

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155148	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/03/2013
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NAME OF PROVIDER OR SUPPLIER NORTH PARK NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 650 FAIRWAY DR EVANSVILLE, IN 47710
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F000000	<p>This visit was for the Investigation of Complaint IN00136646.</p> <p>Complaint IN00136646 Substantiated - Federal/State deficiencies are cited at F323.</p> <p>Survey dates: October 2 and 3, 2013</p> <p>Facility number: 000069 Provider number: 155148 AIM number: 100288980</p> <p>Survey team: Anne Marie Crays RN</p> <p>Census bed type: SNF: 10 SNF/NF: 82 Total: 92</p> <p>Census payor type: Medicare: 17 Medicaid: 69 Other: 6 Total: 92</p> <p>Sample: 6</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2.</p>	F000000	<p>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 alleged deficiencies, or of any violation of regulation. This Provider respectfully requests a face to face IDR for tag 323 to reduce and or delete this tag. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a post certification review on or after October 25, 2013.</p>	
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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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	Quality review completed on October 9, 2013, by Jodi Meyer, RN			

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F000323 SS=G	<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 observation, interview, and record review, the facility failed to provide supervision for a resident at risk for falls, resulting in a fall with a head injury, for 1 of 3 residents reviewed for falls, in a sample of 6. Resident C</p> <p>Findings include:</p> <p>The clinical record of Resident C was reviewed on 10/2/13 at 3:00 P.M. Diagnoses included, but were not limited to, weakness.</p> <p>A Minimum Data Set (MDS) assessment, dated 6/24/13, indicated the resident scored a 15 out of 15, indicating no memory impairment. The resident required extensive assistance of two+ staff for transfer, walking in the room and corridor, and toilet use. A test for "Balance During Transitions and Walking" indicated the resident was "Not steady, only able to stabilize with staff assistance."</p> <p>A resident care plan, dated 4/1/13,</p>	F000323	<p>It is the practice of this provider to ensure resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident C is ambulated using gait belt. Resident C receives care and services per resident's plan of care. Per resident C, this resident continues to prefer to have privacy while toileting by using the call light for assistance. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents who are a fall risk have the potential to be affected by the deficient practice. Residents who are a fall risk were reviewed by the IDT to ensure assessment, orders and care plans were updated with individualized interventions as needed. Staff were re-educated on fall prevention by October 25,</p>	10/25/2013			

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	<p>indicated: "Problem, Resident is at risk for fall due to: muscle weakness, hx [history] of falls." The Approaches included: "8/15/13 Use gait belt for ambulation...Therapy screen as ordered and prn [as needed]."</p> <p>A Physical Therapy Progress Note, dated 7/8/13, included: "...The patient is able to safely transfer from bed <> wheelchair requiring stand by assistance [close enough to reach patient if assist needed]...Patient continues to have deficits in BLe [bilateral lower extremities] dorsiflexion which limit ability to ambulate and transfer independently...Continued pt [patient] training required in BLe strength, gait training, transfer training to improve safety in all functional mobility including safe toilet transfers, and ambulation...Precautions:...fatigues quickly; fall risk...."</p> <p>Progress Notes included the following notations:</p> <p>7/14/13 at 6:32 P.M.: "Resident reports she doesn't feel well...had nausea this AM and emesis x 1...a/o x 3 [alert and oriented to person, place, and time], did report dizziness when sitting up from lying position...."</p>		<p>2013 by EDC/designee. What measure will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? IDT will review resident's plan of care upon admission and with significant change regarding fall risk to ensure residents plan of care are individualized based on residents needs. Resident's change of condition is reviewed during clinical meetings with a change to plan of care as needed. Weekend manager reviews changes on weekends. Resident's are screened no less than quarterly to determine individualized plan of care. DNS/designee will conduct rounds each shift to ensure fall interventions are implemented per plan of care. DNS/designess to ensure compliance. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, ie; what quality assurance program will be put into place? Compliance will be monitored through the fall CQI tool weekly x 4, monthly x 6 months. The result of the audit will be reviewed by the CQI committee. If the threshold is less than 90% benchmark, an action plan will be developed and implemented. What is the date by which the systemic changes will be completed? October 25, 2013.</p>		

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	<p>An Event Report, dated 7/15/13, indicated: "7/15/13 11:06 PM, Witnessed fall. Resident stated, 'was standing lost footing.' Resident lying on bathroom floor on her back...Is the resident in pain...Yes - pain at back of head. Did the resident hit her head? Yes...Describe injuries, if any...Noted small contusion to back of head, noted also cut to back of head moderate amount of bleeding present unable to measure...Resident was sent out to [hospital name] E.R. for evaluation...."</p> <p>Progress Notes continued:</p> <p>7/16/13 at 6:00 A.M.: "Res [resident] had fall with head injury and was sent to [hospital] ER for evel [sic] per orders...res returned at 0050 [12:50 A.M.] and was reassessed and neuro checks continued...res assisted up to toilet w/2 [with two] assist this am - c/o [complained of] 'little dizzy' at first...res c/o back of head being 'sore' and just generally being 'sore all over' this am...2.6 cm area on back of head that was 'gelled' at hospital - hematoma on back of head...."</p> <p>7/16/13 at 4:21 P.M.: "IDT [interdisciplinary team] RE FALL: Resident lost footing on way back to bed from bathroom with walker.</p>			

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	<p>Resident hit head on floor and was sent out for evaluation to [hospital]...IDT recommendation of using gait belt for ambulation."</p> <p>On 10/3/13 at 9:25 A.M., during interview with CNA # 1, she indicated staff is always required to use a gait belt during transfers and ambulation.</p> <p>On 10/3/13 at 10:05 A.M., during interview with CNA # 2, she indicated Resident C required 1 assist with transfer and ambulation, and a gait belt is used. CNA # 2 indicated a gait belt is always used to transfer and ambulate with residents.</p> <p>On 10/3/13 at 11:00 A.M., CNA # 1 was observed transferring Resident C from the wheelchair, and ambulating with her to the bathroom, holding onto a gait belt wrapped around the resident's waist. Resident C ambulated with a walker and CNA # 1's assist. Her gait was slow and halting.</p> <p>On 10/3/13 at 11:15 A.M., Resident C was interviewed. Resident C indicated she fell on "July 15th." Resident C indicated, "I was in the bathroom. [CNA # 3] was in the other room playing on her phone. I started walking from the bathroom to my bed,</p>			

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	<p>lost my balance, fell backward and cut my head." Resident C indicated she went to the hospital, and "they glued it back together." Resident C indicated CNA # 3 did not assist her with toileting and a gait belt was not used, because "she was on her phone." Resident C indicated she kept a gait belt in her room, so all staff would use one when ambulating with her.</p> <p>On 10/3/13 at 11:35 A.M., during interview with the Administrator, she indicated the fall event on 7/15/13 was investigated. The Administrator indicated the resident was not actually walking when she fell, and that was why a gait belt was not used. The Administrator indicated she thought CNA # 3 was reminded to use her gait belt, and received a written warning regarding her phone use. The Adminsitrator indicated a strict cell phone policy was put into effect after this incident.</p> <p>On 10/3/13 at 3:00 P.M., the Administrator indicated the facility did not have a policy regarding the use of gait belts.</p> <p>This Federal tag relates to Complaint IN00136646.</p>			

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	3.1-45(a)(1)			