

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155620	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/25/2014
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NAME OF PROVIDER OR SUPPLIER  ZIONSVILLE MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 675 S FORD RD ZIONSVILLE, IN 46077
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F000000	<p>This visit was for the Investigation of Complaints IN00152012, IN00154538 and IN00151350.</p> <p>Complaint: IN00151350 Substantiated. State deficiencies related to the allegations are cited at R0041 and R0214.</p> <p>Complaints: IN00152012 Unsubstantiated due to lack of evidence.</p> <p>IN00154538 Substantiated. Federal/State deficiency related to the allegation is cited at F323.</p> <p>Survey dates: August 21, 22, &amp; 25 2014</p> <p>Facility Number: 000538 Provider Number: 155620 AIM Number: 100267290</p> <p>Survey Team: Mary Jane G. Fischer RN</p> <p>Census Bed Type: SNF: 15 SNF/NF: 145 Residential: 62 Total: 222</p>	F000000	<p>The creation and submission of this plan of correction doesnot constitute an admission by this provider of any conclusion set forth in thestatement of deficiencies, or of any violation of regulation.</p> <p>This provider respectfully requests that the 2567 plan ofcorrection be considered as the letter of credible allegation and request a <b>desk review</b> on after September 24, 2014.</p>	
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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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F000323 SS=D	<p>Census Payor Type: Medicare: 18 Medicaid: 117 Other: 87 Total: 222</p> <p>Sample: 5</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review was completed by Tammy Alley RN on August 27, 2014.</p> <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 supervision of a resident, in that when a resident was assessed with the ability to transfer impulsively, and also had a history of falls the facility failed to ensure supervision for 1 of 5 sampled resident's reviewed for falls. (Resident "B").</p> <p>Findings include:  The record for Resident "B" was reviewed on 08-21-14 at 11:00 a.m.</p>	F000323	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>Resident B's care plan and resident profile have been updated to include standby supervision required after staff transfers resident to toilet. All staff working with Resident B have been educated.</p> <p><b>How will you identify other residents having the potential to be affected by the same deficient</b></p>	09/24/2014

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	<p>Diagnoses included, but were not limited to, history of a dislocated hip, peripheral edema, congestive heart failed, hypertension, anxiety, pain and osteoporosis. These diagnoses remained current at the time of the record review.</p> <p>A review of the resident's current Minimum Data Set (MDS) Assessment, dated 06-23-14 indicated the resident required the support of two + staff persons, and extensive assistance with toileting. The MDS further indicated the resident was not steady with balance and only able to stabilize with staff assistance in regard to moving form a seated to a standing position, moving on and off the toilet and surface to surface transfers.</p> <p>The resident's current plan of care related to behaviors, and dated 08-14-14 indicated the resident is "compulsive with transfers. Will transfer without staff &lt;sic&gt; without assistance from staff. Does not use call light when needing to use rest room." In addition a subsequent plan of care, originally dated 03-04-13, indicated the resident had "falls." The "problem" noted indicated the resident was at "risk for falls due to osteoarthritis, the use of antihypertensive's, impaired gait/balance and a history of falls. "Able to voice needs to staff and use call light to call for help, refuses to use call light</p>		<p><b>practice and what corrective action will be taken?</b></p> <p>All residents have the potential to be affected by thisdeficient practice. DNS and designees will conduct an audit of fall residents that are listed as fall risk, and are prone to impulsivebehaviors to ensure appropriate interventions are in place and beingutilized. This audit will be completedby September 8, 2014, and all resident's care plans and profiles will beupdated as appropriate.</p> <p><b>What measures will be put into place or what systemic changesyou will make to ensure that the deficient practice does not recur?</b></p> <p>Allresidents that are prone to impulsive behaviors and require assistance withtransfers will be provided standby supervision with toileting. All residents will be reviewed quarterly andPRN to ensure proper interventions are in place. All nursing staff will be re-educated on thefacility fall management protocol including appropriate interventions by 9/12/14. DNS or designee will make daily rounds toensure that all appropriate fall interventions are in place</p> <p><b>How will the corrective action(s) be monitored to ensure thedeficient practice will not recur, i.e., what quality assurance program will beput into place?</b></p>	

