

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 02/05/2015
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NAME OF PROVIDER OR SUPPLIER CHRISTINA PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 1435 CHRISTIAN BLVD FRANKLIN, IN 46131
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R000000	<p>This visit was for the Investigation of Complaint IN00163808.</p> <p>Complaint IN00163808 - Substantiated. State deficiencies related to the allegations are sited at R0091 and R0217.</p> <p>Survey date: February 5, 2015</p> <p>Facility number: 004017 Provider number: 004017 AIM number: N/A</p> <p>Survey team: Dorothy Plummer, RN-TC Patsy Allen, SW</p> <p>Census bed type: Residential: 64 Total: 64</p> <p>Residential sample: 3</p> <p>These state findings cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed on February 12, 2015; by Kimberly Perigo, RN.</p>	R000000		

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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R000091	<p>410 IAC 16.2-5-1.3(h)(1-4) Administration and Management - Noncompliance (h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request. Based on interview and record review, the facility failed to ensure implementation of their fall response policy in that assessments were not completed, the facility failed to develop interventions to ensure resident safety after a fall, and failed to ensure resident service plans were updated to include identified fall prevention interventions for 3 of 3 residents reviewed for accidents. (Resident #D, Resident #E, and Resident #F)</p> <p>Findings include:</p> <p>1. The clinical record review, completed on 2/5/15 at 3:00 p.m., indicated Resident #D had diagnoses including, but not limited to, dementia.</p> <p>The Assessment and Negotiated Service Plan Summary dated 9/22/14, indicated the resident required assistance with</p>	R000091	<p>Care Service Manager or Designee assumes responsibility for Fall Follow-up. After falls occur Resident will be evaluated by appropriate staff member and the Mobility Management Tool will be updated appropriately.</p> <p>All Residents were found to potentially be at risk.</p> <p>The community will ensure compliance by educating clinical staff on Company tools and policies that include the need for evaluation, use of mobility management tool and proper use of Short Term monitors. Education will be completed by 2/27/15.</p> <p>Following incidents such as falls, The</p>	02/27/2015			

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	<p>transfers and needed full assistance of 2 staff to get out of bed or the chair, needed assistance to dress and perform personal hygiene, and was unable to use the bathroom independently.</p> <p>A Resident Services Note dated 2/1/15 at 5 :30 a.m., indicated the resident was found on the floor. The note indicated, "When entering res [resident] rm [room] to get up for AM [morning], we found res on floor. Nurse assessed her and instructed us to call hospice and POA [Power of Attorney]. Both were notified..." The note was signed by Certified Nursing Assistant (CNA) #1.</p> <p>An Universal Incident/Occurrence Report, dated 2/1/15, also completed by CNA #1, indicated the type of occurrence was an unwitnessed fall in the resident's room. In the section marked Injury/Complaints, the type of injury was noted as a bruise and the body part affected was noted as skull/scalp.</p> <p>The next notation in the Resident Services Note was 8 hours later on 2/1/15 at 1:35 p.m. The note indicated the resident had a bluish purple area on the forehead near the hairline. The note was signed by Licensed Practical Nurse (LPN) #2.</p>		<p>Care Service Manager or Designee will review the incident report and documentation to ensure proper follow up.</p> <p>Falls and other incidents will be discussed at monthly Quality and Safety meetings and the committee will determine if further interventions or education are needed.</p>	

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	<p>At 3:46 p.m. on 2/5/15 the Interim Case Services Manager (ICSM) provided A Visit Note Report dated 2/1/15, which was received from the hospice agency. The ICSM indicated the hospice agency did not leave a copy of the visit notes in the facility. The visit note indicated the resident was seen by the hospice nurse at 10:34 a.m., five hours after the resident was found on the floor.</p> <p>During an interview with the Executive Director and the ICSM on 2/5/15 at 4:30 p.m., the ICSM indicated the clinical record lacked documentation of an assessment by a licensed nurse for 5 hours after the resident experienced a bruise to the forehead. The ICSM indicated a Mobility Assessment was not completed as indicated by the facility policy, Resident Fall Response, nor was the Service Plan updated with interventions to prevent future falls.</p> <p>2. The clinical record review of Resident #E, completed on 2/5/15 at 1:30 p.m., indicated the resident had diagnoses including, but not limited to, anxiety.</p> <p>The Assessment and Negotiated Service Plan Summary dated 8/24/14, indicated the resident required staff to administer medications, staff to assist with providing personal hygiene, bathing and grooming,</p>						

