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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155587 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 10/17/2011 |
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| F0000 | <p>This visit was for the Investigation of Complaint IN00098203.</p> <p>Complaint IN00098203 - Substantiated. Federal/state deficiencies related to the allegation are cited at F223.</p> <p>Survey dates: October 14 and 17, 2011</p> <p>Facility number: 000415 Provider number: 155587 AIM number: 100291250</p> <p>Survey team: Kimberly Perigo, RN</p> <p>Census bed type: SNF/NF: 33 Total: 33</p> <p>Census payor type: Medicare: 01 Medicaid: 30 Other: 02 Total: 33</p> <p>Sample: 03</p> <p>Summerfield Health Care was found to be in substantial compliance with 42 CFR Part 483 Subpart B in regard to the Investigation of Complaint IN00098203.</p> | F0000 | | |

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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| F0223 SS=A | <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 10/19/11 by Suzanne Williams, RN</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on observation, interviews, and record reviews, the facility failed to ensure each resident had been free from abuse for 1 of 1 incident of resident [# B] to resident [# A] abuse, reviewed in a sample of 3 residents.</p> <p>Findings include:</p> <p>Resident B's clinical records were reviewed on October 17, 2011 at 10:00 a.m.</p> <p>Resident B's diagnoses included but were not limited to Huntington's disease [disease of the central nervous system marked by movement disorder, behavioral decline, and loss of cognitive function]; personality disorder [a pathological disturbance of the patterns of perception, communication, and thinking]; psychosis [a mental disorder in which there is a severe loss of contact with reality];</p> | F0223 | <p>I. Resident A was sent to Putnam County Hospital ER on 10/10/11 after the incident for evaluation and treatment. He was then seen by an ENT for the fracture of his left orbit on 10/17/11, at which time he did not receive any further treatment. II. All residents had the potential to be affected by Resident B. Resident B was arrested and placed in the Putnam County Jail after the incident. Resident B is currently in the Putnam County Jail and will not be returning to Summerfield Health Care Center. III. When a resident is showing highly agitated or aggressive behaviors, the following will occur: 1. The resident will be removed from the situation. 2. Allow the resident to calm down and vent frustrations or feelings to staff. 3. If agitation or aggression persist, the resident will be placed on 1:1 monitoring until episode has stopped. 4. If agitation/aggression does not stop, then Pharmacological or</p> | 10/31/2011 | | | |

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| | <p>organic brain syndrome [a mental disorder associated with impaired cerebral function]; depression; anxiety and paranoid schizophrenia [a thought disorder characterized by delusions of persecution].</p> <p>A Pre-Admission Screening Assessment Determination (PAS/PASRR) dated September 01, 2011, did not indicate any poor impulse control, suicidal, and/or homicidal thought(s). Resident B was admitted to the nursing facility on September 12, 2011.</p> <p>The nursing facility received on September 12, 2011, a Neurology Report dated July 07, 2011. The report indicated Resident B had a social history [date(s) not documented/prior to 2008] of; "jail. for four years ... sexual misconduct with a minor, battery." History of Present Illness indicated; "... The patient complains of disturbance in coordination, poor balance, and tremors, but denies change in health ... mood swings ... Problems reviewed and addressed today include: Huntington's Disease. ... The patient returns because of severe involuntary movements due to his Huntington's chorea ... The movements have gotten much worse. ... Balance is becoming impaired. He also is concerned that he cannot remember people's names. ..."</p> | | <p>psychiatric intervention will be sought by the charge nurse. 5. 1:1 monitoring will continue until severe agitation/aggression has ceased or the resident is transferred to another medical facility. IV. This system will be monitored by the DON, BSW or Administrator to ensure compliance with each episode. Agitation/Aggression of the resident will be discussed at the next IDT Stand-up meeting to ensure proper use of the system. Behaviors are reviewed at each QA meeting to establish consistency of care.</p> | | |

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| | <p>A Behavioral Evaluation [completed by a psychiatric professional] dated September 14, 2011, indicated; "Mood: Pleasant. Thought Process: Logical, Coherent. Affect [emotional reaction to experiences]: WNL [within normal limits]. Delusions: None. Hallucinations: Denies. Risk of Harm Assessment: Self harm risk: low. Risk to others: No evidence."</p> <p>An admission Minimum Data Set Assessment [evaluation of physical, mental, and psychosocial health status] dated September 22, 2011, indicated when communicating Resident B could understand others and others could understand him. His cognitive [thinking] skills for daily decision making were moderately impaired. He required cues and supervision from nursing staff for daily decision making. He was independent with activities of daily living, after help with set up. His mood, behavior, and psychosocial evaluation lacked an indication of thoughts to hurt himself and/or others.</p> <p>Resident B's care plan dated September 12, 2011; indicated a risk for psychosocial stress, due to his history. Interventions [care staff implemented due to identified risk] included, but were not limited to,</p> | | | |

