

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155378	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/16/2014
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NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE AT PARKWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 N GRANT ST LEBANON, IN 46052
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F000000	<p>This visit was for the Investigation of Complaint IN00156113.</p> <p>This visit was done in conjunction with the Recertification and State Licensure Survey and included the Investigation of Complaint(s) IN00155903 and IN00154731.</p> <p>Complaint IN00156113 - Substantiated. Federal deficiencies related to the allegations are cited at F153, F282 and F323.</p> <p>Survey Dates: September 8, 9, 10, 11, 12, 15, 16, &amp; 17, 2014.</p> <p>Facility Number: 00468 Provider Number: 155378 AIM Number: 100290270</p> <p>Survey Team: Kewanna Gordon RN-TC (September 8, 11, 12, 15, 16, &amp; 17, 2014) Lora Brettnacher RN</p> <p>Census bed type: SNF/NF: 92 Total: 92</p> <p>Census payor type:</p>	F000000	<p>F000000</p> <p>The facility requests that this plan of correction be considered its credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of the deficiencies. The plan of correction is prepared and/or executed solely because of federal and state law.</p>	

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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F000153 SS=D	<p>Medicare: 10 Medicaid: 62 Other: 20 Total: 92</p> <p>Sample: 5</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed 9/24/14 by Brenda Marshall, RN.</p> <p>483.10(b)(2) RIGHT TO ACCESS/PURCHASE COPIES OF RECORDS The resident or his or her legal representative has the right upon an oral or written request, to access all records pertaining to himself or herself including current clinical records within 24 hours (excluding weekends and holidays); and after receipt of his or her records for inspection, to purchase at a cost not to exceed the community standard photocopies of the records or any portions of them upon request and 2 working days advance notice to the facility.</p> <p>Based on interview and record review, the facility failed to provide requested medical records to residents' medical representatives within the required 24 hour time period. This deficient practice affected 2 of 3 residents reviewed for</p>	F000153	F 153- D It is the intent of the facility to provide the Right of Access/ Purchase copies of records.What corrective action will be accomplished for the resident affected: Resident B has deceased and Power of Attorney	10/17/2014

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	<p>resident rights regarding medical record access (Resident B and Resident F).</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. A document entitled, "Authorization for Use and Disclosure of Protected Health Information," received from the Administrator (ADM) on 9/12/14 at 2:17 p.m., indicated Resident B's Power of Attorney requested the residents medical records on 8/19/14.</li> </ol> <p>During an interview with the Administrator (ADM) on 9/12/14 at 2:17 p.m., she indicated the facility failed to provide medical records as required to Resident B's legal representative within the required time frame.</p> <ol style="list-style-type: none"> <li>2. Resident F's closed record was reviewed on, 9/15/14 at 10:06 A.M.</li> </ol> <p>An admission Minimum Data Set assessment tool (MDS), dated, 5/18/14, indicated Resident F had severe cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 3 out of 15. The record indicated Resident B had a legal representative.</p> <p>During a telephone interview on, 9/16/14 at 3:00 p.m., Resident F's legal representative indicated she requested</p>		<p>has received records. Resident F has been discharged. Records provided for Resident F to the Home Health Company upon the verbal request several weeks after discharge. However facility did not keep confirmation receipt. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All residents have the potential to be effected. Nurses and Department Managers in-serviced on resident and/or legal representative's right to access/purchase copies of records What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur: Administrator to be notified if resident and/or legal representative make a verbal request for medical records. Medical Records or designee will make copies of requested information and ensure delivery within 2 working days after request is made. Medical Records or designee will obtain signature of resident or legal representative on Authorization for Use and Disclosure of Protected Health Information Form. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place: Audit tool implemented to track all requests for medical records which</p>				