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	<p>most of the time and request help despite hx [history] of falls, hx of trying to transfer self despite hx. of falls and staff encouragement to always request assistance."</p> <p>A review of the Physician Progress Note, dated 06-18-14 indicated the resident had a recent fall and was "sent out with reported left hip dislocation, s/p [status post] repair." The notation indicated the resident had "confusion," "decreased range of motion," and a "surgical wound" to the left hip which measured 22.5 cm (centimeters) at the time of the visit.</p> <p>The resident received physical therapy for "gait, transfers, balance control, strengthening and bed mobility. The resident was discharged from therapy services on 08-03-14. A review of the Physical Therapy Discharge Summary indicated the resident was a high fall risk as the Tinetti Assessment Tool (for balance) scored the resident with 11/28 and noted her to be a "high fall risk."</p> <p>The Physician Progress Note, dated 08-07-14, indicated the resident remained "confused, a decrease in range of motion and had weakness."</p> <p>The record contained documentation from the orthopedic surgeon, dated</p>		<p>To ensure compliance, the DNS/Designee is responsible for the completion of the Fall Management CQI tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.</p>	

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	<p>08-11-14, and indicated the "Pt. [patient] had history of chronic dislocated left hip. Now 9 weeks s/p [status post] revision of the left hip, today's x-rays show recurrent dislocation."</p> <p>A current Physician Progress Notes, dated 08-19-14 indicated the following: "[Resident name} was seen for acute visit, she was seen today at Zionsville Meadows, seen today for f/u [follow up] concerns of reports of fall, resident was seen per [name of outpatient clinic] as f/u 9 week s/p revision left [hip]. X-rays reported recurrent dislocation , no surgical repair agreed upon with family at time of visit. There is a question if resident had fall. Upon my interview today when resident asked if she had a fall she said no not since this and pointed to left hip. I then inquired more about timing and she said July 7, 2014, nursing RN [registered nurse] was present however reported from nursing upon return from leave of absence with daughter on 08-15-14 at approximately 3:50 p.m. daughter reports resident states she fall three weeks ago. Daughter states, 'I've asked her repeatedly at the beginning of this week, when I learned her hardware to left hip is no longer connected. Until now she has said, no.' Resident was interviewed by SSD [Social Service Designee] and UM [unit</p>				

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	<p>manager] with daughter present.</p> <p>Resident at that time described a fall that was similar to her last fall which was recorded on 06-07-14. Resident between 'Monday and three weeks ago.' Resident admits to never telling nursing staff at the time of fall and has denied fall States 'two ordinary people' helped her off floor." The progress notes continued to indicate the resident had "confusion, weakness, joint pain and decrease range of motion." The "Plan - treatment plan" at the conclusion of the physician progress note indicated "established problem that is worsening hip dislocation, f/u with orthopedics in 6 weeks and nursing measure for fall precautions."</p> <p>During an observation on 08-22-14 at 10:20 a.m., the door to the resident's room and bathroom were opened. The resident was observed seated on the commode without supervision of a staff member. The Staff nurse was summoned, as the resident had been left attended. The Staff nurse indicated "I think they went out to get something."</p> <p>During an interview on 08-22-14 at 10:30 a.m., the Unit Manager indicated "the resident's CNA [certified nurses aide] went to get something and she'll be right back. [Name of resident] has her</p>			

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R000000	<p>call light."</p> <p>This Federal tag relates to Complaint IN00154538.</p> <p>3.1-45(a)(2)</p> <p>These state findings are cited in accordance with 410 IAC 16.2-5.</p>	R000000	<p>The creation and submission of this plan of correction doesnot constitute an admission by this provider of any conclusion set forth in thestatement of deficiencies, or of any violation of regulation.</p> <p>This provider respectfully requests that the 2567 plan ofcorrection be considered as the letter of credible allegation and request a <b>desk review</b> onrafter September 24, 2014.</p>	
R000041	<p>410 IAC 16.2-5-1.2(o)(4) Residents' Rights - Deficiency (4) The facility shall develop and implement policies for investigating and responding to complaints when made known and grievances made by: (A) an individual resident; (B) a resident council or family council, or both; (C) a family member; (D) family groups; or (E) other individuals.</p>			

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	<p>Based on record review and interview the facility failed to ensure a resolution to family members concerns, in that when a family member expressed written concerns to the facility, the facility failed to respond to the family member for 1 of 1 complaints reviewed. (Resident "C").</p> <p>Findings include:</p> <p>The record for Resident "C" was reviewed on 08-22-14 at 11:00 a.m. Diagnoses included, but were not limited to, atrial fibrillation, dementia, Parkinson's disease, arthritis and cataracts. These diagnoses remained current at the time of the record review.</p> <p>The resident resided at the facility from 03-26-11 until the time of her death on 02-17-14.</p> <p>During a telephone interview on 08-21-14 at 1:45 p.m., a concerned family member indicated that after her mother had expired she "sent a registered letter to [name of employee] at American Senior Communities." The family member indicated, "I think his secretary signed for it so I'm not sure he had even seen it. No one has ever gotten a hold of us regarding my mom's care."</p> <p>A review of the facility Admission packet</p>	R000041	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>Resident C's family member was contacted via telephone on 9/3/14 and corrections to grievances discussed.</p> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <p>All residents have the potential to be affected by the deficient practice. GM conducted an audit of all previous, documented grievances/ concerns for 2014 to ensure that each had the appropriate follow up.</p> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b></p> <p>All staff will be re-educated by the General Manager on American Senior Communities' policy regarding grievances and follow up. Re-education will be completed by September 5, 2014 and education will be incorporated upon new hire orientation.</p> <p>General Manager/other designee and other assisted living management staff will review grievances/concerns weekly during morning meeting to ensure</p>	09/24/2014			

