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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 09/06/2012 |
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| R0000 | <p>This visit was for a State Residential Licensure survey.</p> <p>Survey dates: September 4, 5, and 6, 2012</p> <p>Facility number: 005657 Provider number: 005657 AIM number: N/A</p> <p>Survey team: Janet Stanton, R.N.--Team Coordinator Melanie Strycker, R.N. Heather Lay, R.N. (9/4, 9/6)</p> <p>Census bed type: Residential--115 Total--115</p> <p>Census payor type: Other--115 Total--115</p> <p>Sample: 10</p> <p>These State Residential findings are cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on September 9, 2012 by Bev Faulkner, RN</p> | R0000 | <p>This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This plan is submitted to meet requirements established by state and federal law.</p> | |

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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| R0148 | <p>410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows:</p> <p>(1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected.</p> <p>Based on observation, interview, and record review, the facility failed to secure sharp scissors and hazardous spray paint and adhesive in a safe manner; in 1 of 1 Activity rooms; and for 1 of 4 residents residing in proximity to the Activity room and who was identified with memory/behavior/dementia problems. [Resident #25]</p> <p>Findings include:</p> <p>Upon entrance to the facility on 9/4/12 at 10:00 A.M., the door to the Activity Room was observed to be open. Several residents were in the room at that time.</p> | R0148 | <p>R 148 All hazardous materials and/or sharps have been identified within the Activity Room and stored to prevent access to residents with reduced cognitive abilities. Locks have been installed on a cabinet and one drawer. Identified materials and/or sharps have been secured within locked compartments. To ensure hazards are not accessible in the future, keys to locked compartments will remain with authorized personnel only. Director of Activities and Activity staff will ensure compartments are locked after each use. Resident #25 was in the process of transitioning to a skilled nursing facility and has since transferred to</p> | 09/06/2012 | | | |

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| | <p>At 1:15 P.M. and 3:00 P.M., the door was open, but there was no one in attendance in the room.</p> <p>On 9/5/12 at 9:00 A.M., the door to the Activity Room was observed to be open. No one was in attendance at that time.</p> <p>The "General Observations of the Facility" environmental task was done on 9/5/12 at 9:20 A.M., with the Director of Maintenance and Environmental Services in attendance.</p> <p>The facility Activity Room was located on the southeast corner at a "T" junction. The top of the "T" was the main hallway between the Phase I building main entrance and a hallway to the Phase II building. The leg of the "T" was a short hall having 5 resident rooms. The doorway to the Activity Room faced the long hall, and was immediately next to the corner of the junction.</p> <p>The door to the Activity Room was open at the time of the environmental tour, and no one was in the room.</p> <p>Six pair of shears, with sharp points, were observed in an unlocked drawer. The drawer was in a lower cabinet to the left of the doorway, and at a height of 3 feet from the floor.</p> | | <p>another facility. Upon review of residents, no additional residents were identified to be at risk. Any future resident identified to be at risk, will have an updated service plan to reflect the behavior. The Administrator or designee will monitor daily to assure these storage areas are locked when not in attendance of staff.</p> <p>Completion Date & Systemic Implementation Date: September 6, 2012</p> | | | | |

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| | <p>One can of "Craft Bond Multi Purpose Spray Adhesive," two cans of Krylon brand spray paint, and three cans of Rustoleum brand spray paint were observed in an unlocked cabinet. The cabinet was located under a sink, directly across the room from the doorway.</p> <p>Each spray can had warning labels that included "Highly Flammable," Harmful or fatal if swallowed," "Avoid breathing fumes;" and "Seek medical help or call a Poison Control center if ingested."</p> <p>In an interview at 10:00 A.M., the Activity Director indicated the door to the room was not kept locked when she or other staff were not in attendance.</p> <p>During the initial orientation tour on 9/4/12 at 10:30 A.M., the Director of Nursing identified four residents who were ambulatory, had dementia, memory problems, and/or behaviors, and who lived in the proximity of the Activity Room. She indicated Resident #25 was an insulin-dependent diabetic who was ambulatory, had memory problems, and had experienced falls.</p> <p>The resident's room was located near the end of the short hall, the leg of the "T." Residents living on that hall were</p> | | | |