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	<p>copies of his medical records from the DON (Director of Nursing) a few days after Resident F had been discharged in, June 2014. She indicated the requested medical records had been "thrown away" and therefore could not be provided to her.</p> <p>During an interview on, 9/15/14 at 1:23 p.m., with the DON, Education Coordinator, Administrator, MDS/Care plan Coordinator, and the Director of Nursing (DON) present, the DON indicated she "remembered" Resident B's responsible party had requested from her to have copies of his medical records faxed to his Home Health Agency. The DON indicated she "could not remember" to which Home Health Agency the records were faxed nor had she documented the request for the records. She indicated she "threw away" documentation which indicated the requested medical records were faxed. During this interview the Administrator was asked to provide the facility's policy on residents' rights of access to medical records.</p> <p>During an interview on, 9/17/14 at 1:20 P.M., with the DON, Education Coordinator, Administrator, MDS/Care plan Coordinator, and DON, and during the Exit Conference on 9/17/14 at 4:00</p>		<p>includes date request was made, date medical records were provided to resident or legal representative, and whom they were provided to. Medical Records will track requests for Medical Records. Audit tool will be reviewed in the Monthly Performance Improvement Committee meeting monthly x6 months and then quarterly until PI Committee determines compliance or further action needed. Completion Date: October 17th, 2014.</p>		

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F000282 SS=E	<p>P.M., the DON indicated documentation was not available which indicated the requested medical records had been provided to the Resident's legal representative or the Home Health Agency.</p> <p>A policy and procedure received from the ADM on 9/12/14 at 2:19 p.m., indicated, "The resident or his or her legal representative has the right... upon an oral or written request, to access all records pertaining to himself or herself including current clinical records within 24 hours (excluding weekends and holidays)..."</p> <p>This Federal tag relates to Complaint IN00156113.</p> <p>3.1-4(b)(2)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents were provided with services according to their plan of care in regards to blood sugar monitoring, medication administration, diagnostic lab test,</p>	F000282	F 282-E It is the practice of the facility to provide services and/ or arrange services by qualified persons in accordance with each resident's written plan of care. What corrective action will be accomplished for the resident	10/17/2014

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	<p>sensory stimulation, and Foley catheter care. This deficient practice had the potential to affect 5 of 28 residents reviewed for services provided as ordered (Residents F, #89, #55, #61, and #8).</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Resident F's closed record was reviewed on 9/15/14 at 10:06 A.M. Resident F had a diagnosis which included, but was not limited to, insulin dependant diabetes.</li> </ol> <p>An untimed physician's order, dated 5/16/14, indicated an order for blood sugar accu-checks twice a day at 11:00 a.m. and 4:00 P.M. and for sliding scale insulin coverage.</p> <p>Medication Administration Records (MARs) for May and June 2014 were reviewed. The May MAR indicated Resident F did not receive blood sugar monitoring and/or insulin coverage on the following dates: May 17, 18, 19, 20, 22, 23, 26, 27, and 28, 2014 (all 11:00 A.M.).</p> <p>During an interview on 09/15/2014 at 1:23 p.m., the Director of Nursing (DON) indicated documentation was not available which indicated Resident F was provided blood sugar monitoring with</p>		<p>affected: Resident F has been discharged. Resident # 89 has deceased. Resident #55 - Catheter tubing has been secured and draining bag positioned in proper drainage position. Resident #61- Digoxin level was obtained, physician notified and orders were reviewed and clarified. Resident #8 – Remains in the facility, and has had no complications How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: Audit has been completed to ensure that Activity Interventions are in place as in accordance with the plan of care. Audit has been completed to ensure those residents with a Foley catheter have had their care plans and care guides reviewed and updated as necessary. Audit has been completed to ensure those residents receiving blood draws have had their physician orders reconciled to the lab draw list and current results are in the charts as appropriate. Audit has been completed to ensure that blood sugars are being obtained in accordance with the physician's order. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur: Staff Development Coordinator (SDC) has educated staff on Catheter Care, including</p>	

