| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 155539 | A. BUILDING 00<br>B. WING | 10/28/2015 |

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| BERTHA D GARTEN KETCHAM MEMORIAL CENTER | 601 E RACE ST<br>ODON, IN 47562 |

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| F 0000<br><br>Bldg. 00 | This visit was for the Investigation of Complaint IN00184034 and Complaint IN00181005.<br><br>Complaint IN00184034-Substantiated, Federal and State deficiencies related to allegations are cited at F-282, F-312.<br><br>Complaint IN00181005-Substantiated, Federal and State deficiencies related to allegations are cited at F-323, F-514.<br><br>Survey dates: October 27 & 28, 2015<br><br>Facility number: 000300<br>Provider number: 155539<br>AIM number: 100287340<br><br>Census bed type:<br>SNF: 6<br>SNF/NF: 52<br>Total: 58<br><br>Census Payor Type:<br>Medicare: 4<br>Medicaid: 41<br>Other: 13<br>Total: 58<br><br>Sample: 5 | F 0000 | By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings orallegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request the plan of correction be considered our allegation of compliance<br>effective November 20th, 2015 to the state findings ofthe complaint survey conducted on October 27th and 28th,2015. We respectfully request a DESK REVIEW of this Plan of Correction. Sincerely,<br>KathyWittmer, HFA Administrator | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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| | These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. -3.1.<br><br>Quality review completed by #02748 on 11/6/15. | | | |
| F 0282 SS=D Bldg. 00 | 483.20(k)(3)(ii)<br>SERVICES BY QUALIFIED PERSONS/PER CARE PLAN<br>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.<br><br>Based on interview and record review, the facility failed to ensure medications were administered as ordered by the physician for 2 of 3 residents reviewed for medication administration. (Resident Z, Resident T)<br><br>Findings included:<br><br>1. On 10/27/15 at 1:15 P.M., Resident T's clinical record was reviewed. Her clinical record included but was not limited to, a telephone order dated 10/20/15 for Augmentin 875 mg 1 tablet orally twice a day for 10 days. | F 0282 | F - 282 The corrective action taken for those residents found to have been affected by the deficient practice isthat the residents identified as resident Z and T are now receiving their medications inaccordance with their physician's orders. *The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. A housewide review off all MARs has been conducted to ensure that each resident is receiving their medications in accordance with their physician's orders.<br>The measures that have been put into place to ensure that | 11/20/2015 |

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| | On 10/27/15 at 1:35 P.M., Resident T's Medication Administration Record (MAR) October 2015 was reviewed with Qualified Medication Aide (QMA) #9. QMA #9 was observed passing medications on Resident T's hall that day. The MAR included a medication of "...Augmentin [antibiotic] 875 mg [milligrams] i[one] po [by mouth] BID [twice daily] x 10 days Dx [diagnosis] Wound infection. Order date of 10/20/15 and medication times of 8 A [am] and 8 P [PM] were documented. The MAR included documentation of the medication being administered on 10/21/15, 10/22/15, 10/23/15, 10/24/15, 10/25/15, 10/26/15, and 10/27/15 at 8:00 A.M. Evening doses were documented as administered were on 10/21/15, 10/22/15, 10/23/15, 10/24/15, 10/25/15, and 10/26/15 at 8:00 P.M. QMA #9 provided the card of Resident T's medication Augmentin 875 mg with a label that indicated an order date of 10/20/15 and documentation of 20 tabs total of medication to be administered. QMA #9 agreed 9 pills were left on the Augmentin card and that documentation indicated 13 tablets had been administered. LPN # 4 (Nurse on Resident T's unit) and QMA #9 were made aware that 2 extra doses/tablets of Augmentin were present. | | the deficient practice does not recur is that the facility has reviewed and revised it policy and procedure on transcription of physician's orders and medication administration. The policy has been revised to include instructions on use of medications from the EDK kit until the medication can be delivered by the pharmacy to ensure timely administration of medications. A mandatory in-service has been conducted for all licensed nurses and QMAs on the revised facility policy. *The corrective action taken to monitor to assure compliance is that* a Quality Assurance tool has been developed and implemented to monitor the accurate and timely administration of medications in accordance with physician's orders. This tool will be completed by the Director of Nursing and/or her designee daily for one week, then weekly for three weeks, then monthly for three months and then quarterly for three quarters. The outcomes of this tool will be reviewed at the morning QA clinical meetings Monday – Friday to ensure compliance and to address any concerns identified based on the outcome of this tool. | |