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| | <p>required to come to the junction, and turn left to go the the dining room area for the Phase I building. The door to the Activity Room was immediately to the right at the junction.</p> <p>In an interview on 9/6/12 at 9:30 A.M., the Director of Nursing indicated the resident was not able to ambulate by herself, and staff was always with her when going to and from the dining room.</p> <p>The clinical record for Resident #25 was reviewed on 9/4/12 at 12:20 P.M. Diagnoses included, but were not limited to, Parkinson's disease, chronic obstructive pulmonary disease, and Lewy body dementia.</p> <p>A physician's progress note, dated 4/2/12, indicated "Worsening dementia. Hallucinations...." The physician ordered an anti-psychotic medication at that time, and increased the dose on 4/30/12.</p> <p>A "Nurse's Notes" entry, dated 8/10/12 at 11:00 P.M., indicated "Staff called to resident's room at 9:00 P.M. Resident was in the bathroom; staff noted many cords on floor and in trash. Staff, C.N.A., asked resident where these electric cords came form. Resident stated they were sparking so she cut them. Staff member told writer and writer and C.N.A. went to</p> | | | | | | |

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| | room and gathered all cut electronic cords. Writer unplugged all items that were plugged into outlets and removed items that were cut. Also, writer removed scissors from room. Resident stated she had to use the scissors to stop the sparks...." | | | |

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| R0217 | <p>410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows:</p> <p>(1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident.</p> <p>(2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review.</p> <p>(3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request.</p> <p>(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.</p> <p>(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.</p> <p>Based on record review and interview, the facility failed to ensure that service plans included interventions to address falls and behaviors, as well as bleeding in a resident that was receiving Coumadin (a blood-thinning medication). This deficient practice affected 2 of 3 residents reviewed in a sample of 10. (Residents</p> | R0217 | R217 Service Plans were updated for Resident #25 and Resident #37 to address interventions related to falls and/or incidents. Due to decline in physical and cognitive function, Resident #25 was in the process of discharging at the time of state review. Resident #25 has since discharged to a skilled nursing | 09/14/2012 | | | |

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| | <p>#25, #37)</p> <p>Findings include:</p> <p>1. On 9/4/12, the clinical record of Resident #37 was reviewed. Resident #37 was admitted to the facility on 4/20/12 with diagnoses that included, but were not limited to, Parkinson's disease, bipolar affective disorder, hypertension, seizures, and history of lithium toxicity. The current service plan for Resident #37, dated 4/20/12, included, but was not limited to, the following parameters and services:</p> <p>Mobility: "Monitor use of assistive devices - walker" and "Encourage safety precautions."</p> <p>Transfer: "No services needed at this time."</p> <p>Toileting: "No services needed at this time"</p> <p>Physical Health: "No services needed at this time"</p> <p>The 4/24/12 Nurses Notes entry at 12:30 P.M., indicated the resident had a scab on his forehead and had stated he "fell yesterday" and does not know how.</p> | | <p>facility. All residents have the potential of being affected. Assessments and Service Plans of all residents, with a history of falls and/or incidents, were reviewed by the Director of Nursing, for appropriate interventions. This includes, but is not limited to, follow-up procedures for residents receiving anti-coagulation therapy. Interventions were in place for all identified, with one additional resident's Service Plan requiring update, which was completed. Service Plans will be reviewed quarterly and as needed due to resident change and updated as appropriate. Director of Nursing or designee, will review all Service Plan updates to assure service plan is updated to reflect increased needs of the individual. Service Plans will include contracted services as provided. Contracted provider's care notes will be reviewed by Assistant Director of Nursing or designee, to ensure appropriate updates to Service Plan are made. In-service regarding process for Service Plan updating was provided to the nursing staff on 9/14/2012 by the Director of Nursing. Completion Date & Systemic Implementation Date: September 14, 2012</p> | | | | |

