

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155202	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/02/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF GREENCASTLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135
---	--

(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
F000000	<p>This visit was for the Investigation of Complaint(s) IN00136878 &amp; IN00136880.</p> <p>Complaint IN00136878-Substantiated. Federal/State deficiencies related to the allegation(s) are cited at F280 and F323.</p> <p>Complaint IN0000136880-Substantiated. Federal/State deficiencies related to the allegation(s) are cited at F323.</p> <p>Survey date(s): October 1 &amp; 2, 2013</p> <p>Facility number: 000109 Provider number: 155202 AIM number: 100266290</p> <p>Survey team: Lora Brettnacher, RN-TC Jeanna King, RN (October 2, 2013)</p> <p>Census bed type: SNF/NF: 79 Total: 79</p> <p>Census payor type: Medicare: 10 Medicaid: 47</p>	F000000		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155202	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/02/2013
NAME OF PROVIDER OR SUPPLIER  WATERS OF GREENCASTLE THE			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135		
(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>Other: 22 Total: 79</p> <p>Sample: 3</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed by Brenda Marshall Nunan, RN.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155202		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/02/2013	
NAME OF PROVIDER OR SUPPLIER  WATERS OF GREENCASTLE THE				STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135			
(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			
F000280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on observation, interview, and record review, the facility failed to assess and revise a fall prevention care plan for interventions to prevent/reduce falls for 1 of 3 residents reviewed for fall care plans (Resident B).</p> <p>Findings include:</p> <p>Resident B's record was reviewed on 10/1/2013 at 1:30 P.M. Resident B had diagnoses which included, but were not limited to, aphasia (difficulty speaking), atrial fibrillation, and congestive heart failure. A re-admission Minimum Data Set</p>	F000280	<p>It is the intent of this facility to ensure to assess\revise a fall prevention care plan for interventions to prevent/reduce falls. 1. Action Taken</p> <p>a) Resident B no longer resides in facility. 2. Others Identified a) 100% medical record review has been completed on residents having falls in the past 3 months. The Care Plans of identified residents have been reviewed and updated as needed. 3. Systems in Place: 1) A Clinical Data Information (CQI) meeting has been implemented. This meeting will be attended by the Interdisciplinary Team (IDT) and will be held 5 times weekly. Any resident identified as having a fall</p>	10/18/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155202	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/02/2013
NAME OF PROVIDER OR SUPPLIER  WATERS OF GREENCASTLE THE			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135		
(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>Assessment Tool (MDS) dated 9/26/2013, indicated the following: 1) Resident B had been re-admitted to the facility from an acute hospital 2) She was unable to complete the Brief Interview for Mental Status (BIMS). 3) She had modified independence with cognitive skills for daily decision making. 4) She required limited physical assistance of one person for bed mobility, transfers, ambulation to walk in her room, with dressing, toilet use, and with personal hygiene. 5) Her balance was not steady but she was able to stabilize without staff assistance. 6) She had two or more falls with injury since her last assessment.</p> <p>On 10/1/2013 at 1:05 P.M., Resident B was observed sitting on the side of her bed. A large bruised raised area was observed on the left side of her forehead. She had no socks on her feet. A bed alarm was attached to her bed and to her recliner. When resident B was queried regarding what happened to her head she mumbled several words that could not be understood. She pointed to the bathroom and stated, "fall."</p> <p>During an interview on 10/1/2013 at 1:08 P.M., Qualified Nursing Aide (QMA) #1 indicated Resident B fell.</p>		<p>will be reviewed by the IDT to ensure Care Plans are in place and updated with appropriate interventions. 2) Nursing staff and IDT will be re-educated on Care Planning process to include updating Care Plans in a timely manner. 4. Monitoring: 1) The Administrator will audit 100% of fall Care Plans x 30 days, 10% of fall Care Plans weekly x 60 days, 10% of fall Care Plans monthly for 90 days and as needed thereafter. Audit will include but not limited to updating in a timely manner and appropriate interventions. Any identified non-compliance will be immediately addressed and result in 1:1 re-education with progressive discipline up to and including termination. 2) Results of audits will be forwarded to the Quality Assurance Committee (QA) monthly for review for the first 90 days and quarterly thereafter and recommendations as deemed appropriate.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155202	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/02/2013
NAME OF PROVIDER OR SUPPLIER  WATERS OF GREENCASTLE THE			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135		
(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>QMA #1 indicated alarms were used on her bed and her chair. QMA #1 checked the bed alarm and indicated it worked but it was not turned on. QMA #1 indicated she was not aware of Resident B having a history of turning off the alarms.</p> <p>During an interview on 10/2/2013 at 10:15 A.M., the MDS/Care plan coordinator indicated care plans were updated quarterly or when scheduled, if physician orders indicated a change, or by word of mouth. The MDS/Care plan coordinator stated, "Every time a resident falls [DON named] adds an intervention. The MDS/Care plan coordinator indicated she reviewed the care plans and updated them except in regards to falls.</p> <p>During an interview on 10/2/2013 at 10:40 A.M., the DON (Director of Nursing) indicated she was aware Resident B turned off her personal alarms. The DON indicated the alarms did not prevent falls but when the alarms went off it warned the staff Resident B had attempted to get up without assistance and gave them time to get to her before she fell. The DON indicated staff were to check to see if the alarms were functioning during care however, they did not</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155202	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/02/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF GREENCASTLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135
---	--