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	<p>on 08-22-14 at 2:30 p.m., indicated the following: "Resident Rights and Complaint Resolution - Resident concerns and complaints (or the complaints of the Responsible Party or any other designated representative of Resident) are treated in accordance with the Community's Care and Concern Program. The Community and/or Lessor shall make a good faith, continuous effort to address and resolve all complaints and concerns, to the satisfaction of all parties involved, within the parameters and framework of it's policies, procedures and purposes."</p> <p>During an interview on 08-25-14, during the Exit Conference the facility Executive Director indicated he was aware the family sent a letter to (name of employee), and that (name of employee) gave a copy of the letter to the Director of Operations, the Clinical Manager at the home office, and he also received a copy/e-mail of the letter on 07-07-14.</p> <p>On 08-25-14 at 9:15 a.m., the Executive Director called the Director of Operations in regard to the status of the family members concern. The Executive Director indicated he was told by the Director of Operations he tried to call the family member twice, but without</p>		<p>appropriate follow up has beencompleted.</p> <p><b>Howwill the corrective action(s) be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place?</b></p> <p>. To ensure compliance, the General Manager/Clinical Director/Designee is responsible for thecompletion of the Grievance ResolutionCQI tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 andthen quarterly to encompass all shifts until continued compliance is maintainedfor 2 consecutive quarters. The results of these audits will be reviewed by theCQI committee overseen by the General Manager. If threshold of 95% is not achieved an action plan will be developed toensure compliance.</p>		

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	<p>success.</p> <p>The Executive Director also indicated the Clinical Manager no longer worked for the company and was unsure if she had followed up with the family.</p> <p>A review of the facility policy on 08-25-14 at 9:20 a.m., titled "Care and Concern Program," dated as revised "01-2014," indicated the following:</p> <p>"Purpose - Our ASC [American Senior Communities] Care and Concern (Grievance) Policy was developed in accordance with state guidelines to capture and resolve our residents' and families' concerns. The intent of our policy is to support each resident's right to voice grievances (e.g. complaints about treatment, care, management of funds, lost clothing, violation of right, etc.) and to assure that after receiving a complaint/grievance, we actively seek a resolution and keep the resident appropriately apprised of our progress toward resolution."</p> <p>"The purpose of the Care and Concern Program are:</p> <ul style="list-style-type: none"> <li>* to ensure that each concern is responded to in a timely manner</li> <li>* to ensure that each concern is responded to properly</li> </ul>				

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R000214	<p>* to evaluate all concerns to determine possible patterns so that adjustments can be made to reduce future issues</p> <p>* to identify families or personnel who tend to have the most concerns so a special effort can be made to address their special needs."</p> <p>"Procedure Definition: a care and concern (grievance) is any written or verbal [bold type] concern by a resident, relative or any other representative relating to resident care or the quality of services provided. 4. All care and concern/grievance forms will be reviewed and signed off by the Executive Director/General Manager. 5. Responses, appropriate plan/resolution to all complaints, and follow up with resident and/or family will be made within 72 hours. 6. The Executive Director/General Manager will sign off on all completed care and concerns/grievance forms, ensuring resident and/or family satisfaction."</p> <p>This State finding relates to Complaint IN00151350.</p> <p>410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least</p>			

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	<p>semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident.</p> <p>Based on record review and interview the facility failed to ensure an accurate evaluation of the resident needs, in that when resident's had multiple falls, with some incurred injuries which included head injury, bruising and skin tears, the facility failed to ensure a corrected assessment of the resident's abilities and needs, and also failed to ensure ongoing nursing evaluation related to injuries and emergency assistance for 4 of 4 resident's. (Residents "A", "B", "C" and "D").</p> <p>Findings include:</p> <p>1. The record for Resident "A" was reviewed on 08-21-14 at 2:00 p.m. Diagnoses included, but were not limited to, osteoporosis, cerebral vascular accident, osteoarthritis, gait instability a history of falls and a history of a fractured humerus. These diagnoses remained current at the time of the record review.</p> <p>A review of the current service plan dated 03-26-14 indicated the resident needed no assistance with transport &amp;/or transfer, had confusion in regard to mental status</p>	R000214	<p><b>Whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice?</b></p> <p>ResidentA, C, and D were closed chart reviews. Resident B has h/o of hypertensive episodes and clinical director hasobtained new call orders per physician. Clinical Director reviewed and updatedpersonal service plan.</p> <p><b>Howwill you identify other residents having the potential to be affected by thesame deficient practice and what corrective action will be taken?</b></p> <p><b>All residents have the potential to be affected by thisdeficient practice. The ClinicalDirector</b></p>	09/24/2014