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| | <p>The 5/17/12 Nurses Notes entry at 1:00 P.M., indicated a scratch was noted on the resident's left cheek. The resident stated he "rolled out of bed and hit the floor yesterday."</p> <p>The 5/19/12 Nurses Notes entry at 12:50 A.M., indicated the resident was found on the floor in the bathroom. "The resident became dizzy while attempting to self toilet and lowered himself to the floor..."</p> <p>The 5/23/12 Nurses Notes entry at 11:00 P.M., indicated "Resident called for assistance getting up from the floor. Stated the last thing he remembers was lying on couch watching t.v.; does not know how he got on floor..."</p> <p>The 7/20/12 Nurses Notes entry at 5:00 A.M., indicated "Message on phase I office phone that resident needed assistance. Resident states he 'fell at 4 AM..."</p> <p>The 7/26/12 Nurses Notes entry, no time noted, indicated the resident pressed the call light and an aid found the resident on the floor in the kitchen. "He stated he was in his room and got on the floor and crawled to kitchen and was unable to get up..."</p> <p>The 7/30/12 Nurses Notes entry at 3:00</p> | | | | | | |

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| | <p>A.M., indicated "Resident pushed the emergency button around 2:30 AM. CNA [certified nurse aide], 1st to find resident lying on kitchen floor... One scratch noted midline back, just below neck..."</p> <p>The 8/17/12 Nurses Notes entry at 2:10 A.M., indicated the resident was found on the floor and stated, "I fell going to the bathroom..." A reddened area was noted to the left knee.</p> <p>On 9/5/12, at 1:30 P.M., the Director of Nursing (DON) provided a copy of the service plan for Resident #37 including, but not limited to, an update effective 9/4/12, of the following parameters and services:</p> <p>Transfer: "Supervise transfer to and from bed - assist as needed." "Supervise transfer to and from chair - assist as needed." "Increased Resident's Parkinson's medication on 8/24/12."</p> <p>Physical Health: "Other - Resident wears a Cord Mate for assistance."</p> <p>In an interview on 9/6/12, at 9:45 A.M., the Executive Director (E.D.) and DON were asked to provide any additional documentation of interventions relating to fall prevention for Resident #37.</p> | | | |

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| | <p>At exit conference on 9/6/12, at 10:30 A.M., the E.D. and DON did not provide additional documentation that addressed fall prevention for Resident #37.</p> <p>2. In an interview during the initial orientation tour on 9/4/12 at 10:30 A.M., the Director of Nursing indicated Resident #25 was an insulin-dependent diabetic, was ambulatory with episodes of falls, and had memory issues.</p> <p>The clinical record for Resident #25 was reviewed on 9/4/12 at 12:20 P.M. Diagnoses included, but were not limited to, Parkinson's disease, atrial fibrillation, chronic obstructive pulmonary disease, diabetes Type II, and Lewy body dementia.</p> <p>The September, 2012 physician order rewrite sheets listed medications that included, but were not limited to, the following: Januvia 100 mg. [milligrams] and Glimepiride 4 mg.--oral medications for diabetes; Seroquel--an antipsychotic medication for behaviors; and Coumadin with alternating doses of 4 mg. and 6 mg. doses--for anti-coagulation ["thinning" the blood].</p> <p>A. "Nurse's Notes" entries, from 4/1/12, had documentation of the following:</p> <p>4/20/12, at 11:40 A.M.--"Resident had a</p> | | | |

