

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155152	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/21/2015
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NAME OF PROVIDER OR SUPPLIER  MONTICELLO HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960
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F000000	<p>This visit was for the Investigation of Complaints IN00163056 and IN00163172.</p> <p>Complaint IN00163056-Substantiated. No deficiency related to the allegation was cited.</p> <p>Complaint IN00163172-Substantiated. Federal/State deficiency related to the allegation was cited at F323.</p> <p>Survey Dates: January 21, 2015</p> <p>Facility number: 000072 Provider number: 155152 AIM number: 100287440</p> <p>Survey team: Regina Sanders, RN, TC</p> <p>Census bed type: SNF: 14 SNF/NF: 87 Total: 101</p> <p>Census Payor type: Medicare: 15 Medicaid: 63 Other: 23 Total: 101</p>	F000000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests a face to face IDR due to the facility disagrees with the severity of F323.	
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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=G	<p>Sample: 4</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on January 23, 2015, by Janelyn Kulik, RN.</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 record review and interview, the facility failed to ensure a resident received adequate supervision and assistance devices to prevent accidents, related to a pressure alarm not being on a resident as ordered and care planned, The resident stood from the wheelchair, fell and received a laceration to the forehead and a dislocated finger, for 1 of 3 residents reviewed for falls in a total sample of 4. (Resident #E)</p>	F000323	<p><b>F323 Free of Accident hazards/supervision/devices</b> It is the practice of this provider to ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This provider respectfully requests a face to face IDR due to the facility disagrees with the severity of F323. <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> Based on the</p>	01/26/2015	

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	<p>Findings include:</p> <p>Resident #E's record was reviewed on 01/21/15 at 1 p.m. The resident's diagnoses included, but were not limited to, dementia and hypertension.</p> <p>A Quarterly Minimum Data Set assessment, dated 12/04/14, indicated the resident's cognition was intact, required extensive assistance for transfers, and had a history of two falls without injury and one fall with injury.</p> <p>A care plan, dated 09/02/14, indicated the resident was a fall risk and had a history of falls. The interventions included wheelchair pressure alarm, which was added as an intervention on 10/20/14.</p> <p>A Physician's Order, dated 10/20/14, indicated an order for a pressure alarm to the resident's wheelchair, to alert the staff of unassisted attempts at transfers.</p> <p>A Nurses' Progress Note, dated 01/03/15 at 2:59 p.m., indicated the resident had been sitting in the dining room watching TV, when he attempted to stand from the wheelchair, without assistance and fell. The resident received a cut to the center of the forehead which was approximately, "1.5 inches" and complained of severe pain to the right</p>		<p>information provided, Resident E's wheelchair alarm is in place per physician's order and care plan. <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> All residents that are at risk for falls have the potential to be affected by the alleged deficient practice. The interventions and care plans for residents at risk for falls have been reviewed to ensure compliance by the Director of Nursing Services or her designee. Residents with physician's orders for wheelchair alarms were reviewed to ensure the alarm is in place by the Director of Nursing Services or her designee. The aide assignment sheets have been updated to reflect appropriate fall interventions. Nursing staff were re-educated on fall interventions by January 26, 2015 by the Director of Nursing Services or her designee. <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> Nursing staff were re-educated on fall interventions by January 26, 2015 by the Director of Nursing Services or her designee. Aide Assignment sheets are updated to reflect changes in the residents' needs regarding fall interventions. Each</p>		

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	<p>shoulder, hip, and elbow. The resident was immediately transferred to the hospital Emergency Room.</p> <p>A Nurses' Progress Note, dated 01/03/15 at 6:36 p.m., indicated the resident returned to the facility from the Emergency Room. The report from the hospital indicated the cut to the head had been glued and the resident had a dislocated finger, which had been reduced and now had a splint on the right ring finger.</p> <p>The Emergency Room transfer papers, dated 01/03/15 at 4:49 p.m., indicated the resident had a dislocated finger, which was reduced (aligned) and would take about six weeks for the ligaments to heal. The Progress Notes, indicated the resident's right ring finger had swelling and bruising and the resident had a 1 centimeter laceration to the forehead with mild amount of swelling.</p> <p>The facility's Interdisciplinary Team Notes, dated 01/05/15 at 10:15 a.m., indicated the resident attempted to stand up with assistance and fell, which resulted in a cut to the forehead and complaints of sever pain to his right shoulder, right hip, and right elbow. The note indicated the resident returned from the Emergency Room with a skin tear to</p>		<p>resident's care plan is reviewed and updated quarterly and as needed to reflect the residents' needs regarding fall interventions. The Charge Nurse will ensure that resident's fall interventions are in place and ensuring CNA assignment sheets are followed each shift per the care plan by conducting rounds. The Restorative team is auditing alarm placement daily on the fall intervention log. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <ul style="list-style-type: none"> <li>· The CQI tool titled "Fall Management" will be utilized by the Interdisciplinary team weekly times four, monthly times three and quarterly thereafter for at least six months to ensure compliance.</li> <li>· The CQI committee reviews the audits monthly and action plans are developed as a threshold of 95% is not met to ensure continual compliance.</li> <li>· The Director of Nursing Services or her designee is responsible to monitor for compliance. <b>Compliance Date: January 26, 2015</b></li> </ul>		

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	<p>the head, which was glued back together and a splint to the right ring finger for the dislocation. The note indicated the facility would use a pull pin alarm while the resident was in the wheelchair instead of a pressure sensor alarm.</p> <p>The Fall Investigation, received from the Director of Nursing, dated 01/03/15, indicated, "...Where was the last place you saw resident before the fall occurred...Sitting in w/c (wheelchair) in dining room @ (at) table watching TV et eating watermelon. Did you witness the fall? No...Were all care planned or ordered interventions in place? Res (resident) in 1W (West) D/R (dining room), w/in (within) view of all staff @ Nurses' Station, Res stood and fell before staff could assist...Per nursing documentation, w/c alarm was not sounding at time of fall..."</p> <p>During an interview on 01/21/15 at 2:45 p.m., the Director of Nursing (DoN) indicated the Nurse on Duty at the time of the fall (LPN #1) had not heard the wheelchair alarm sound. The DoN indicated the alarm was not on at the time of the resident's fall, then continued to indicate the alarm was not in place at the time of the fall. The DoN indicated the LPN #1 was inserviced about the alarm placement.</p>			

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	<p>During an interview on 01/21/15 at 3:40 p.m., LPN #1 indicated she could not recall if the pressure alarm was on at the time of the fall. She indicated there was no alarm activated. She indicated the resident was in view of the staff at all times and the staff could not get to the resident quick enough to prevent the fall. LPN #1 indicated there was no alarm sounded at the time of the fall.</p> <p>This Federal Tag relates to complaint IN00163172.</p> <p>3.1-45(a)(2)</p>			