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	<p>and decision making, set up assistance with dressing and undressing, reminders with toileting and incontinence, set up assistance only with a.m. and p.m. care and displayed no behaviors.</p> <p>A review of the resident's record indicated the resident had "unwitnessed falls" on 11-08-13 at 7:30 a.m., 12-31-13 at 6:25 p.m., 01-09-14 at 7:45 a.m., 02-14-14 at 2:45 a.m., 06-25-14 at 5:15 a.m., 07-07-14 at 4:50 a.m., 08-09-14 at 10:45 a.m. and again 3:00 p.m.</p> <p>A review of the available "fall circumstance reports" for review, indicated the following "circumstances" related to the above falls:</p> <p>a.) 12-31-13 - 6:25 p.m. - the record indicated the resident suffered a fractured left shoulder from this fall. The orthopedic report, dated 01-03-14 indicated the resident had a "fracture of the humerus, proximal, closed and stiffness of the shoulder." The "fall circumstance report" indicated the resident was attempting to transfer. The "medical factors" documented in the report indicated the resident had "arthritis and was incontinent." An additional medical factor included "TIA" (transischemic attack).</p>		<p><b>completed an audit of all falls in the last thirty days to ensure accuracy and appropriateness of interventions and to identify environmental, continence, care routines, assistive devices, medications, and/or behavioral causes. Care plans and CNA</b></p>		

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	<p>Directions on the record instructed the nursing staff to perform a neurological assessments "every eight hour times 72 hours." The nurse initiated neurological assessments for the resident. However the nursing staff failed to assess the resident on 01-02-14 during the day shift and 01-03-14 during the night shift.</p> <p>b.) 01-09-14 - 7:45 a.m. - the resident was found in the apartment in the bathroom doorway. The nurse documented the resident "could not remember exactly what happened - could state she tried to get up alone." The form indicated the resident had range of motion with the exception to the left arm and shoulder. The "medical factors for consideration" included "dementia and osteoarthritis." The nurse initiated neurological assessments for the resident. However the nursing staff failed to assess the resident on 01-10-14 during the night shift and day shift, and again on 01-11-14 on the evening shift and 01-12-14 on the night shift.</p> <p>A review of the nurses notes, dated 01-09-14 indicated the resident was found "lying on right side between bathroom and living room. Resident had been sitting on toilet."</p> <p>c.) 02-14-14 - 2:45 a.m. - the resident</p>		<p><b>assignment sheets were updated as appropriate. ClinicalDirector /designee will conduct daily rounds to ensure identified fallinterventions and documentation are in place.</b></p> <p>Whatmeasures will be put into place or what systemic changes you will make toensure that the deficient practice does not recur?</p> <p>All nursing staff were re-educated by the calllight system provider, Freedom Communications, regarding the call light usage. Clinical Director and other members of themanagement team educated on</p>	

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	<p>"slipped down from the restroom" and was "incontinent" at the time. The record indicated the resident sustained a bruise on the right leg, left upper arm and nose. The record contained neurochecks for the resident. However although the neurochecks were started on the night shift on 02-14-14, the form lacked documentation of neurological assessment for the day and evening shift on 02-14-14, the night and day shift on 02-15-14 and the night and day shift on 02-16-14. The nursing staff failed to ensure continued evaluation of the resident's neurological assessment as instructed on the assessment sheet.</p> <p>d.) 06-25-14 - 5:15 a.m. - the resident fell in the bedroom. The "fall circumstance report" queried the resident as if she was able to tell what happened. The nurse documented the resident responded, "she could not tell." The report indicated the resident was incontinent. The nurse initiated the "neurological assessment" form on the day shift. However the nursing staff failed to complete the form as the instructions noted and documented neurological assessments on 06-26-14 on the evening shift and again on 06-27-14 on the evening shift.</p> <p>The nurse's notes dated 06-25-14</p>		<p>how to run call light reports on a daily, weekly and monthly basis. All nursing staff were re-educated on the call light response policy. All were completed on 8/22/14.</p> <p>Clinical Director created new fall/event assessment and intervention tool to be completed upon each new incident. Each includes CQI Event Report, fall circumstance report, 72 hour follow up charting, including a neurological exam each shift, and post fall investigation to look for external factors. All nursing staff have been educated on the new assessment tool and falls management expectations. Education completed on 8/12/14. All new staff members will be educated on the new assessment tool upon hire.</p> <p><b>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <p>To ensure compliance, the charge nurse/Designee is responsible for the completion of the fall/event assessment and the Clinical Director will be responsible to complete an audit daily. The results of these audits will be reviewed by the management team, overseen by the GM. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. Clinical Director will identify any</p>				