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| | <p>fall at 9:00 A.M. Was found on the floor... sitting by recliner on the floor with walker by T.V.... stated she lost her balance while trying to get up...." No injuries were noted.</p> <p>5/3/12, at 8:50 P.M.--"Resident fell after tripping in living room... Found on knees, leaning on recliner... stated shoes were loose and not tied so she tripped... Incontinent urine...." No injuries were noted.</p> <p>5/17/12, at 12:01 A.M.--"Resident pushed emergency button... found resident on floor next to head of bed. Complained of left shoulder discomfort... Upon assessment found small hematoma to right posterior thigh, just above knee. No other injury noted... Was noted that bed appears too high to facilitate getting in and out easily."</p> <p>5/17/12, at 10:30 P.M.--"Resident had a fall at approximately 6:40 P.M. Found on floor in room, face down with abrasion to left orbital under eye... Complained of pain to left knee and left shoulder (resident has baseline pain to left shoulder)... Per resident, she fell because she tripped over dog. Resident [family member] stated she is coming to pick up dog...."</p> | | | | | | |

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| | <p>5/18/12, at 5:40 A.M.--"Resident alerted staff via call light. Found resident laying on floor in front of bed. States saw someone in room, and tried to get out of bed, but 'I just slid'...." No injuries were noted.</p> <p>6/12/12, at 3:00 P.M.--"Called to resident's room, found sitting on floor in kitchen. States her legs got weak and she sat down...."</p> <p>6/29/12, at 3:00 P.M.--"... found on floor in bathroom, lying on left side of hip. Denies injury, states hip is 'a little sore.' Resident was attempting to weight self in bathroom without assist...."</p> <p>7/11/12, at 10:30 P.M.--"Staff called to resident's room at 8:00 P.M. Resident found on floor. Resident states she hit her left arm and shoulder on bathtub. No injuries noted...."</p> <p>8/23/12, at 6:00 A.M.--"Resident found in bathroom doorway, lying on side. Resident states she was trying to get from bathroom to bed. Walker in living room...." No injuries were noted.</p> <p>8/29/12, at 4:00 A.M.--"Resident found on the floor of living room, next to recliner, with left temple resting on recliner. Resident states she was trying to</p> | | | |

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| | <p>go to bathroom and fell. Resident incontinent of urine when found...." No injuries were noted.</p> <p>A "Level of Service Assessment/Evaluation" form, dated 4/30/12, indicated the resident made poor decisions requiring cueing and supervision; had difficulty remembering and using information; required an every-2-hour check and toileting during the night; needed direct assistance less than 3 times in a 7-day period for transfers and changes in position; could toilet self without physical assistance or supervision; and had [for "Mobility"] "risk of falling inside and outside, poor gait, difficulty getting from room to room--needs direct assistance of another person inside 3 or more times in a 7-day period...."</p> <p>A subsequent "Level of Service Assessment/Evaluation" form, dated 8/10/12, identified the same areas at the same level of service, except for the category of "Mobility." This section indicated "Can only get around with regular assistance of another person both inside and outside. Not safe to ambulate alone. Needs constant cueing or standby assistance inside and outside to address safety. Does not have required strength or endurance to use mechanical aides."</p> | | | | | | |

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| | <p>The most recent Service Plan found in the clinical record was dated 4/30/12, and included, but was not limited to, the following services to be provided by the facility:</p> <p>"Transfer--Other: Assist PRN [as needed] wheelchair assist to/from dining room." An additional service was dated 8/10/12, and indicated "Assist daily to dining room. Not safe to ambulate alone."</p> <p>"Toileting--Assist with toileting care, including use of adult briefs; Other: Every 2 hour room checks and toileting at night, 7 days."</p> <p>During the daily conference on 9/4/12 at 2:35 P.M., the Director of Nursing was given the opportunity to submit any additional services related to fall prevention that had been initiated prior to the survey.</p> <p>On 9/5/12 at 9:10 A.M., the Director of Nursing provided a copy of the second page of the Service Plan dated 4/30/12, with an additional date of 9/4/12 added. In an interview on 9/6/12 at 9:30 A.M., the Director of Nursing indicated she had updated the Service Plan following the daily conference the previous day.</p> | | | |