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	<p>insulin coverage as ordered. She indicated most of the nurses who worked at that time no longer work here and were not available to interview.</p> <p>2a. Observations were made of Resident #89 in bed with his eyes open, blinds closed, lights off, with no television or music playing on the following dates:</p> <p>9/8/2014: 2:30 p.m. 9/9/2014: 9:44 a.m., 9:59 a.m., and 11:29 a.m. 9/10/14: 9:30 a.m., 10:15 a.m., and 11:00 a.m. 9/11/14: 9:30 a.m., and 10:10 a.m. 9/15/14: 9:25 a.m.</p> <p>Resident #89's record was reviewed on 9/11/14 at 9:47 A.M. Resident #89 had a diagnosis which included, but was not limited to, dementia. The record indicated Resident #89 was a hospice patient for end of life care.</p> <p>An untimed activity note, dated 4/2/14, indicated Resident #89 could not always make his needs known but could respond with yes and no answers. This note indicated Resident #89 had music in his room he enjoyed and staff were to turn it on for him. Big band and classical music were a "major like of his."</p> <p>An activity care plan, dated 9/5/14,</p>		<p>securing catheter competency, review of insulin/ accu-check policy and procedure, sensory stimulation, medication administration, education regarding the reconciliation of monthly orders (i.e. Lab orders), and transcription of physician orders, pain management, pain assessments, physician notification of change of condition/pain, and pain signs/symptoms in residents with dementia. In-services were completed on October 7, 2014 at 6:30a.m., 2:30p.m, 9:30p.m and October 8, 2014 at 2:30p.m and individually as needed by the SDC/DON/DesigneeCare plans will be reviewed upon admission, quarterly and with significant change. Interventions will be reviewed, validated, in place and C.N.A care guides will be validated to ensure continuity in the plan of care. Unit Managers/ ADON/DON/SDC will utilize the White Board process in the daily clinical meeting to ensure physician orders are executed timely, lab orders obtained and appropriate notifications are made. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place: Accu-check logs will be monitored daily x 7 days, then weekly x3, and then, at random monthly by the UM/ ADON/ DON/SDC. Findings will be</p>				

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	<p>indicated Resident #89 had an interest for music sensory programming. Interventions included the resident would be provided with classical and big band music in his room.</p> <p>During an interview on 9/10/14 at 10:28 a.m., Nurse #60 indicated Resident #89 "...Could get up for lunch and that was it."</p> <p>During an interview on 9/16/2014 at 11:59 a.m., the Activity Director indicated Resident #89 did not get out of bed much because of his health condition. She indicated the Certified Nursing Assistants and Activity Staff were supposed to turn his CD player on for him. She indicated they did not have a way to monitor if his music had been turned on for him.</p> <p>2b. During an observation on 9/15/14 at 9:30 a.m., Nurse #60 and the Education Nurse changed a pressure ulcer dressing on Resident #89. Resident #89 was repositioned while care was provided. Resident #89's Foley catheter tubing was pulled taunt and without a method to secure the tubing to prevent it from being pulled out.</p> <p>A care plan, dated 7/31/14, indicated Resident #89 had a Foley Catheter in</p>		<p>reported to the Performance Improvement Committee monthly x 6 mos. and then quarterly until PI Committee determines compliance or further action is needed. DON/designee will perform daily rounds checklist x7, then weekly x 3 and then at random monthly times to observe for proper catheter tubing and drainage bag placement. Findings will be reported to the Performance Improvement Committee monthly x6mos and then quarterly until PI Committee determines compliance or further action needed. Completion Date: October ---17th, 2014.</p>				

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	<p>place. A goal indicated he would not develop complications related to the use of a catheter. Interventions to meet this goal included provide catheter care per the facility policy and prevent tension on urinary meatus from catheter.</p> <p>During an interview on 9/15/14 at 9:50 a.m., Nurse #60 indicated Resident #89's catheter was secured with a "bulb" inflated inside his bladder. She indicated he did have a clip on the catheter to secure the tubing but it currently was not secured. She stated, "He doesn't move around-well, he does, but not enough to pull it. It is anchored with a bulb."</p> <p>During an interview on 9/15/14 at 10:00 a.m., the Nurse Educator indicated the facility utilized Foley catheter clips to avoid tugging on the catheter tubing during transfers and care delivery to prevent inadvertent catheter removal or tissue injury from dislodging the catheter.</p> <p>3. Resident #55's record was reviewed on 9/6/14 at 10:18 a.m. Resident #55 had diagnoses which included a history of urinary tract infections and pressure ulcers.</p> <p>During an observation on, 9/5/14 at 9:44 a.m., Resident #55 was observed in bed on her right side. Her catheter tubing was</p>			