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| | LPN#4 reviewed the pharmacy Emergency Drug Kit (EDK) to see if Augmentin had been used from the EDK to start the medication before pharmacy sent the card of Augment. LPN #4 indicated at that time documentation was lacking that Augmentin had been used from the pharmacy EDK to start the 10/20/15 ordered Augmentin. LPN #4 indicated there were at present 2 extra tablets of Augmentin.<br><br>On 10/28/15 at 11:18 A.M., the Director of Nursing (DON) was made aware of the Augmentin 875 mg order (dated 10/20/15) on the MAR indicated a total of 20 doses to be administered. The DON was made aware of 13 doses documented as administered as of 10/27/15 8:00 A.M. The DON was also made aware of 9 pills left on the card and documentation lacking of pharmacy EDK being utilized. The DON indicated she had also checked the EDK and no doses had been utilized and 7 tablets should have been left to administer on 10/27/15 at 1:45 P.M., instead of 9 tablets ( 2 extra tablets).<br><br>2. On 10/27/15 at 1:40 P.M., Resident Z's clinical record was reviewed. His clinical record included but was not limited to a telephone order dated 10/22/15 for Prednisone 20 mg orally-2 | | | |

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| | pills daily for 3 days and then 1 pill daily for 3 days.<br><br>On 10/27/15 at 1:46 P.M., Resident Z's October 2015 Medication Administration Record (MAR) was reviewed with QMA (Qualified Medication Aide) #7 who was administering medication on Resident Z's hall. The MAR included a medication ordered on 10/22/15 of "...Prednisone (steroid medication) 20 mg [milligrams] po [by mouth] ii [2 tablets] daily x 3 days then Prednisone 20 mg po i [1 tablet] daily x 3 days..."<br>The medication times listed on the MAR for the first 3 days were 8:00 A.M., and 8:00 P.M. The medication times listed on the MAR for the second 3 days was 8:00 A.M.<br>Documentation indicated that Prednisone 20 mg, 2 tablets were administered on 10/23/15, 10/24/15, 10/25/15 at 8:00 A.M. and 8:00 P.M. Documentation also indicated Prednisone 20 mg, 1 tablet had been administered on 10/26/15, 10/27/15, and 10/28/15 at 8:00 A.M.<br><br>On 10/27/15 at 1:46 P.M., during interview with QMA #7 she was made aware that she had administered the Prednisone 20 mg for the 10/28/15 date, today on 10/27/15 at 8:00 A.M. She indicated she had not been aware she had administered the dose of Prednisone for 10/28/15 on 10/27/15. She | | | |

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| | indicated she had shredded the label for the Prednisone ordered on 10/22/15 for Resident Z due to all the medication had been administered.<br><br>On 10/28/15 at 11:13 A.M., the Director of Nursing (DON) was made aware of Resident Z's MAR in regard to Prednisone (order date of 10/22/15) administrated. The DON agreed the Prednisone had not been administered the dates ordered. The DON also indicated she was aware the 20 mg, 2 tablets ordered daily had been documented as administered twice daily when the medication had been ordered daily.<br><br>On 10/28/15 at 12:51 P.M., the DON provided facility documentation entitled, "PHYSICIAN ORDER PROCEDURE (undated)." The documentation included but was not limited to, "... Medication Administration sheet and/or Treatment Administration sheet and care will be delivered as ordered and delivery documented."<br><br>This Federal Tag related to Complaint IN001840434.<br><br>3.1-35(g)(2) | | | |