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| | <p>The Director of Nursing indicated the resident had received Physical Therapy on and off during the last year. She believed the last time the resident had received therapy was 12/16/11, but it had been re-ordered on 8/29/12. She indicated she would need to check the clinical records for other dates. She indicated the services provided, related to falls, were the 2 hour checks and toileting around the clock, and assistance with ambulation to and from the dining room.</p> <p>A "Care Communication Note" from the Home Health therapy agency, dated 9/5/12, indicated the resident had last received physical/occupational therapy some time in March and/or April, 2012.</p> <p>B. A "Nurse's Notes" entry, dated 5/10/12 at 8:00 P.M. indicated "Upon toileting resident, aid [sic] noticed blood in urine. Resident stated no pain but did state she has the urge to go more often. Will inquire about urinalysis" Two entries on 5/11/12 indicated there was no further blood in the urine.</p> <p>A "Nurse's Notes" entry, dated 6/4/12, indicated the resident had returned from a physician's appointment with new orders for a urinary tract infection antibiotic, and "... she is also to make appointment with</p> | | | |

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| | <p>gyn [Gynecologist] for vaginal bleeding."</p> <p>The Service Plan, dated 4/30/12 and updated 9/4/12, listed the following in the "Medications" section: "Assist in ordering/picking up medications as needed; monitor for signs and symptoms of medication effectiveness; Nursing to administer medications, oxygen at night."</p> <p>There were no services identified on the Service Plan related to the Coumadin anti-coagulant medication, such as routine checks for signs of bleeding.</p> <p>In an interview on 9/6/12 at 9:30 A.M., the Director of Nursing indicated a 3-day follow-up was done after each fall, and part of the follow-up process would include checking for new bruising. She indicated she would be informed if the resident displayed any signs or symptoms of bleeding.</p> <p>C. A physician's progress note, dated 4/2/12, indicated "Worsening dementia-hallucinations." The physician prescribed an antipsychotic medication, Seroquel, at that time. On 4/30/12, the dosage was increased.</p> <p>"Nurse's Notes" entries had the following documentation:</p> | | | | | | |

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| | <p>4/19/12 at 11:00 P.M.--"Resident has increased confusion HS [bedtime]... Resident stated she did not want to get to bed and stated 'I want to go home. Where's my husband?' Resident put tennis shoes on and thought she was leaving...."</p> <p>4/20/12 at 11:40 A.M.--"Resident had fall at 9:00 A.M.... Resident stated she was confused and was having hallucinations this A.M....."</p> <p>5/16/12 at 6:55 A.M.--"Resident refused to get up at 4:30 A.M. to toilet, yelling at staff, she had removed her brief and soaked the bed...."</p> <p>7/3/12 at 4:00 A.M.--"Resident refusing toileting and oxygen, yelling at staff, belligerent with care. Very confused. Refusing brief...."</p> <p>8/10/12 at 11:00 P.M.--"Staff called to resident's room at 9:00 P.M. Resident was in the bathroom; staff noted many cords on floor and in trash. Staff, C.N.A., asked resident where these electric cords came from. Resident stated they were sparking so she cut them. Staff member told writer and writer and C.N.A. went to room and gathered all cut electronic cords. Writer unplugged all items that were plugged into outlets and removed</p> | | | |

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| | <p>items that were cut. Also writer removed scissors from room. Resident stated she had to use the scissors to stop the sparks...."</p> <p>The Service Plan, dated 4/30/12 and updated 9/4/12, listed the following services to be provided in the "Behavior" section: "Monitor for early warning signs of problem behavior; keep family informed of resident's behaviors; resident has Lewy body dementia." An additional note, dated 8/10/12, indicated "Resident cut multiple electrical cords in room."</p> <p>In an interview on 9/6/12 at 9:30 A.M., the Director of Nursing indicated staff conducted an every-2-hour "safety' check- -they observe the resident in the room to "make sure she is o.k.," take her to the toilet if she needs to go; and make sure someone is always with her when she walks.</p> | | | | | | |