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	<p>observed stretched taunt over the left side of the bed with the Foley catheter bag lying on the floor. The catheter tubing was not secured to prevent inadvertent catheter removal.</p> <p>During an observation on 9/15/2014 at 9:54 a.m., with Nurse #60 present, Resident #55 was observed in bed with her Foley catheter tubing pulled through a pair of pants that were bunched up at the bottom of her bed. The Foley catheter tubing was not secured to avoid tugging on the catheter during transfer and care delivery to prevent inadvertent catheter removal or tissue injury from dislodging the catheter.</p> <p>A care plan, dated 5/21/14, indicated Resident #55 was dependent on staff for care. A goal included she would have self care needs anticipated per staff daily. An intervention included Foley catheter care every shift.</p> <p>During an interview on 9/15/14 at 9:54 a.m., Nurse #60 indicated Resident #55's catheter was missing the clip needed to secure the tubing.</p> <p>During an interview on 9/15/14 at 10:00 a.m., the Nurse Educator indicated the facility utilized Foley catheter clips to avoid tugging on the catheter tubing</p>			

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	<p>during transfers and care delivery to prevent inadvertent catheter removal or tissue injury from dislodging the catheter.</p> <p>A policy titled "Catheter Care-Indwelling," dated 12/10, and identified as current by the Education Coordinator Nurse on, 9/15/14 at 10:01 a.m., indicated, "...Care of the Drainage Bag: 1. Secure tubing to avoid any unnecessary pulling on tubing..."</p> <p>4. Resident #61's record was reviewed on, 9/16/14 at 9:31 a.m. Resident #61 had a diagnosis which included, but was not limited to, atrial fibrillation (irregular heart rhythm).</p> <p>Physician recapitulation orders, dated 9/2014, indicated Resident #61 had an order for Digoxin 0.125 mcg (micrograms) one tablet every other day for the diagnoses of atrial fibrillation and indicated an order for blood work to be obtained every three months to monitor the Digoxin level. The record did not indicate the Digoxin level blood work had been obtained as ordered.</p> <p>During an interview on 9/16/14 at 11:04 a.m., the Director of Nursing (DON) indicated Resident #61 had been prescribed Digoxin for years with an order to monitor her Digoxin level every</p>			

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F000323 SS=G	<p>three months. She indicated the labs had not been obtained since, 11/18/13. She indicated "It must have dropped off." The Digoxin levels due in 2/14, 5/14, and 8/14, had not been obtained.</p> <p>5. During an observation on 9/16/14 at 9:00 a.m., during medication administration, RN (Registered Nurse) #4 was observed to enter Resident # 8's room to perform her a.m. accucheck. The resident had already began eating her breakfast at this time. RN #4 indicated he would not be able to check her accucheck as ordered because he failed to obtain it before she had eaten.</p> <p>Resident #8's record was reviewed on, 9/16/14 at 11:00 a.m., Resident #8 had a diagnosis which included, but was not limited to, insulin dependant diabetes. An untimed physician's order dated, 8/24/14 indicated blood sugar monitoring with sliding scale insulin coverage three times daily.</p> <p>This Federal tag relates to Complaint IN00156113.</p> <p>3.1-35(g)(2)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p>			

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	<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 interview and record review the facility failed to ensure a resident was safely transferred with her assessed need of extensive physical assistance of two staff resulting in harm as evidenced by a fractured rib, extensive bruising to the chest area, and a fractured elbow. This deficient practice affected 1 of 5 residents reviewed for accidents (Resident D).</p> <p>Findings include:</p> <p>1. During a telephone interview on, 9/9/14 at 7:30 a.m., Resident D's son indicated he had concerns regarding injuries to his mother. He indicated during the "last several months" his mother had sustained bruising to her chest and a fractured arm.</p> <p>During a telephone interview on, 9/10/14 at 8:30 a.m., Resident D's daughter indicated she visited her mother daily. She indicated several months ago the facility notified her that they had found a bruise on her mother's chest. She indicated the bruise to her mother's chest was "very large."</p> <p>Resident D's record was reviewed on, 9/12/14 at 10:45 p.m. Resident D had</p>	F000323	F 323 – G It is the practice of this facility to ensure that the resident environment remains as free of accidents hazards as is possible; and that each resident receives adequate supervision and assistance to prevent accidents. What corrective action will be accomplished for the resident affected: Resident D remains in the facility. Care plans and C.N.A assignment sheet have been reviewed and updated. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All residents have the potential to be affected. Facility will review all care plans as related to ADL needs, and C.N.A assignment sheets updated to ensure assistance is accurately communicated. DON/Designee audited the last 90 days of accidents to ensure that assessments are complete, interventions are care planned and in place at the bedside and that they are communicated on the C.N.A Assignment Sheets. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur: IDT team reviews	10/17/2014