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| | <p>psychiatric care as needed; medications as ordered; assess for unmet needs ... anxiety; encourage participation; and provide supervision.</p> <p>The Ombudsman was interviewed on October 14, 2011 at 12:55 p.m. During the interview, the Ombudsman indicated having visited Resident B twice since his admission on September 12, 2011, and indicated Resident B was "fine," and had not been exhibiting any "adjustment" symptoms.</p> <p>Resident B's clinical record documentation dated September 12, 2011 through October 10, 2011, lacked documentation of mood and/or behavior risks.</p> <p>Interview of direct care nursing staff: Certified Nursing Assistant A on October 14, 2011 at 11:10 a.m.; Certified Nursing Assistant B on October 14, 2011 at 11:21 p.m.; Certified Nursing Assistant C on October 14, 2011 at 11:32 a.m.; and Certified Nursing Assistant D on October 14, 2011 at 11:44 a.m., indicated having provided direct activities of daily living set-up care for Resident B. The staff interviewed indicated no observation of mood and/or behaviors, which would have indicated a direct threat of harm to himself and/or others.</p> | | | |

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| | <p>The Social Service Director was interviewed on October 14, 2011 at 1:40 p.m. During the interview the director indicated having talked with and observed Resident B on several occasions and not having observed any change in mood and/or behavior, which indicated a risk of harm to himself and/or others. Resident B would often come to talk with the Social Service Director. During the day on October 10, 2011, Resident B came and talked with the Social Service Director. Resident B discussed concerns Resident A [his roommate] made threats he was going to break his TV. If this occurred, what would happen? Social Service explained staff would watch to make sure it would not happen, and if so, the nursing facility would replace the TV. "____ [Resident B's name] seemed fine with this explanation and left my office."</p> <p>Resident A, [Resident B's roommate] is provided one-on-one care from nursing staff.</p> <p>During the day shift on October 10, 2011; Certified Nursing Assistant D provided one-on-one care for Resident A. During the interview on October 14, 2011; Certified Nursing Assistant D indicated Resident A and Resident B had exchanged words with each other.</p> | | | | |

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| | <p>Neither resident exhibited angry and/or aggressive behavior.</p> <p>During the evening shift on October 10, 2011; Nursing Assistant E provided sitting one-on-one care for Resident A.</p> <p>Nursing Assistant E was interviewed on October 14, 2011 at 1:07 p.m. During the interview, Nursing Assistant E indicated no interaction between Resident A and Resident B had occurred. At approximately 9:15 p.m. Resident A was positioned on the side of his bed listening to music, via a CD player with head phones. Resident B was observed to stand up from his bed, put his clothes on and then put his shoes on. Nursing Assistant E indicated thinking Resident B was going to use the bathroom. Resident B then came over to Resident A "and out of the blue, started beating him up." Nursing Assistant E obtained assistance from other nursing staff. Resident B was separated from Resident A, the police were immediately contacted, and Resident B was arrested for battery.</p> <p>Licensed Staff's documentation dated October 10, 2011; in Resident A's Nurse's Notes indicated; "8:30 p [p.m.] HS [hour of sleep/bedtime] meds given s [without] difficulty. Res resting quietly in bed. ... 9:15 p Alerted by staff that resident had</p> | | | | |

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| | <p>been hit in the face by roommate. 1:1 staff witnessed incident, stating that res was sitting on the side of bed listening to his CD's, not yelling or agitated at all, when room mate [Resident B] pulled his curtain & hit him in face several times. 1:1 alerted other staff for assistance. Found res sitting on bed, blood noted to face, clothing & linens. Res face washed & assessed. (L) [left] eye sclera [outer layer of the eyeball] red, around (L) eye discolored c [with] purplish raised area noted under eye. Small amt. [amount] of blood noted to (L) nostril & lip. [sic]" Continued review of Resident A's Nurse's Notes indicated, following the incident, Resident A had been sent to a local acute care hospital for evaluation and treatment. Resident A was diagnosed with an "Acute contusion [bruise/a traumatic injury to the skin in which blood vessels are broken but tissue surfaces remain intact] & fx [fracture] to (L) orbit [the bony area of the skull that contains and protects the eyeball]."</p> <p>Resident A was observed on October 14 and 17, 2011. Resident A's left eye bruise showed improvement, and he was not exhibiting any behavior changes since the incident.</p> <p>Resident B remains incarcerated at a county jail, and will not to return to the</p> | | | | |

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| | nursing facility upon release. This deficiency is related to Complaint IN00098203. 3.1-27(a)(1) | | | | |