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	<p>indicated the resident had an unwitnessed fall and "resident laid in between the bed and an arm-chair in her bedroom. Resident was found laying on her left side and complained of slight pain in her left arm."</p> <p>e.) 07-4-14 - 4:50 a.m. - the resident was "found on her left side and had one slipper on." The form indicated the resident was "incontinent" and was "unable to tell what happened, can't remember, c/o [complains of] general pain and stomach ache."</p> <p>The nurse initiated the "neurological assessment" form on the night shift but failed to document the resident assessment on 07-04-14 for the day shift, 07-05-14 for the night and day shift and 07-06-14 for the night and the day shift.</p> <p>The nurses notes dated 07-04-14 indicated the resident had "one slipper on and rolling walker was away from her."</p> <p>An additional nurses note dated 07-14-14 at 7:00 p.m., indicated the resident was "seen by home health physical therapist states resident needs transported in w/c [wheelchair] to and from all meals in dr [dining room]. Resident is too unstable with gait and too weak to walk independently at this time."</p>		<p>trends and/or patterns noted from the fall/event assessment. Any noted concerns will be addressed immediately. Clinical Director will complete a personal service plan review upon each new fall/event. Clinical director will monitor call light reports on a daily basis. Any trends and/or patterns will be identified and corrected immediately. To ensure compliance, the Clinical Director/Designee is responsible for the completion of the Falls CQI tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the General Manager. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.</p>				

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	<p>f.) 08-09-14 - 10:45 a.m. -- the resident had an unwitnessed fall in the bedroom. The "resident couldn't explain what happened." The resident has a "condition causing unsteadiness," with a "history of falls." "Resident is alert but confused." A neurological assessment was initiated on the day shift at the time of the fall.</p> <p>The nurses notes dated 08-09-14 indicated the resident was "found by house keeper...resident did not use call light but it was attached. When asked resident says she doesn't know how she fell."</p> <p>The resident was again found on the floor on 08-09-14 at 3:00 p.m. The "fall circumstance report," indicated the resident was found in her bedroom but "couldn't explain what had happened." The report indicated the resident had a condition which caused unsteadiness which included a history of falls and osteoarthritis. The nurse indicated the resident had "increased confusion noted." A neurological assessment was initiated on the evening shift at the time of the fall.</p> <p>The nurses notes, dated 08-09-14 (no time documented) indicated the resident "had just fell in the morning and fall had been unwitnessed. Resident has a call</p>			

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	<p>light button but refused to use it. Resident states 'I don't know what happened.'"</p> <p>A nurses note dated 08-10-14 at 12-1:45 a.m. indicated "resident was changed at 12:00 a.m. by the CNA [certified nurses aide] on duty. Nurse was called by CNA at 1:25 a.m. by CNA to bring her tools to take resident v/s [vital signs] CNA saw resident vomitted &lt;sic&gt; and looking weak. CNA was asked to rush and cleaned resident while resident guggle &lt;Sic&gt; the mouth and replenish some fluid as an intervention. Cleaning was done and resident was uncooperative. Paramedics were called in at 1:30 a.m. to take resident to the hospital for evaluation. 2:10 a.m. ambulance returned with the resident that they did not even reach the hospital when the resident passed out and they have to return her to the bed."</p> <p>Although the resident's vital signs were taken the nurse failed to perform the scheduled neurological assessment to determine the resident's status.</p> <p>A review of an "incident report," dated 08-10-14 indicated that at 1:30 a.m. the "res. [resident] was found unresponsive with emesis noted in bed." "Ambulance returned with resident at 2:10 a.m. Res.</p>			