(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>document the alarms were checked. The DON indicated her staff were aware Resident B turned the alarms off and knew to check to make sure they were turned on during care. The DON indicated they were informed of this via verbal communication but they did not have a system in place to document the alarms had been checked. The DON stated, "The alarm has never been a good intervention for her because she can remove it or shut it off." The DON indicated Resident B was independent with ambulation in her room.</p> <p>During an interview on 10/2/2013 at 11:25 A.M., the DON indicated since Resident B had returned to the facility in February 2013, she had fallen ten times. The DON indicated she had fallen three times in September 2013, and two of the falls occurred on September 15, 2013. The DON indicated Resident B fell in the evening on September 15, 2013 and was sent to the hospital to be evaluated due to her anticoagulant therapy which increased her risk for bleeding. The DON indicated Resident B fell again the same evening and was sent back to the hospital, at which time, she was admitted and given a blood</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155202	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/02/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF GREENCASTLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135
---	--

(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>transfusion due to a low hemoglobin level. The DON indicated the care plan was not evaluated for efficacy of current interventions and/or revisions were not made to the plan to reduce/prevent Resident B from falling when she returned to the facility.</p> <p>During an interview on 10/2/2013 at 12:00 P.M., the DON was queried regarding the effectiveness of current interventions implemented to decrease injury related falls. The DON indicated after Resident B fell on 5/23/2013, the intervention of pressure alarms was added to her care plan and implemented. The DON indicated the pressure alarms irritated Resident B and because Resident B was able to ambulate independently in her room the pressure alarm was removed from her bed. The DON indicated Resident B's care plan had not been updated to reflect this change. The DON indicated Resident B currently had personal alarms, not pressure alarms, and they were not effective for Resident B because she was able to turn them off and because she was independent with ambulation in her room. The DON indicated Resident B was a high risk for falls however, Resident B's previous fall</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155202	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/02/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF GREENCASTLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135
---	--

(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>prevention interventions were not reviewed for effectiveness and/or new interventions were not implemented after her fall on 9/8/2013, or her falls with injuries on 9/15/2013.</p> <p>A care plan revision data report, identified as current by the MDS/Care plan coordinator, was reviewed on 10/2/2013 at 10:30 A.M. This report indicated Resident B's fall care plan was last evaluated on 8/13/2013, at which time a fall prevention intervention of "keep phone base close to bed" was added. The record lacked documentation which indicated the pressure/personal alarms were evaluated for efficacy and interventions modified to reduce/prevent Resident B from falling after the falls on 9/15/2013.</p> <p>A fall incident report dated 9/15/2013 at 10:00 P.M., indicated, "...resident found on the floor by the bedside face down @1605 [4:05 P.M.]. When asked, she stated "was trying to fix my hair." has contusion on forehead 15 mm [millimeters] x 30 mm and bruise on left knee about 8 cm diameter, applied ice pack on affected areas.... EMT (Emergency Medical Technicians) arrived and picked resident up at 1715 [5:45 P.M.]..."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155202	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/02/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF GREENCASTLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135
---	--