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NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE AT PARKWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 N GRANT ST LEBANON, IN 46052		
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	<p>diagnoses which included, but were not limited to, Alzheimer's disease, muscle weakness, and osteoporosis.</p> <p>Minimum Data Set assessment tools (MDS) dated, 12/17/13 and 3/11/14, indicated Resident D had severe cognitive impairment and required extensive physical assistance of two plus staff for transfers from the bed to a chair, wheelchair, and to a standing position.</p> <p>Activity of daily living documentation records dated, 3/9/14 through 3/20/14, indicated Resident D was transferred without adequate assistance of two staff fifty-nine times.</p> <p>A nurse's note dated, 3/20/14 at 10:30 p.m., indicated at "approximately" 3:45 p.m., a Certified Nursing Assistant (CNA) noted bruising on Resident D's chest. The resident was not "interviewable" and was not able to "recall the origin of the bruising." The bruising was located on the right breast to mid chest. The bruising measured "11 cm [centimeters] in length and 8 cm in width. Coloring at bruising indicated "several stages of bruising" and the "investigation into possible source of bruising suggested that bruising was likely caused by gait belt..."</p>		<p>events in the daily clinical meeting to determine root cause of the event, examines the scene of the event, both as a part of the investigation and to validate interventions are in place at the bedside, care plan is updated and C.N.A Assignment sheets are reviewed and updated. IDT provides immediate communication to staff at the bedside. Events are evaluated weekly and monthly looking for patterns /trends and are a standing agenda item in the facility monthly Performance Improvement Committee. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place: Events are reviewed weekly and monthly. Trends are identified and action plans developed and reported monthly to Performance Improvement Committee. This will continue indefinitely on a monthly basis. Completion Date: October 17th, 2014.</p>		

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	<p>A signed statement dated, March 20, 2014, indicated, "I Certified Nursing Assistant (CNA) #99 named) transferred [Resident D named] from her bed to her wheelchair by myself... transferring [Resident D named] is some what kind of difficult. She fights and can't bare weight. I will sometimes ask for assistance to transfer her but not all the time. I feel she should be a two person transfer or a lift to help with less bruising or her feeling unsafe and fighting. When I transfer her by myself I put my arms under hers and lift, when I transfer her with someone else we lift her arm and leg or pants..."</p> <p>A statement signed by CNA #98 and dated, 3/20/14, indicated, "...I transferred [Resident D named]... before and after lunch. The transfers were from bed to wc [wheelchair] and wc to bed. The first transfer from bed to wc I used the gait belt. [Resident D] named got very agitated. She started to grab at my arm and to shout at me. That is not the usual reaction from [Resident D named]. During a transfer I got her into the wc and went to lunch. After lunch I took her back to bed to rest. Because of her prior reaction, I tried to transfer her by putting my arms under hers and lifting her that way she did not resist as much and was not as agitated. I transferred her that way.</p>			

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	<p>As an aide, I feel [Resident D named] should really be marked as a 2 person or mechanical lift. She is not comfortable with one person transfers and I feel as though I am causing her discomfort with or without the gait belt in transfer. She cannot bare weight to assist in the transfer. It agitates and I believe scares her to be transferred..."</p> <p>A nurse's note dated, 3/22/14 at 5:30 a.m., indicated, "Dark purple bruise remains on R [right] breast. Area 9 cm in diameter et [and] painful to touch. Bruise on chest above R breast 12 cm in length et starting to fade..."</p> <p>A nurses note dated, 4/22/14 at 1030 a.m., indicated, "Bruising on R breast et chest remain. Tender to touch..."</p> <p>A nurse's note dated, 3/22/14 at 5:30 p.m., indicated, "Bruising remains to R breast/chest area. Tender to touch...Bruise show 0 (Zero) change from yesterday. Continues dk. [dark] purple-edema, tender to touch..."</p> <p>A nurse's note dated, 3/23/14 at 9:30 a.m., indicated, "Called Dr. to report, hard lump to R upper chest near axillary area. Reported darkening bruising to chest..." This note indicated the physician ordered a chest and right rib</p>			