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	<p>[resident] had passed away en route to hospital. Res. returned to facility per EMT's [Emergency Medical Technicians]."</p> <p>During an interview on 08-21-14 at 1:20 p.m., Resident "B" indicated she was concerned because another resident (Resident "E") told Resident "B", that she found Resident "A" on the floor next to the dresser. (Name of Resident "E") indicated the "nurses were in the nurses station and she alerted them that the resident was on the floor. The nurses assured her that they would be there, but they didn't come." "[Name of Resident "E"] told me that when they finally did come they picked her [Resident "A"] up and put her in her wheelchair. The next day she was dead."</p> <p>During an interview on 08-21-14 at 1:40 p.m. Resident "E" indicated, "Her apartmentn door was open and I saw her on the floor. She was in front of her dresser and the bottom drawer was open. I couldn't tell if she hit her head. I pushed the button and no one came, so I went to look for someone. The nurses were sitting in the nursing station and I told them she fell and needed help. They said OK. I left and went back to her room to stay with her and they still didn't come. I went part of the way back down</p>			

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	<p>the hall and started yelling 'nurse, nurse.' One of the nurses poked her head out from the nurses station and said, 'I know [name of resident] - we're coming.' It was still awhile before they came and I stayed with her until they did. They took her blood pressure and then put her in her wheelchair. Well she was dead the next morning."</p> <p>The record lacked an accurate assessment of the resident's abilities and needs.</p> <p>2.) The record for Resident "C" was reviewed on 08-22-14 at 11:00 a.m. Diagnoses included, but were not limited to, atrial fibrillation, chronic obstructive pulmonary disease, dementia, Parkinson's disease, arthritis and cataracts. These diagnoses remained current at the time of the record review.</p> <p>A review of the resident's current Service Plan, dated 12-10-13 indicated the resident needed escort services to and from meals, to and from out of room activities, assistance with mobility, set up assistance with a.m. and p.m. care, hands on assistance with bathing two times a week, hands on assistance with dressing and undressing, assistance with toileting/incontinence, and was alert and oriented with confusion at times. The resident required no intervention for</p>			

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	<p>behaviors and had "special needs" with monitoring of labs/xray results." The "service plan" indicated the resident had the services of Home Health Care.</p> <p>The resident was readmitted to the facility after a hospitalization on 12-23-13 for bronchitis and aspiration pneumonia.</p> <p>The resident had Home Health Services, with a "start of care date" of 12-23-14. The Home Health Assessment indicated the resident was "incontinent, requires food set up" and the resident "has problems with the mechanics of eating because of arthritis bilateral hands, with bone/joint problems, pain/stiffness upper bilateral extremities, gait/ambulation disturbance, requires assistance with toileting, bathing, dressing, grooming."</p> <p>The resident had unwitnessed falls on 11-09-13 at 8:00 a.m., 12-2-13 at 4:00 p.m., 12-08-13 at 7:15 a.m., 12-26-13 at 7:45 a.m., 12-27-13 at 2:30 p.m., 01-27-14 at 7:30 a.m., 01-29-14 at 7:35 a.m., and 02-05-14 at 2:30 p.m.</p> <p>A review of the available "fall circumstance reports" for review, indicated the following "circumstances" related to the above falls:</p>			

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	<p>a.) 11-09-13 - 8:00 a.m. - resident was in the bathroom sitting in wheelchair. The nurse indicated the resident explained "she said she just fell ???" The record indicated the Medical Factors for Consideration included "arthritis, Parkinson's, Incontinence and Osteoporosis." The notation indicated "Res. [resident] was found on the bathroom floor. "She said she just fell and couldn't get up." Neurological assessments were completed.</p> <p>b.) 12-02-13 - 4:00 p.m. - "Resident says she was going to the bathroom" and fell. The nurse initiated neurological assessment on the evening shift.</p> <p>The nursing staff failed to ensure the neurological assessment was completed every eight hours for 72 hours, without documentation on 12-04-13 for the day shift.</p> <p>c.) 12-08-13 - 7:15 a.m. An "Incident Report" indicated the incident was related to a fall, without injury. The form indicated the resident had "other falls" and the resident was "reminded/taught and reinforced using the call button."</p> <p>The nurse initiated the neurological assessment on the night shift of 12-08-13 but failed to complete the assessments as</p>						

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	<p>instructed on 12-08-13 day shift, 12-09-13 day shift and 12-10-13 for the night and the day shift.</p> <p>d.) 12-26-13 - 7:45 a.m. - The "72 hour follow up charting report" indicated the resident had a "fall" trying to "get out of bed and fell between the bed and the dresser."</p> <p>The nurse initiated the neurological assessment on the day shift of 12-26-13 but failed to complete the assessments as instructed on 12-27-13 for the night shift and day shift, 12-28-13 for the evening shift, and 12-29-13 for the night and the day shift.</p> <p>e.) 12-27-13 - 2:30 p.m. - The "72 hour follow up charting report" indicated the resident had a "fall." The record lacked details of the incident, but indicated the resident did not complain of pain.</p> <p>The nurse initiated the neurological assessment on the day shift of 12-27-13 but failed to complete the assessments on 12-28-13 for the day and evening shift, 12-29-13 for the night, day and evening shift, and 12-30-13 for the night shift.</p> <p>f.) 01-27-14 - 7:30 a.m. - The "72 hour follow up charting report" indicated the resident "slid out of bed." The record</p>			