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	<p>and required staff assistance for transfers including getting into or out of the bed and chair.</p> <p>The clinical record indicated the resident was found on the floor (as the result of a fall) on 1/8/15, on 1/19/15, on 1/27/15, and 2 times on 2/3/15.</p> <p>The resident experienced a bruise to the back from the fall on 1/8/15, fractured ribs from the fall on 1/19/15, and a head injury on 1/27/15.</p> <p>The Resident Services Notes indicated the resident was found on the floor on 2/3/15 at 12:15 a.m. The notes indicated the Emergency Medical Technicians (EMT) were called to assess the resident and then assisted the resident into the recliner.</p> <p>The next note in the Resident Services Notes, documented more than 9 hours after the resident was found on the floor, indicated the resident was found on the floor by the therapist at 9:40 a.m., on 2/3/15. The note indicated the resident had hit her head above the left eye and cheek. The note indicated, "...Will continue to monitor...." As of 2/5/15 at 1:30 p.m., the clinical record lacked documentation of any further monitoring of the resident.</p>			

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	<p>During an interview with the Interim Care Services Manager (ICSM) on 2/5/15 at 1:40 p.m., the ICSM indicated the facility had failed to monitor the resident after 2 falls on 2/3/15.</p> <p>During an interview with the Executive Director and the ICSM on 2/5/15 at 4:30 p.m., the ICSM indicated a Mobility Assessment was not completed as indicated by the facility policy, Resident Fall Response, after each fall nor was the Service Plan updated with interventions to prevent future falls.</p> <p>3. The clinical record review of Resident #F, completed on 2/5/15 at 2:15 p.m., indicated the resident had diagnoses including, but not limited to, coronary artery disease (hardening of the arteries in the heart).</p> <p>The Assessment and Negotiated Service Plan Summary dated 10/19/14, indicated the resident was independent with medication administration, needed assistance with showering but was independent with personal hygiene, needed staff to set up supplies for dressing and grooming, and used a standard walker independently.</p> <p>On 1/12/15, at 11:00 a.m., the resident</p>			

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	<p>was sitting on a chair in the bathroom when the chair broke and the resident fell to the floor. The resident indicated he hit his head during the fall and the resident refused to be taken to the Emergency Room for evaluation.</p> <p>During an interview with the Executive Director and the Interim Case Services Manager (ICSM) on 2/5/15 at 4:30 p.m., the ICSM indicated a Mobility Assessment was not completed as indicated by the facility policy, Resident Fall Response, nor was the Service Plan updated with interventions to prevent future falls.</p> <p>On 2/5/15 at 2:36 p.m., the ICSM provided the Fall Response policy dated 7/1/14, and indicated the policy was the one currently used by the facility. In the section marked Documentation, the policy indicated, "...Be sure the following items are addressed in both the Incident Report and Resident Services Notes:...Remedial measures taken to ensure continued resident safety (i.e. frequent checks, Negotiated Risk Agreement, Physician Therapy assessment, etc.)...Care Services Manager should complete Mobility Assessment. Measures to prevent further falls to be added to the STHM [Short-Term Health Monitor] and/or Negotiated Service</p>			

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R000217	<p>Agreement...."</p> <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: (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. (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. (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. (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. (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. Based on interview and record review, the facility failed to update service plans</p>	R000217	All care plans will be reviewed to reflect fall plan interventions for fall	02/27/2015			

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	<p>as indicated by the Fall Response policy for residents who had experienced a fall to ensure resident care included updated interventions for fall prevention for 3 of 3 residents reviewed for accidents. (Resident #D, Resident #E, and Resident #F)</p> <p>Findings include:</p> <p>1. The clinical record review, completed on 2/5/15 at 3:00 p.m., indicated Resident #D had diagnoses including, but not limited to, dementia.</p> <p>The Assessment and Negotiated Service Plan Summary dated 9/22/14, indicated the resident required assistance with transfers and needed full assistance of 2 staff to get out of bed or the chair, needed assistance to dress and perform personal hygiene, needed staff assistance with eating, and was unable to use the bathroom independently.</p> <p>A Resident Services Note dated 2/1/15 at 5 :30 a.m., indicated the resident was found on the floor. The note indicated, "When entering res [resident] rm [room] to get up for AM [morning], we found res on floor. Nurse assessed her and instructed us to call hospice and POA [Power of Attorney]. Both were notified...." The note was signed by</p>		<p>prevention on these affected by the alleged deficient practice.</p> <p>All residents are at risk to be affected by the alleged deficient practice.</p> <p>All care plans will be reviewed to make sure all current care plans are updated for fall interventions and are reflected on the care plans.</p> <p>Care plans will be monitored for fall interventions upon admission, 30 days after admission, 90 days thereafter and/or upon significant changes in conditions or falls.</p> <p>Education of nurses will be completed by February 27, 2015 on fall interventions and updating care plans.</p> <p>The systemic changes will be completed by February 27, 2015.</p>				