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| F 0312<br>SS=D<br>Bldg. 00 | 483.25(a)(3)<br>ADL CARE PROVIDED FOR DEPENDENT RESIDENTS<br>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.<br><br>Based on observation, interview, and record review, the facility failed to ensure a resident frequently incontinent of urine received assistance for incontinence care and hygiene for 1 of 3 residents reviewed for urinary incontinence. ( Resident Z)<br><br>Findings included:<br><br>On 10/27/15 at 1:15 P.M., Resident Z's clinical record was reviewed. Resident Z had been admitted to the facility on 2/28/13. His current Quarterly Minimum Data Set assessment (MDS) dated 8/12/15, indicated a moderate cognitive impairment (score of 12). The MDS also indicated limited assistance of 1 staff needed for transfers and personal hygiene and extensive assistance of 1 staff needed for toilet use. His diagnoses included but were not limited to, vascular dementia with behavior disturbance, bipolar disorder, psychosis, and poor visual acuity without explanation.<br><br>The current care plan with revision date | F 0312 | F - 312 The corrective action taken for those residents found to have been affected by the deficient practice is that the resident identified as resident Z has been reassessed related to his level of need of assistance with ADLs including incontinence care. The resident is now being offered to toiletor checked and changed every hour while awake and every two hours through the night to ensure the resident has the assistance he needs with his incontinence. *The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that* a housewide audit has been conducted on all residents who require assistance with toileting to ensure that each of them receive the level of assistance they need with toileting or incontinence care. The care plans have been up-dated to reflect the current interventions to address the resident's toileting/incontinentneeds. The measures that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service has been | 11/20/2015 |

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| | of 11/21/14, indicated, a problem of "...Urinary Incontinence Functional Cognitive deficit Resident up ad lib, but unable to toilet self and get clean-does not always realize he is soiled..." Interventions included but was not limited to, "... Toilet resident promptly upon request..." and "...Provide pericare after each incontinent episode..."<br><br>Resident Z's care plan also addressed the problem of the resident being at risk for falls (revision date 9/20/15). Interventions included but not limited to, "Offer comfort and toileting rounds at least every 1-2 hours..."<br><br>On 10/28/15 at 8:47 A.M., LPN #6 (Resident Z's nurse) was made aware nursing care needed to be observed for Resident Z. QMA #5 was observed in Resident Z's hall at that time and was also made aware nursing care needed to be observed for Resident Z. QMA #5 indicated at that time she had not provided nursing care after breakfast for Resident Z.<br><br>On 10/28/15 at 8:48 A.M., Resident Z was observed sitting in his recliner in his room. The front side of the right leg of his blue sweat pants was observed to be discolored from urinary incontinence from the peri area to approximately 3 | | conducted for all nursing staff on providing each resident with the level of assistance to meet their ADL needs including assistance with toileting or incontinence care.<br>*The corrective action taken to monitor to assure compliance is that* a Quality Assurance tool has been developed and implemented to monitor to ensure that residents who need assistance with toileting and/or incontinence care are receiving the level of assistance to meet those needs. This tool will be completed by the Director of Nursing and/or her designee daily for one week, then weekly for three weeks, then monthly for three months and then quarterly for three quarters. The outcomes of this tool will be reviewed at the morning QA clinical meetings Monday – Friday to ensure compliance and to address any concerns identified based on the outcome of this tool. | |

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| | inches above the ankle area. A strong urine odor was noted in his room.<br><br>On 10/28/15 at 9:36 A.M., during interview with QMA #5 she indicated, she had changed Resident Z 's wet clothes at approximately 9:15 A.M (28 minutes after Resident Z had been observed wet in his recliner).<br><br>On 10/28/15 at 10:10 A.M., during interview with CNA #3, she indicated Resident Z needed help from staff to clean up but he can transfer self. CNA #3 indicated she tried to check Resident Z every hour due to he can't clean himself after being incontinent. Resident Z was observed at that time to be incontinent of urine and bm stool. His black sweat pants (left leg) was observed to have a large amount of dark discoloration from being incontinent of urine and a strong urine odor was noted.<br><br>On 10/28/15 at 2:22 P.M., the Director of Nursing (DON) was made aware of Resident Z had been observed x 2 that morning with his clothes wet due to urinary incontinence.<br><br>On 10/28/15 at 2:35 P.M., Resident Z's urinary incontinence care plan was reviewed with the Director of Nursing (DON). The DON during interview at | | | |

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| | that time indicated she didn't think Resident Z was able to request toileting as the care plan had indicated.<br><br>A facility policy entitled "Prevention of Pressure Ulcers (Revised October 2010)" was received and reviewed on 10/28/15 at 2:45 P.M.<br>The policy included but was not limited to,<br>"...6. