

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155121	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/28/2016
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NAME OF PROVIDER OR SUPPLIER ROSEWALK VILLAGE AT LAFAYETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 1903 UNION ST LAFAYETTE, IN 47904
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00198902.</p> <p>Complaint IN00198902-Substantiated. Federal/State deficiencies related to the allegations are cited at F157 and F323.</p> <p>Survey dates: April 27 and 28, 2016</p> <p>Facility number: 000051 Provider number: 155121 AIM number: 100275490</p> <p>Census bed type: SNF: 11 SNF/NF: 112 Total: 123</p> <p>Census payor type: Medicare: 19 Medicaid: 94 Other: 10 Total: 123</p> <p>Sample: 3</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review was completed by 21662</p>	F 0000	Rosewalk Village of Lafayette respectfully request consideration for desk review for this survey	

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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F 0157 SS=D Bldg. 00	<p>on May 4, 2016.</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 interview and record interview, the facility failed to notify the resident's family member (Power of Attorney) regarding a fall for 1 of 3 residents reviewed for family notification (Resident B).</p> <p>Finding includes:</p> <p>A Nursing progress note dated 4/24/16 at 11:51 p.m., indicated "Resident sister came in this evening, was upset when resident told her he had fallen yesterday. Explained writer had tried to call, insisted nobody had tried to call. Showed her the numbers called, the home phone number was disconnected. States that home number is an old number. Wrote the new number in the chart...."</p> <p>On 4/27/16 at 12:00 p.m., the "Resident/Family Concern/Grievance Form" binder was reviewed and there was a grievance form dated 4/25/16 at 11:15 a.m., which was partially filled out. The Executive Director (ED) indicated earlier when she provided the grievance binder that she was still working on a grievance that a family had recently filed. The grievance form indicated the date of concern was 4/23/16, with the date the form was received as 4/25/16, regarding the department of nursing. The POA of the</p>	F 0157	<p>Resident face sheet was corrected with preferred phone number to help ensure POA is notified timely per facility policy. Nurse was educated to ensure POA is notified utilizing correct phone number. All residents have the potential to be affected. All face sheets were updated to ensure the face sheet in the resident chart matches the information in matrix. Licensed nurses inserviced on the Fall Management Program which includes notification of family, MD and DNS/ED Medical Records will continue to update face sheets every 3 months or more frequently as needed to help ensure accurate phone numbers are utilized. IDT care plan meetings include review of face sheet to help ensure accurate phone numbers are on face sheet. Monthly news letter will include information reminding families to notify staff of any changes in contact phone numbers. Licensed nurses inserviced on the Fall Management Program which includes notification of family, MD and DNS/EDA CQI tool will be completed for each resident experiencing a fall for family notification and submitted to CQI committee for evaluation monthly for 1 year. If threshold of 95% is not achieved, an action plan will be developed to ensure compliance. All corrective actions will be completed on or</p>	05/20/2016

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	<p>resident was upset because the resident had a fall over the weekend and she was not notified.</p> <p>On 4/27/16 at 12:30 p.m., Resident B's record was reviewed. Diagnoses included, but were not limited to, nontraumatic intracranial hemorrhage, cerebral infarction, paranoid schizophrenia and encephalopathy.</p> <p>A document titled "Safety Events--[Name of Company] Fall Event" date recorded 4/24/16 at 11:38 p.m., provided by the Executive Director on 4/27/16 at 3:55 p.m., indicated the resident had an unwitnessed fall. The resident was sitting up in his wheelchair prior to the fall. He was found lying on the floor with his head towards his roommates bed, with the wheelchair tipped over and the bedside table was broken. The resident fell in his room. The fall was unwitnessed. The resident had an area on the back of his neck, which looked like a strawberry colored birth mark, but the resident denied having a birth mark.</p> <p>During an interview on 4/27/16 at 12:45 p.m., the ED indicated the Director of Nursing Services (DNS) had an original of the grievance form she was still working on from the grievance filed by the resident's family member on 4/25/16.</p>		before 5/20/16	

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	<p>The ED indicated the resident's family member's concern was regarding the resident falling over the weekend and she was not notified. She indicated the nurse on duty the day the resident fell (4/23/16) did not notify the family member of the fall. She indicated LPN #1 was coming into the facility to discuss not notifying the family regarding the fall with the Director of Nursing Services (DNS).</p> <p>During an interview on 4/27/16 at 2:08 p.m., the ED indicated the DNS spoke to LPN #1. LPN #1 indicated she called the resident's POA regarding the fall on 4/23/16. She indicated she used an "old" disconnected phone number on the facesheet from the resident's hard chart instead of using the correct phone number from the facesheet in the computer. The ED indicated LPN #1 called the wrong number and the POA was not notified of the resident's fall on 4/23/16, until she heard about it on 4/24/16 from the resident when she came to visit.</p> <p>A document titled "Employee Coaching & Counseling" dated 4/27/16, provided by the DNS on 4/27/16 at 4:59 p.m., indicated the incident occurred on 4/23/16 at 4:00 p.m. The policy/procedure/performance action, which was violated was the family was</p>			

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	<p>not notified regarding a resident fall and use of chart versus Matrix (charting system) for emergency contact information. The details of coaching & counseling indicated "Multiple attempts were made to notify family using phone numbers in resident chart. Contact numbers were incorrect in the chart and the family provided the correct information in person. The contact information was correct in the Matrix. It is preferred to use the Matrix for resident information as information is the most up to date. If chart must be used and still unable to contact, refer [sic] to Matrix For correct information."</p> <p>A document titled "Resident Admission Record: [Name of Resident]" dated 7/1/15 at 12:38 p.m., indicated the POA's primary and cell phone numbers were crossed out with a black pen and a phone number was handwritten in under the phone numbers, which were marked out.</p> <p>During a phone interview on 4/27/16 at 4:23 p.m., a family member indicated she was the resident's POA. She indicated she came to visit the resident on 4/24/16, and he indicated to her he could not believe he fell and broke the beside table the day before (4/23/16). She indicated she asked him what he was talking about and he indicated he had fallen and she</p>			

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	<p>had not been notified of the fall. She indicted the resident had told her and she had been not notified of his fall from the day before. She indicated when she asked LPN #1 about the fall that occurred on 4/23/16, LPN #1 indicated she had called this family member regarding the fall. She indicated she told LPN #1 she was not informed about the resident's fall. She indicated she had told the facility staff in the past not to use her cell phone because she did not turn it. She indicated she told the facility she only used her cell phone for emergencies.</p> <p>A undated typed statement from LPN #1 provided by the ED on 4/28/16 at 1:35 p.m., indicated "...Went to nurses station at 4 pm, got residents chart and looked at the second sheet of the face sheet and called the number listed from his [name of family member]. Got a recording saying it had been disconnected, called again with the same result Called the cell phone number listed for his [name of family member] and it went to voice mail. Message left for her to call this writer when she got the message. Was also hoping [name of family member] would come in as she is usually visiting on the week-end. She didn't visit... April 24th the [name of the family member] came in to visit and resident told [name of the family member] he had fallen the</p>			

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	<p>night before. [Name of the family member] became upset and loudly complained that nobody had called her. I told her I had called the home phone number 2 x [times] and got a disconnect recording, then her cell phone and left a message. [Name of the family member] insisted she had been home and nobody called, she requested to see the numbers listed. She said that the home phone number was not a working number and she never uses her cell phone and she put her working number in the chart...."</p> <p>During an interview on 4/28/16 at 3:10 p.m., the ED indicated the date LPN #1 typed the signed statement was 4/27/16.</p> <p>A current policy titled "Fall Management Program" dated 7/01 with a revision date 2/2015, indicated "...Post fall...3. The family will be notified immediately by the charge nurse of falls with injury. If there are no injuries, notify the family during day or evening hours (if a fall occurred during the middle of the night, wait unit morning."</p> <p>This Federal tag relates to Complaint IN00198902.</p> <p>3.1-5(a)(1)</p>			

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F 0323 SS=D Bldg. 00	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <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.</p> <p>Based on observation, interview and record review, the facility failed to ensure a complete assessment was performed for an injury to a resident after a fall and there was a delay of requested hospital evaluation and treatment after a fall for 1 of 3 residents reviewed for a fall (Resident B).</p> <p>Findings include:</p> <p>1. On 4/27/16 at 12:30 p.m., Resident B's record was reviewed. Diagnoses included, but were not limited to, nontraumatic intracranial hemorrhage, cerebral infarction, paranoid schizophrenia and encephalopathy.</p> <p>A document titled "Safety Events--[Name of Company] Fall Event" date recorded 4/24/16 at 11:38 p.m., provided by the Executive Director on 4/27/16 at 3:55 p.m., indicated the resident had an unwitnessed fall. The resident was sitting up in his wheelchair prior to the fall. He was found lying on the floor with his head towards his roommates</p>	F 0323	<p>Resident was transported to hospital for evaluation per family request and Physician order on 4/25/16. An assessment of the reddened area to the back of the head was completed and documented with family and physician notification. All residents experiencing falls have the potential to be affected. Each resident experiencing a fall will be assessed immediately by the charge nurse per facility policy. Licensed nurses have been inserviced on the Fall Management Program which includes assessment immediately following a fall. Each resident experiencing a fall will be assessed immediately by the charge nurse per facility policy. Licensed nurses have been inserviced on the Fall Management Program which includes assessment immediately following a fall. A CQI tool will be completed for each resident experiencing a fall for assessment and submitted to CQI committee for evaluation monthly for 1 year. If threshold of 95% is not achieved, an action plan will be developed to ensure compliance. All corrective actions</p>	05/20/2016

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	<p>bed, with the wheelchair tipped over and the bedside table was broken. The resident fell in his room. The fall was unwitnessed. The resident had an area on the back of his neck, which looked like a strawberry colored birth mark, but the resident denied having a birth mark.</p> <p>Resident B's record lacked assessments of the resident's reddened and scattered splotchy areas from the top of his occipital area of his head down the middle of the occipital area to the base of the resident's neck and across the neck area.</p> <p>"Shower Reports" dated 4/27/16, indicated the resident did not have any skin issues.</p> <p>"Nursing--[Name of Company] Weekly Summary" dated 4/27/16, indicated the resident did not have any skin issues.</p> <p>A Nursing progress note recorded as a Late Entry on 4/24/16 at 11:52 p.m., dated as being charted for 4/24/16 at 11:51 p.m., indicated "Event occurred 4/23/16 at 3:45 pm. Heard a loud crash in residents room Resident found lying on his back on the floor with head towards roommates bed. Bedside table broken. Wheelchair turned over. No injuries noted-no redness or bruising.</p>		will be completed on or before 5/20/16.	

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	<p>Resident denies feeling any injury...."</p> <p>A Nursing progress note dated 4/24/16 at 11:51 p.m., indicated "Resident [name of family member] came in this evening, was upset when resident told her he had fallen yesterday. Explained writer had tried to call, insisted nobody had tried to call. Showed her the numbers called, the home phone number was disconnected. States that home number is an old number. Wrote the new number in the chart. She insisted she wanted him checked out. Called [name of Nurse Practitioner, vital signs WNL [within normal limits], neuro signs wnl, denies pain. Explained about the area on back of neck. [Name of Nurse Practitioner] instructed to monitor resident."</p> <p>An undated typed statement signed by LPN #1 provided by the Executive Director on 4/28/16 at 1:35 p.m., indicated she noticed an area to the back of Resident B's back of his neck, which looked like a "raspberry birthmark." This statement was signed on 4/27/16 by the LPN.</p> <p>During a phone interview with the resident's Power of Attorney on 4/27/16 at 4:23 p.m., the resident's POA indicated to LPN #1 she wanted to have him sent out to the ER to be "checked out"</p>			

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	<p>because of the red mark on the back of his head. LPN #1 indicated she thought the red mark was a "birth mark." The resident's POA indicated to LPN #1 the resident did not have a birth mark.</p> <p>On 4/27/16 at 12:00 p.m., the "Resident/Family Concern/Grievance Form" binder was reviewed and there was a grievance form dated 4/25/16 at 11:15 a.m., which was partially filled out. The Executive Director (ED) indicated earlier when she provided the grievance binder that she was still working on a grievance that a family had recently filed. The grievance form indicated the date of concern was 4/23/16, with the date the form was received as 4/25/16, regarding the department of nursing. The POA of the resident was upset because the resident had a fall over the weekend and she was not notified.</p> <p>During a phone interview on 4/27/16 at 4:23 p.m., a family member indicated she was the resident's POA. She indicated she came to visit the resident on 4/24/16, and he indicated to her he could not believe he fell and broke the beside table the day before (4/23/16). She indicated she asked him what he was talking about and he indicated he had fallen and she had not been notified of the fall. She</p>			

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	<p>indicated she asked LPN #1 about Resident B's fall from 4/23/16, and the nurse indicated the resident did not hit his head when he fell. The POA indicated she wanted the resident "checked out" because of the fall and she indicated LPN #1 walked away without saying anything to her. She indicated LPN #1 came back and "checked" his vital signs and looked at his eyes with a flashlight and indicated he was "ok." The POA indicated to LPN #1 at that time she wanted his head x-rayed because of the red mark on the back of his head. LPN #1 indicated at that time, she thought the red mark was a birth mark and the POA indicated to LPN #1 he did not have a birth mark. She indicated she told LPN #1 the resident was complaining of blurry and double vision. The POA indicated LPN #1 called the doctors office, then LPN #1 indicated to the POA the resident was going to be monitored instead of being sent out to the hospital. The POA indicated she did not know what to do at that point, so she went home. She indicated she and another family member came to the facility the next day on 4/25/16, and spoke to management regarding their concerns about the residents fall and he was not sent out to the hospital on 4/24/16 as requested. She indicated an emergency Care Plan meeting was called and at the end of the</p>			