(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>A care plan, identified as current by the DON, indicated on 5/23/2013, Resident B was identified as a fall risk. A goal listed for Resident B indicated she would have no injuries due to falls. Interventions to meet this goal included pressure alarms to her bed and chair and staff were to check alarms while they provided care due to Resident B, "Sometimes turn alarms off or take alarms off." The record lacked documentation which indicated the care plan was reviewed/ revised by the interdisciplinary team after each fall occurrence.</p> <p>A policy titled "Safety Alarm Devices" and identified as current by the MDS coordinator on 10/2/2013 at 10:54 A.M., indicated, "...It is the intent of the facility that the safety alarm devices are utilized when deemed appropriate by the care plan team, as an intervention to alert staff of an unassisted transfer to intervene for fall prevention.... 1. Residents at risk for falls will be discussed for appropriate fall prevention and safety alarm devices..... 3. The interdisciplinary team will review use of alarms for fall prevention at least quarterly or as needed."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155202	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/02/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF GREENCASTLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135
---	--

(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>A policy titled "Care Plans, and identified as current by the DON on 10/2/2013 at 11:41 A.M., indicated, "...It is the intent of the facility that each resident will have a plan of care to identify problems, needs and strengths that will identify how the interdisciplinary team will provide care. RESPONSIBILITY: All members of the interdisciplinary team. Coordinated by the MDS Coordinator.... Each resident upon admission or a significant change of condition will be assessed by all disciplines.... For each problem, need or strength a resident-centered goal is developed. Whenever possible the goal should be measurable.... Staff approaches are to be developed for each problem/strength need.... All goals and approaches are to be reviewed and revised as appropriate by a team of qualified persons after each assessment and upon significant change of condition.... It is the intent of the facility for all residents to receive a review of the Plan of Care by the Interdisciplinary Team at least quarterly... 1. Assess the resident-visually and verbally, as well as obtain information from the Health Record and interview Nursing Assistants prior to completing the MDS and reviewing the Plan of Care.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155202	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/02/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF GREENCASTLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135
---	--

(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>2. Evaluate each resident's progress, or lack there of, toward each care plan goal; as each resident's Plan of Care is reviewed. 3. Document and date progress or lack there of, toward goals. 4. Document progress in measurable terms...."</p> <p>This Federal tag relates to Complaint IN00136878.</p> <p>3.1-35(d)(2)(B)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155202		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/02/2013	
NAME OF PROVIDER OR SUPPLIER  WATERS OF GREENCASTLE THE				STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135			
(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			
F000323 SS=G	<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 observation, interview, and record review, the facility failed to ensure implementation of assistive devices/interventions to prevent a fall resulting in large contusions to the abdomen/hip area and forehead and cheekbone requiring two hospitalizations for 1 of 3 residents reviewed for falls (Resident B).</p> <p>Findings include:</p> <p>Resident B's record was reviewed on 10/1/2013 at 1:30 P.M. Resident B had diagnoses which included, but were not limited to, aphasia (difficulty speaking), atrial fibrillation, and congestive heart failure. A re-admission Minimum Data Set Assessment Tool (MDS) dated 9/26/2013, indicated the following: 1) Resident B had been re-admitted to the facility from an acute hospital 2) She had unclear speech, was rarely/never understood, sometimes understood others, and responded adequately to simple, direct communication only 3) She was</p>	F000323	<p>It is the intent of this facility to 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. 1. Action Taken: Resident B no longer resides in this facility. 2. Others Identified: 1) Reviewed Interventions in place for all residents having falls in the past 3 months. Changed interventions as needed to assure all interventions are appropriate. 3. Systems in Place: 1) A Clinical Data Information (CQI) meeting has been implemented. This meeting will be attended by the Interdisciplinary Team (IDT) and will be held 5 times weekly. Any resident identified as having a fall will be reviewed by the IDT to ensure the appropriate fall prevention intervention is in place. 2) Nursing staff and IDT will be re-educated on fall prevention to include appropriate interventions put in place in a timely manner. 4. Monitoring: 1) The Administrator will audit 100% of falls for prevention interventions x 30 days, 10% of</p>	10/18/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155202	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/02/2013
NAME OF PROVIDER OR SUPPLIER  WATERS OF GREENCASTLE THE			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135		
(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>unable to complete the Brief Interview for Mental Status (BIMS). 4) She had modified independence with cognitive skills for daily decision making. 5) She did not exhibit behaviors that were necessary to achieve her goals for health and well-being. 6) She required limited physical assistance of one person for bed mobility, transfers, ambulation to walk in her room, with dressing, toilet use, and with personal hygiene. 7) Her balance was not steady but she was able to stabilize without staff assistance. 8) She was occasionally incontinent of urine. 9) She had two or more falls with injury since her last assessment. 9) She was on anticoagulant therapy (blood thinner).</p> <p>On 10/1/2013 at 1:05 P.M., Resident B was observed sitting on the side of her bed. A large bruised raised area was observed on the left side of her forehead. She had no socks on her feet. A bed alarm was attached to her bed and to her recliner. When resident B was queried regarding what happened to her head she mumbled several words that could not be understood. She pointed to the bathroom and stated, "fall."</p> <p>During an interview on 10/1/2013 at 1:08 P.M., Qualified Nursing Aide</p>		<p>fall prevention interventions weekly x 60 days, and 10% of fall prevention interventions monthly for 90 days and as needed thereafter. Audit will include but no be limited to updating in a timely manner and appropriate fall prevention interventions. Any identified non-compliance will be immediately addressed and result in 1:1 re-education with progressive discipline up to and including termination. 2) Results of audits will be forwarded to the Quality Assurance Committee (QA) monthly for review and recommendations as deemed appropriate for the first 90 days and quarterly thereafter.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155202	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/02/2013
NAME OF PROVIDER OR SUPPLIER  WATERS OF GREENCASTLE THE			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135		
(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>(QMA) #1 was queried regarding the injury to Resident B's head. QMA #1 indicated Resident B fell. QMA #1 indicated alarms were used on the bed and her chair. QMA #1 checked the bed alarm and indicated it worked but it was not turned on. QMA #1 indicated she was not aware of Resident B having a history of turning off the alarms.</p> <p>During an interview on 10/2/2013 at 10:40 A.M., the DON (Director of Nursing) indicated she was aware Resident B turned off her personal alarms. The DON indicated the alarms did not prevent falls but when the alarms went off it warned the staff Resident B had attempted to get up without assistance and gave them time to get to her before she fell. The DON indicated staff were to check to see if the alarms were functioning during care however, they did not document the alarms were checked. The DON indicated her staff were aware Resident B turned the alarms off and knew to check to make sure they were turned on during care. The DON indicated they were informed of this via verbal communication but they did not have a system in place to document the alarms had been checked. The DON stated, "The alarm has never been a good</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155202	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/02/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF GREENCASTLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135
---	--