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	<p>x-ray.</p> <p>A radiology report dated, 3/23/14, indicated, "...EXAM Ribs UNI-LAT 2V, Right [Uni-lateral 2 view]. Results: Healing right fifth posterior rib fracture..."</p> <p>An untimed physician's note dated, 3/24/14, indicated Resident D had a "healing" right fractured rib, bruises to her right "breast into sternum," bruise to her "right axilla yellowish and bruising down to breast," and her skin had "severe bruising..."</p> <p>An untimed physician's note dated, 3/27/14, indicated, "...presents with left hip deformity...lateral left hip area swelling 2 inch x 1 inch hard but mobile...increased pain with movement...rom [range of motion] decreased...pulses present but weak...plan..x-ray..." This note indicated Resident D had a "healing" 5th rib fracture.</p> <p>An untimed physician's note dated, 5/13/14, indicated Resident D was examined due to complaints of right arm and elbow pain. The note indicated Resident D's daughter was present for the examination and indicated Resident D had no history of previous injury to the</p>			

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	<p>arm or elbow. The note indicated, "...painful right arm elbow... alert... hurting when right elbow moved...tenderness just below elbow...old bruise over radius...bruising upper breast better..."</p> <p>A radiology report dated 5/13/14, X-rays of Resident D's right shoulder and right elbow were obtained. The report indicated "...The visualized osseous structures demonstrate a complete subacute fracture involving the right olecranon. No dislocation is seen. Mild diffuse soft tissue swelling is noted..."</p> <p>An untimed physician's note dated, 5/15/14, indicated Resident D had a fractured right ulnar "old 6 week plus," had continued pain in her right arm "especially on rotation of her wrist..."</p> <p>An untimed nurse's note dated, 6/12/14, indicated Resident D had a right rib fracture and a right elbow fracture. The note indicated, "...both happened at the same time... Res [Resident] unable to voice cause. Bruising present current and past..."</p> <p>During an interview on, 9/12/14 at 1:50 p.m., the Director of Nursing (DON) indicated Resident D's chest was injured during a one person transfer. She</p>			

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	<p>indicated at the time of the injury Resident D's care plan lacked specifications which informed staff of the assessed need for the assistance of physical assistance of two staff for transfers.</p> <p>"During an interview on, 9/12/14 at 2:15 p.m., with the DON and Administrator present, the Administrator indicated at the time Resident D's chest was injured, according to the MDS, Resident D did require the physical assistance of two persons for transfers.</p> <p>During an interview on, 9/15/14 at 8:25 a.m., CNA (Certified Nursing Assistant) #99 indicated at the time Resident D was injured the CNA assignment sheet indicated she only required the assistance of one person for transfers. CNA #99 stated, "...There were times I couldn't transfer her by myself. After she was hurt they changed her to a Hoyer and a Hoyer requires two people..."</p> <p>During an interview on, 09/15/2014 at 10:24 a.m. and at 11:12 a.m., with the Administrator, the Minimum Data Assessment/Care Plan Coordinator Nurse, and the DON present, the MDS/Care plan Coordinator Nurse indicated she developed care plan from the MDS assessments. She indicated</p>			

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	<p>Resident D's MDS indicated she required extensive assistance of two staff for transfers but her care plan did not reflect the need for the extensive assistance of two persons for transfers. She stated, ..."Yes, if the MDS indicated they were a two person they should have been a two person on the care plan. The care plan is driven from the MDS..." The DON indicated Resident D's care plan did not indicate how many staff were needed to transfer because "her CNAs were allowed to make that judgment."</p> <p>This Federal tag relates to Complaint IN00156113.</p> <p>3.1-45(a)(2)</p>			