 11:30 A.M., the DON (Director of Nursing) indicated the new, effective interventions should be implemented when a resident experiences a fall.</p> <p>The Policy and Procedure for Falls provided by the DON on 2/12/16 at 11:51</p>			

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NAME OF PROVIDER OR SUPPLIER  FREELANDVILLE COMMUNITY HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 310 W CARLISLE ST, PO BOX 288 FREELANDVILLE, IN 47535
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F 0502 SS=D Bldg. 00	<p>A.M. indicated, "...provide appropriate strategies and interventions directed to resident, environmental factors...implement fall prevention interventions and modify plan of care as necessary..."</p> <p>3.1-45(a)(2)</p> <p>483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. Based on observation, interview, and record review, the facility failed to ensure labs were obtained in a timely manner for 1 of 1 residents reviewed for following physicians orders. (Resident #6)</p> <p>Findings include:</p> <p>1. On 2/8/16 at 12:40 A.M., Resident #6 was observed sitting up in a wheel chair in her room. Resident #6 was asleep and in no apparent distress.</p> <p>The clinical record for Resident #6 was</p>	F 0502	<p><b>F502 It is the practice of this facility to always assure that lab orders are obtained in a timely manner. The correction action taken for those residents found to be affected by the deficient practice include:</b> Resident #6 is receiving labs drawn within an acceptable time frame based on the order. <b>Other residents that have the potential to be affected have been identified by:</b> Potentially all residents could be affected. The systems that are in place are meant to assure that all residents receive laboratory services as</p>	03/13/2016

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NAME OF PROVIDER OR SUPPLIER  FREELANDVILLE COMMUNITY HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 310 W CARLISLE ST, PO BOX 288 FREELANDVILLE, IN 47535		
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	<p>reviewed on 2/8/16 at 2:00 P.M., the diagnoses included, but were not limited to, epilepsy, traumatic brain injury, bi polar disorder and depression.</p> <p>The care plans dated 12/13/15 were provided and included but were not limited to, "[name of resident] has altered labs" the interventions included, but were not limited to "labs as ordered"</p> <p>A nursing note dated 1/23/16 at 2:41 P.M., "Reported to [name of Medical Doctor] that resident has been more tired than usual...New order for Dilantin level, CBC [complete blood count], and CMP [Complete metabolic panel]..."</p> <p>A nursing note dated 1/26/16 at 10:22 A.M., "Reported critical Dilantin lab to [name of MD]. No new orders at this."</p> <p>A physician's progress note dated 1/26/16 at 10:38 A.M., included, "Was called with lab results. Resident has been more sleepy lately. Dilantin level was checked and is critical at 22.4 (10-20 range) ....I asked them to hold hs [bedtime] dose x [times] 2 nights, but continue with the am dose ...Recheck Dilantin in 1 week..."</p> <p>The lab results for Resident #6 included, but were not limited to, "Date obtained 1/26/16 [3 days after ordered] ...Dilantin</p>		<p>ordered in a timely manner. <b>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</b> The facility has in-serviced nurses related to the obtaining of laboratory orders and assuring that the labs are drawn in a timely manner based on the specific order. If the resident has a change of condition, the facility will assure that the resident is evaluated timely including labs or transfer as necessary. <b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b> A Performance Improvement Tool has been initiated that randomly review 5 residents (if applicable) for the labs being drawn in accordance with the physician's order. The Director of nursing, or designee, will complete this tool weekly x3, monthlyx3, and quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on any negative outcome of the tools. <b>The date the systemic changes will be completed:</b> March 13, 2016</p>		

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	<p>level 22.4 ug/ml [micrograms per milliliter] HH [critical high] Ref Range 10.0-20.0 [ug/ml] ..."</p> <p>On 2/11/16 at 9:45 A.M., Resident was observed in bed with her father at bedside. Resident #6 was observed to be staring out into the room, Resident #6 was observed to have a small amount of food in her mouth. Resident #6's father indicated she was not swallowing today and he was unsure of what was wrong.</p> <p>During an interview with LPN #10 on 2/11/16 at 10:00 A.M., she indicated they had received an order to obtain labs on Resident #6 this morning due to her being sleepy. She indicated the lab had not arrived yet and she was unsure of what time they would come so she was attempting to reach the physician and see if they could send her out to be evaluated. At the time she indicated resident #6's vital signs were ok, and she was in no distress, just sleepy.</p> <p>The nurses notes were reviewed and indicated Resident # 6 was sent to the hospital on 2/11/16 at 12:59 P.M. During an interview with LPN #2 on 2/11/16 at 1:12 P.M. she indicated the ordered labs had not been obtained prior to Resident #6 going to the emergency room.</p>			

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	<p>The facility lab contract dated November 30, 2014 was reviewed and included, but was not limited to, "...[name of local hospital] and Facility will agree upon an acceptable schedule by which [name of hospital] routinely and regularly provides labs and services herein between the hours of 6 a.m. and 5 p.m. Monday through Friday. [name of hospital] will also provide reasonable emergency ancillary services to patients at Facility, based upon the urgency of the call...THE FACILITY ASSUMES RESPONSIBILITY FOR THE QUALITY AND TIMELINESS OF LABORATORY SERVICES [sic] ...The facility assists residents with transportation arrangements to and from the source of laboratory service, if the resident needs assistance..."</p> <p>A policy titled "LABORATORY AND RADIOLOGICAL TESTS" was provided by the facility on 2/11/16 at 3:00 P.M., the policy included, but was not limited to, "Purpose: To assure accurate and timely laboratory and radiological exams and comply with state and federal regulations ...All laboratory or radiological tests ordered by the physician will be scheduled with the appropriate department..."</p> <p>During an interview with the Director of</p>			

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	<p>Nursing on 2/12/16 at 11:00 A.M., she indicated Resident #6 had returned from the hospital and was currently doing a little better and more alert. She indicated the lab work had been ordered for Resident #6 on 1/23/16 a Saturday because Resident #6 was lethargic and not eating. She indicated those labs were not obtained until 1/26/16 the following Tuesday as it was the facilities next scheduled lab day. She indicated the lab services were only scheduled 2 days a week on Tuesdays and Thursday. She indicated if a resident needed a lab work done prior to this they would have to make arrangements for Resident to be sent to the hospital for lab work to be completed. She indicated at that time Resident # 6 had not been sent to the hospital to get the ordered lab work done. The DON further indicated on 1/26/16 Resident #6's labs were obtained an she experienced a critical high level of her Dilantin.</p> <p>3.1-49(a)</p>			
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