

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155525	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/15/2011
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NAME OF PROVIDER OR SUPPLIER SHADY NOOK CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 36 VALLEY DR LAWRENCEBURG, IN47025
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F0000	<p>This visit was for the Investigation of Complaint IN00100635.</p> <p>Complaint IN00100635- Substantiated. Federal/state deficiency related to the allegation is cited at F323.</p> <p>Survey dates: December 14, and 15, 2011</p> <p>Facility number: 000304 Provider number: 155525 AIM number: 100266810</p> <p>Survey team: Barbara Gray, RN</p> <p>Census bed type: SNF/NF 66 Total: 66</p> <p>Census payor type: Medicare: 8 Medicaid: 53 Other: 5 Total: 66</p> <p>Sample: 3</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on December</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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F0323 SS=D	<p>19, 2011 by Bev Faulkner, RN</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, interview, and record review, the facility failed to follow one residents plan of care to keep pathways clear and failed to follow one residents plan of care to provide the resident with a clip alarm while seated on the toilet to alert staff if the resident stood. This affected 2 of 3 residents in a sample of 3 residents reviewed for falls. (Resident #A and #B)</p> <p>Findings include:</p> <p>1.) Resident #A's record was reviewed on 12/14/11 at 12:48 P.M. Diagnoses included but were not limited to vascular dementia, osteoporosis, osteoarthritis, T12 compression fracture, back pain, frequent falls, syncope, and back pain.</p> <p>Resident #A's annual Minimum Data Set assessment, dated 11/4/11, indicated Resident #A required extensive assistance of 1 person for bed mobility, transferring, toileting, and walking. Resident #A had fallen in the past month and had fallen in the past 2 to 6 months.</p>	F0323	<p>1. All staff members were re-inserviced in regard to maintaining clear pathways within resident rooms and common areas. Additionally, all nursing staff were in-serviced in regard to the use of resident personal alarms. The employee failing to attach the clip alarm to Resident B was disciplined by the DON and was re-inserviced in regard to the necessity of following the resident plan of care.2. All residents have the same potential to be affected. Beginning on 12/15/11, the DON, nursing supervisors and department heads have continued to observe each resident room and common area used by residents to insure that there were no further issues relative to protective floor mats, furniture arrangement and resident alarms. Results have been discussed with QA and necessary adjustments to these areas have been made.3. All staff have been inserviced in regard to making certain that protective floor mats and pathways remain clear within the limitations of the room and resident belongings. Also, all nursing staff have been</p>	12/23/2011	

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	<p>Resident #A's annual Minimum Data Set summary, dated 11/4/11, indicated Resident #A had a cognitive decline that occurred over time, she was forgetful, she was recovering from pneumonia and was newly readmitted from the hospital, she was aware to ask for assistance to toilet but did not always wait for staff and had fell in the past, she had impaired balance during transition of sit to stand, walking, turning, on and off toilet and surface to surface, she had a history of frequent falls with lower extremity weakness, she had chronic pain, she had back pain prior to admission to the facility and now complained of headaches.</p> <p>A fall care plan for Resident #A, updated 12/3/11, indicated the following interventions: Initiated 10/10/10 - Mat to the right side of the bed. Initiated 10/19/10 - Staff to assist with toileting, turning, and transfers. Keep pathways clutter free.</p> <p>An Incident Fax/Nurses Note Protocol, dated 11/25/11 at 12:30 P.M., indicated Resident #A was found lying on her back near her bedroom door at 12:04 P.M. Resident #A had stated to staff she wanted to see another resident.</p> <p>A nurses note, dated 11/29/11 at 1:30</p>		<p>inserviced regarding the use of resident personal alarms according to the resident care plan.4. QA, Supervisors and Department Heads will be observing for clear pathways and the proper use of resident personal alarms while conducting daily rounds, providing care to residents, and interacting in other ways with residents and visitors. QA will bring observed issues to the daily AM meetings, and these will be reviewed and discussed by the staff to resolve potential problems. Those issues that can be corrected immediately will be resolved at the time of initial observation.</p>		

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	<p>A.M., indicated Resident #A was found sitting on her floor mat, with her back and head against her wheelchair. Resident #A informed staff at that time, she did not know why she was getting up and she had hit her head on her wheelchair.</p> <p>A Transfer sheet to a local hospital for Resident #A, dated 11/29/11, indicated the events leading up to her transfer included glossy eyes, unsteady gait, stumbling, and a 4 centimeter (cm) knot on her left posterior head.</p> <p>A local hospital note for Resident #A, dated 12/1/11, indicated the following: History of present illness - She injured her left frontoparietal area. She was found to have a 4 cm round raised hematoma of her posterior head and complained of a headache. A CT scan of her head found she had a left superior frontoparietal subdural hematoma associated with some underlying subarachnoid hemorrhage in the left frontal lobe with substantial underlying edema.</p> <p>On 12/15/11 at 9:42 A.M., Resident #A was observed lying on her back in bed. Her speech was soft, she was sleepy, and she was slow to respond. During interview, at this time, Resident #A indicated she "slightly" remembered</p>				

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	<p>falling. Resident #A indicated she did not know what she was doing or where she was going when she fell. Resident #A had a small hard plastic trash can placed on her fall mat on the left side of her bed. The Physical Therapy Assistant, who was present, indicated the trash can should be moved and then moved it off of the fall mat.</p> <p>An interview with LPN #1 on 12/15/11 at 3:15 P.M., indicated she was the nurse who found Resident #A in her bedroom after she had fallen on 11/29/11 at 1:30 A.M. LPN #1 indicated she found Resident #A seated on her floor mat that was next to her bed. Resident #A had the back of her head against her wheelchair and her face, was facing her bed. LPN #1 indicated Resident #A's wheelchair had been positioned on the floor, next to the fall mat, at the center of the mat. LPN #1 indicated Resident #A had informed her she hit the back of her head on her wheelchair. LPN # 1 indicated Resident #A was a transfer with one person assist when she fell.</p> <p>2.) Resident #B's record was reviewed on 12/15/11 at 10:17 A.M. Diagnoses included but were not limited to osteoporosis, hypertension, status post right superior ramus fracture, status post back surgery, and right calcified</p>				

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	<p>fibrothorax.</p> <p>Resident #B's quarterly Minimum Data Set assessment, dated 9/19/11, indicated Resident #B required extensive assistance of one person for bed mobility, transferring, walking, and toileting. Resident #B had a history of falls.</p> <p>A fall care plan for Resident #B, dated 6/27/11, indicated the following interventions: Initiated 7/27/11 - Leave the resident seated with a body alarm on until staff are ready to complete the transfer. Initiated 8/30/11 - Leave the resident seated on the commode with a body alarm until staff are ready to complete the transfer.</p> <p>On 12/5/11 at 10:00 A.M., Resident #B was observed seated on a bedside commode frame over her commode. Resident #B was dressed in night wear. A clip alarm was attached to the commode frame. The clip connected to the alarm was not attached to Resident #B's clothing.</p> <p>An interview with LPN #3 on 12/15/11 at 10:10 A.M., indicated QMA #2 had placed Resident #B on the commode. LPN #3 indicated she had removed Resident #B from the commode. LPN #3 indicated Resident #B did not have the</p>				

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	<p>clip for her alarm attached to her clothing when she went in to remove Resident #B off the commode.</p> <p>An interview with QMA #2 on 12/15/11 at 10:25 A.M., indicated she had placed Resident #B on the commode.</p> <p>This federal tag relates to Complaint IN00100635.</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p>				