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	<p>meeting, the DNS asked if she wanted the resident sent out to the hospital and she indicated "yes". She indicated if she would have been notified about his fall on 4/23/16, she would have sent him out to the hospital the day he fell, due to his previous head injury, the red mark on the back of his head, because the overbed table broke when he fell and he indicated his wheelchair was on top of him when he fell. She indicated she felt like he had a delay in treatment because she was not notified that he fell on Saturday (4/23/16) and he was not sent out to the hospital on Sunday (4/24/16) as requested.</p> <p>On 4/28/16 at 9:20 a.m., with the Director of Nursing (DNS) in attendance, the resident's reddened areas were assessed. The DNS looked at (raised the residents hair on the back of his head to view the reddened areas) the reddened areas on the residents occipital and neck areas. The resident had a nickel sized reddened area on top of his occipital area with reddened splotchy areas all the way down to the base of his neck and across the base of his neck. He had two quarter sized reddened areas on the base of his neck with the splotchy reddened areas surrounding these two areas. The DNS indicated she and the Unit Manager of the second floor assessed the area on his neck, but they did not measure the area</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155121	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/28/2016
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NAME OF PROVIDER OR SUPPLIER ROSEWALK VILLAGE AT LAFAYETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 1903 UNION ST LAFAYETTE, IN 47904
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	<p>when they assessed it. The resident indicated during that time, he did not have these reddened areas prior to the fall on Saturday (4/23/16).</p> <p>During an interview on 4/28/16 at 10:23 a.m., the Executive Director (ED) indicated the DNS had indicated the red splotchy areas on the resident's neck appeared to look like red areas residents get from laying down on their pillows.</p> <p>On 4/28/16 at 1:10 p.m., the resident's head and neck was observed and the reddened areas and reddened splotchy areas to his occipital area of his head to the base of his neck were unchanged after sitting up during lunch.</p> <p>A document titled "After Visit Summary" dated 4/25/16, provided by the ED on 4/28/16 at 11:06 a.m., indicated this document was printed for Resident B on 4/25/16 at 4:02 p.m., from the emergency room. The document indicated the resident's diagnosis was "CLOSED HEAD INJURY WITH CONCUSSION, INITIAL ENCOUNTER" and "Schedule an appointment as soon as possible for a visit with [Name of Doctor]". The resident had a document titled "Concussion" dated 4/25/16, provided by the ED on 4/28/16 at 11:06 a.m.,</p>			

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	<p>indicated these documents were printed for this resident on 4/25/16. These documents described what the Causes, Signs and Symptoms, Diagnosis, Treatment, Home Care Instructions of a Concussion and to Seek Medical Care If instructions.</p> <p>During an interview on 4/28/16 at 11:33 a.m., NP #2 indicated she was on call on 4/24/16, when LPN #1 called in regards to Resident B's POA requesting him being sent out to the hospital. NP #2 indicated she was told by LPN #1 the resident's vital signs and neuro checks were WNL (within normal limits), no changes to his vital signs had occurred, his hand grips were equal and his mentation was normal for him. She indicated she was informed he had fallen the day before on 4/23/16, was on fall follow ups, his vitals and neurochecks were being done and maybe he had a red spot, but the nurse was not for sure and the POA had come in that day (4/24/16) and wanted him sent out because he could not remember a phone number. NP #2 indicated not being able to remember a phone number with stable vital signs and neurochecks was not an appropriate reason to send Resident B out to the ER. She indicated she was not informed by LPN #1 the resident indicated he had hit his head, it was an unwitnessed fall, he</p>			

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	<p>broke an overbed side table during the fall, he indicated his wheelchair fell on top of him and his POA was not notified of the fall until she came to visit on 4/24/16, or the red area on his head was not a birth mark. NP #2 indicated if she had been given this information on Sunday (4/24/16) when the nurse called her, she would have sent Resident B to the hospital on Sunday.</p> <p>A undated typed statement from LPN #1 provided by the ED on 4/28/16 at 1:35 p.m., indicated "...Called [Name of Nurse Practitioner], gave her an update and she said his VSS [vital signs stable] remained stable and Neuro checks were normal and she didn't want to send him unless his status changed. Resident's VSS remained stable on the 24th and his neuro checks were unchanged...."</p> <p>During an interview on 4/28/16 at 3:10 p.m., the ED indicated the date LPN #1 typed the signed statement was 4/27/16.</p> <p>This Federal tag relates to Complaint IN00198902.</p> <p>3.1-45(a)(2)</p>			