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	<p>Certified Nursing Assistant (CNA) #1.</p> <p>An Universal Incident/Occurrence Report, dated 2/1/15, also completed by CNA #1, indicated the type of occurrence was an unwitnessed fall in the resident's room. In the section marked Injury/Complaints, the type of injury was noted as a bruise and the body part affected was noted as skull/scalp.</p> <p>The next notation in the Resident Services Note was 8 hours later on 2/1/15 at 1:35 p.m. The note indicated the resident had a bluish purple area on the forehead near the hairline. The note was signed by Licensed Practical Nurse #2.</p> <p>At 3:46 p.m. on 2/5/15, the Interim Case Services Manager (ICSM) provided A Visit Note Report dated 2/1/15, which was received from the hospice agency. The ICSM indicated the hospice agency did not leave a copy of the visit notes in the facility. The visit note indicated the resident was seen by the hospice nurse at 10:34 a.m., five hours after the resident was found on the floor.</p> <p>During an interview with the Executive Director and the ICSM on 2/5/15 at 4:30 p.m., the ICSM indicated the clinical record lacked documentation of an assessment by a licensed nurse for 5</p>						

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	<p>hours after the resident experienced a bruise to the forehead. The ICSM indicated a Mobility Assessment was not completed as indicated by the facility policy, Resident Fall Response, nor was the Service Plan updated with interventions to prevent future falls.</p> <p>2. The clinical record review of Resident #E, completed on 2/5/15 at 1:30 p.m., indicated the resident had diagnoses including, but not limited to, anxiety.</p> <p>The Assessment and Negotiated Service Plan Summary dated 8/24/14, indicated the resident required staff to administer medications, staff to assist with providing personal hygiene, bathing and grooming, and required staff assistance for transfers including getting into or out of the bed and chair.</p> <p>The clinical record indicated the resident was found on the floor (as the result of a fall) on 1/8/15, on 1/19/15, on 1/27/15, and 2 times on 2/3/15.</p> <p>The resident experienced a bruise to the back from the fall on 1/8/15, fractured ribs from the fall on 1/19/15, and a head injury on 1/27/15.</p> <p>The Resident Services Notes indicated the resident was found on the floor on</p>						

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	<p>2/3/15 at 12:15 a.m. The notes indicated the Emergency Medical Technicians (EMT) were called to assess the resident and then assisted the resident into the recliner.</p> <p>The next note in the Resident Services Notes, documented more than 9 hours after the resident was found on the floor, indicated the resident was found on the floor by the therapist at 9:40 a.m., on 2/3/15. The note indicated the resident had hit her head above the left eye and cheek. The note indicated, "...Will continue to monitor...." As of 2/5/15 at 1:30 p.m., the clinical record lacked documentation of any further monitoring of the resident.</p> <p>During an interview with the Interim Care Services Manager (ICSM) on 2/5/15 at 1:40 p.m., the ICSM indicated the facility had failed to monitor the resident after the resident experienced 2 falls on 2/3/15.</p> <p>During an interview with the Executive Director and the ICSM on 2/5/15 at 4:30 p.m., the ICSM indicated a Mobility Assessment was not completed as indicated by the facility policy, Resident Fall Response, after each fall nor was the Service Plan updated with interventions to prevent future falls.</p>			

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	<p>3. The clinical record review of Resident #F, completed on 2/5/15 at 2:15 p.m., indicated the resident had diagnoses including, but not limited to, coronary artery disease (hardening of the arteries in the heart).</p> <p>The Assessment and Negotiated Service Plan Summary dated 10/19/14, indicated the resident was independent with medication administration, needed assistance with showering but was independent with personal hygiene, needed staff to set up supplies for dressing and grooming, and used a standard walker independently.</p> <p>On 1/12/15, at 11:00 a.m., the resident was sitting on a chair in the bathroom when the chair broke and the resident fell to the floor. The resident indicated he hit his head during the fall and the resident refused to be taken to the Emergency Room for evaluation.</p> <p>During an interview with the Executive Director and the Interim Case Services Manager (ICSM) on 2/5/15 at 4:30 p.m., the ICSM indicated a Mobility Assessment was not completed as indicated by the facility policy, Resident Fall Response, nor was the Service Plan updated with interventions to prevent</p>			

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	<p>future falls.</p> <p>On 2/5/15 at 2:36 p.m., the ICSM provided the Fall Response policy dated 7/1/14, and indicated the policy was the one currently used by the facility. In the section marked Documentation, the policy indicated, "...Be sure the following items are addressed in both the Incident Report and Resident Services Notes:...Remedial measures taken to ensure continued resident safety (i.e. frequent checks, Negotiated Risk Agreement, Physician Therapy assessment, etc.)...Care Services Manager should complete Mobility Assessment. Measures to prevent further falls to be added to the STHM [Short-Term Health Monitor] and/or Negotiated Service Agreement...."</p>						