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	<p>lacked details of the incident, but indicated the resident did not complain of pain.</p> <p>The nurse initiated the neurological assessment on the day shift of 01-27-14 but failed to complete the assessments on 01-28-14 for the night and day shift, 01-30-14 for the night, day and evening shifts.</p> <p>g.) 01-29-14 - 7:35 a.m. The "Fall Circumstance Report" indicated the resident "slid out of bed." The "Activity" occurred when the resident was transferring out of bed by herself without assistance from staff. The report indicated the resident was not able to use the call light appropriately.</p> <p>The nurse initiated the neurological assessment on the day shift of 01-29-14 but failed to complete the assessments on 01-30-14 for the day shift, 01-31-14 for the day and evening shifts.</p> <p>h.) 02-05-14 - 2:30 p.m. - The "72 hour follow up charting report" indicated the resident had an "unwitnessed fall." The form indicated the resident sustained injuries which included upper outer arm skin tears and left shoulder bruising. The report indicated that after the fall a notation on 02-07-14 for the night shift</p>						

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	<p>the resident's heart rate had increased from 78 to 113. The nurse documented "HR [heart rate] increased and must be monitored." A subsequent notation on 02-08-14 on the evening shift indicated the resident complained of pain on the left side and had a increase in her heart rate from 97 on the evening shift to 123 on the night shift.</p> <p>The nurse initiated the neurological assessment on the day shift of 02-05-14 and on the evening shift for 02-05-14. The form indicated only one set of neurological assessments on 02-06-14 and 02-07-14.</p> <p>The record lacked an accurate assessment of the resident's abilities and needs.</p> <p>3.) The record for Resident "D" was reviewed on 08-22-14 at 2:30 p.m. Diagnoses included, but were not limited to, a history for right femoral neck fracture, a history of falls and a head injury. These diagnoses remained current at the time of the record review.</p> <p>A review of the resident's Service Plan dated 04-12-14 indicated the resident required no assistance with transport and/or transfers, hygiene, bathing, dressing, or toileting/incontinence.</p>			

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	<p>A review of the nurses notes and fall circumstance reports indicated the following:</p> <p>"12-01-13 7:10 a.m. "Resident was found sitting on the floor in her bathroom. Per resident 'I was sitting on the toilet and it slid off, it was loose.'"</p> <p>"01-17-14 - 11:00 p.m. Writer walked in room to find resident sitting on floor in front of dining room chair. Res. [resident] stated she was sitting on the edge of her chair and slipped onto floor. Call button within reach."</p> <p>The Fall Circumstance Report dated 01-17-14 indicated the resident was found in her "bedroom on the dinning &lt;sic&gt; floor." A review of the 72 hour follow up charting for the resident indicated the resident had a "skin tear on the left arm."</p> <p>The nurse initiated the neurological assessment on 01-17-14 at 11:00 p.m. Neurological assessment continued on the day and evening shift but no further assessment of the resident was documented on this form.</p> <p>"01-19-14 9:05 p.m. Resident [family member] called and stated resident had fallen in her apartment and hit her head.</p>			

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NAME OF PROVIDER OR SUPPLIER  ZIONSVILLE MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 675 S FORD RD ZIONSVILLE, IN 46077
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	<p>[Family member] states resident called him first then [family member] instructed resident to push pendant. Nurse went immediately to residents apartment - found resident in bathroom sitting on walker seat [illegible word] with bowel moderate amount of bleeding noted on top of head. Also noted 2-3 centimeter hematoma. Laceration noted to be 1 1/2 - 2 centimeters unable to determine depth at this time. Resident states she was sitting on side of bed, fell over striking head against walker."</p> <p>The Fall Circumstance Report indicated the resident had Medical Factors for Consideration which included macular degeneration and osteoporosis. The 72 hour follow up charting for the resident indicated "hematoma/laceration remains, blood noted to hair."</p> <p>The nurse initiated the neurological assessment on 01-19-14 at 9:10 p.m. However the nursing staff failed to complete the assessments on 01-20-14 for the day shift and no assessments were completed for 01-21-14.</p> <p>A review of an Incident Report, dated 01-19-14 indicated the fall was unwitnessed, time of incident and location was "unknown." The form indicated the resident had a 3 inch by 1/4</p>			