(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>intervention for her because she can remove it or shut it off."</p> <p>During an interview on 10/2/2013 at 11:25 A.M., the DON indicated since Resident B had returned to the facility in February 2013, she had fallen ten times. The DON indicated she had fallen three times in September and two of the falls occurred on September 15, 2013. The DON indicated Resident B fell in the evening on September 15, 2013 and was sent to the hospital to be evaluated due to her anticoagulant therapy which increased her risk for bleeding. The DON indicated Resident B fell again the same evening and was sent back to the hospital, at which time, she was admitted and given a blood transfusion due to a low hemoglobin level. The DON was queried regarding the circumstances which surrounded the falls on September 15, 2013, and if she had documentation the alarms were in place and functioning. The DON indicated she did not have documentation which indicated the alarms were on and functioning. The DON indicated a fall risk assessment was completed on 9/19/2013, as a result of Resident B's fall with injury. The DON indicated Resident B was a</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155202		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/02/2013	
NAME OF PROVIDER OR SUPPLIER  WATERS OF GREENCASTLE THE				STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135			
(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>high risk for falls however, Resident B's previous fall prevention interventions were not reviewed for effectiveness and/or new interventions were not implemented after her falls on 9/15/2013.</p> <p>Nurse's notes were reviewed from 8/1/2013 through 9/27/2013.</p> <p>A nurse's note dated 8/7/2013 at 3:36 A.M., indicated, "Nurse heard crash and went to room. Resident sitting on buttocks in floor next to recliner with O2 [oxygen] off.... Assessment completed and no injury. Assist of two out of floor and into chair." The record lacked documentation which indicated fall prevention measures were in place.</p> <p>A nurse's note dated 8/8/2013 at 9:49 P.M., indicated, "Noted at this time a small, palm-sized black bruise on right side of resident from fall. Resident indicated that that area is sore. No other injuries noted from fall...."</p> <p>A nurse's note dated 8/13/2013 at 8:40 P.M., indicated, "Called to residents room, resident was in left lateral sims position on the floor beside her bed with face into lowered bed rail. She had tried to hang up her</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155202	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/02/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF GREENCASTLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135
---	--

(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>telephone and rolled out of bed. A bruise is noted to her left eye where 02 tubing rests. Skin is scraped but not quite broken. Resident is on Coumadin therapy...." This note indicated Resident B was sent to the hospital for an evaluation. The record lacked documentation which indicated fall prevention measures were in place.</p> <p>A nurse's note dated 8/14/2013 at 7:32 A.M., indicated Resident B had returned to the facility with new orders for an antibiotic to treat a urinary tract infection. Labs were drawn due to an elevated blood clotting test result. This noted indicated, "...noted 2 large bruised areas to R [right] side of abd [abdomen] and R outer hip area. Measurements for R abd are 21 cm [centimeters] x 8 cm. R outer hip area measures 15 cm x 15 cm..."</p> <p>A nurse's note dated 9/8/2013 at 10:31 A.M., indicated, "Nurse heard yell and resident sitting between toilet and bathtub in [sic] floor...." The record lacked documentation which indicated fall prevention measures were in place.</p> <p>A nurse's note dated 9/8/2013 at 7:52 P.M., and 9/9/2013 at 6:19 P.M., Resident B's pressure alarms were</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155202	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/02/2013
NAME OF PROVIDER OR SUPPLIER  WATERS OF GREENCASTLE THE			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135		
(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>functioning and Resident B continued to get up unassisted causing pressure alarms to sound.</p> <p>A nurse's note dated 9/12/2013 at 5:39 A.M., indicated, "resident alert and responsive. nurse observed resident turning personal alarm off. nurse educated resident on importance of alarms and her safety. Slept most of night...."</p> <p>The nurse's notes lacked documentation from 9/12/2013 through 9/16/2013.</p> <p>A fall incident report dated 9/15/2013 at 10:00 P.M., indicated, "...resident found on the floor by the bedside face down @1605 [4:05 P.M.]. When asked, she stated "was trying to fix my hair." has contusion on forehead 15 mm [millimeters] x 30 mm and bruise on left knee about 8 cm diameter, applied ice pack on affected areas.... EMT (Emergency Medical Technicians) arrived and picked resident up at 1715 [5:45 P.M.]..." The record lacked documentation which indicated fall prevention measures were in place.</p> <p>A fall incident report dated 9/15/2013 at 10:50 P.M., indicated, "CNA found resident on bathroom floor face down.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155202	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/02/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF GREENCASTLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135
---	--