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	<p>skin tear on the left forearm.</p> <p>"08-13-14 at 5:09 p.m. CNA told writer resident fell in dining room. Writer found resident sitting on her buttocks in the Villa [dining room]. Fall was unwitnessed. Resident stated 'I was pulling out the chair and I just fell.' Small s/t [skin tear] to left hand measures approximately .5 by .5 inches."</p> <p>"Fall Circumstance Report" dated 08-14-14 at 11:00 a.m. indicated the resident "hit head in bathroom on grab bar." The incident occurred while the resident was "transferring." The resident stated "I was getting up from the toilet and hit my head on the grab bar." Small reddened area to left temple 0.5 inches by 0.5 inches." The Fall Investigation Worksheet indicated the resident was "oriented times three but forgetful."</p> <p>The nurse initiated the neurological assessment on 08-15-14 on the night shift but failed to complete the assessment on 08-15-14 on evening shift, and 08-17-14 on evening shift.</p> <p>The record lacked an accurate assessment of the resident's abilities and needs.</p> <p>4. The record for Resident "B" was reviewed on 08-21-14 at 2:00 p.m.</p>			

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	<p>Diagnoses included, but were not limited to, hypertension, osteoporosis, diabetes, arthritis, depression and cerebral vascular accident. These diagnoses remained current at the time of the record review.</p> <p>During an interview on 08-21-14 at 1:20 p.m., the resident indicated she recently had an episode where she felt her blood pressure was very high and she pressed the call light but a staff member did not answer. The resident further indicated she fell to the floor, but was able to get to the doorway and called for assistance from her neighbor. "He went to get the nurse because no one ever came to help me."</p> <p>A review of the nurses notes dated 08-02-14 at 5:30 p.m., indicated "Resident had another resident come and get this writer stating '[name of resident] needs you right away.' When this nurse entered res. apartment resident was lying on her bed comfortably in sleep shirt. Resident states 'I had been taking nap when I stood up to get dressed and became very dizzy and started leaning to my left side. I sat back down on bed and then got full feeling on left side of my chest. I have felt his before with my heart. I don't have regular chest pain just full feeling.'"</p>			

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	<p>During further interview the resident indicated the nurse did call for 911 and she went to the hospital, but "you can push and push on your call light they just don't answer. We have to depend on each other. Another time I'm embarrassed to say, I had a bout with vomiting and diarrhea. I was sitting on the toilet and filling up the trashcan at the same time. I push the button and I didn't think anyone was ever going to come."</p> <p>The record indicated the resident was admitted to the hospital on 08-02-14 with a diagnosis of accelerated hypertension.</p> <p>5. A review of the "Resident Handbook," on 08-25-14 at 2:00 p.m., indicated the following: "Section 4.4: Emergency Response (Call) System - The emergency response system is designed for residents to contact a nursing staff member for emergency assistance. Residents can request pendants that may be worn around the neck or as a bracelet. Push buttons are also located in all bathrooms at no additional cost. How it works - Communities with the call system, when the button is pressed, a pager worn by nursing staff is activated. Your name, home number, and phone number appear on a computer screen in the nursing office and are also transmitted to the</p>						

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	<p>paggers nursing staff wears. One firm press in the designated area is needed to activate the pendance or push button.</p> <p>How to use - In the event of an emergency, simply press the designated area on the pendant or push button on the bathroom wall (whichever is nearest). A nursing staff member will respond to assist you. Emergencies include, but are not limited to , falls, chest pain, shortness of breath, difficulty breathing etc."</p> <p>During an interview on 08-22-14 at 1:15 p.m., the licensed nurse indicated "We have a paging system. The call goes to the aide and the nurses pager - everybody gets the page."</p> <p>6. A review of the facility Fall Management Policy on 08-22-14 at 10:00 a.m., and dated as revised 01-2008, indicated the following:</p> <p>"Policy - It is the policy of this facility to ensure the residents residing within the community/facility maintain maximum physical functioning through the establishment of physical, environmental, and psychosocial guidelines. This includes ensuring the safety and comfort of the resident, assisting in continuity of care and identifying any preventable injury related to falls."</p>			

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	<p>"Procedure - 1. Resident's experiencing a fall are to be assessed by a licensed nurse for injury and medical intervention, as indicated. 2. Any resident that has a fall within the facility will have a Fall Circumstance form completed. The form initiates the investigation process and is to be completed by the licensed nurse prior to the end of the shift. 3. Seventy two (72) hour follow up charting from will be initiated and documented on every shift for 72 hours.'</p> <p>This State finding relates to Complaint IN00151350.</p>				