(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>she has a contusion on left side of forehead and left cheekbone approx [approximate] size 150 mm x 60 mm x 30 mm thick, irregular-shaped.... EMT came and picker (sic) resident up by 2325 [11:25 P.M.]...." The record lacked documentation which indicated fall prevention measures were in place.</p> <p>A nurse's note dated 9/16/2013 at 11:36 A.M., indicated a facility nurse had contacted the hospital staff. The hospital staff informed the facility nurse they would keep Resident B in observation over night.</p> <p>A nurse's note dated 9/20/13 at 5:16 A.M., indicated, "Alert and responsive. Bruising areas continue to face, arms, left knee. Resident indicates by gestures and garbled speech that her head hurts...."</p> <p>A nurse's note dated 9/28/2013 at 9:50 A.M., indicated, "...area remains discolored d/t [due to] previous fall.... Res [resident] c/o [complains] tenderness with palpitation.... Res has been more compliant with asking for help with toileting. PA [personal alarm] in place et [and] functional to recliner chair/wc[wheelchair]/bed. Will c/t [continue] to monitor.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155202	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/02/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF GREENCASTLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135
---	--

(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>Nurse's notes from 8/1/2013 through 9/27/13, with the exception of nurse's notes dated 9/8/2013 at 7:52 P.M., 9/9/2013 at 6:19 P.M., and 9/28/2013 at 9:50 P.M., lacked documentation which indicated staff had monitored Resident B's personal alarms to ensure they had been functioning. The record lacked documentation which indicated Resident B's pressure alarms had been monitored to ensure proper functioning prior to her falls on 8/7/2013, 8/13/2013, 9/8/2013, or both falls on 9/15/2013.</p> <p>A care plan, identified as current by the DON, indicated on 5/23/2013, Resident B was identified as a fall risk. A goal listed for Resident B indicated she would have no injuries due to falls. Interventions to meet this goal included pressure alarms to her bed and chair and staff were to check alarms while they provided care due to Resident B, "Sometimes turn alarms off or take alarms off."</p> <p>A policy titled "Fall Risk Assessment" and identified as current by the DON on 10/1/2013 at 1:19 P.M., indicated, "...It is the intent of the facility that all resident will have a Risk Assessment for Falls performed on admission/readmission, with a significant change in condition,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155202		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/02/2013	
NAME OF PROVIDER OR SUPPLIER  WATERS OF GREENCASTLE THE				STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135			
(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>quarterly and annually. Responsible Party Licensed Nurses.... PROCEDURE: ... For residents who score 10 or above, develop a preventative care plan for falls.... Risk Assessments are reviewed on admission, quarterly, and as needed.</p> <p>A policy titled "Safety Alarm Devices" and identified as current by the MDS coordinator on 10/2/2013 at 10:54 A.M., indicated, "...It is the intent of the facility that the safety alarm devices are utilized when deemed appropriate by the care plan team, as an intervention to alert staff of an unassisted transfer to intervene for fall prevention. RESPONSIBILITY: Nursing staff, all facility staff under the direction of the Charge Nurse/Interdisciplinary Team.... 1. Residents at risk for falls will be discussed for appropriate fall prevention and safety alarm devices. 2. When a safety alarm device has been determined as an appropriate intervention, a physician's order is not required. But must be addressed on the residents care plan as an intervention to the risk of falls, and communicated to the appropriate staff. a. The alarm is to be placed on bed or chair as appropriate. b. If the resident is able to remove the alarm and if determined appropriate,</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155202	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/02/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF GREENCASTLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135
---	--

(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>relocate the alarm to another area. c. The safety device will be checked for proper functioning during care.... 3. The interdisciplinary team will review use of alarms for fall prevention at least quarterly or as needed."</p> <p>This Federal tag relates to Complaint IN00136878 &amp; Complaint IN00136880.</p> <p>3.1-45(a)(2)</p>			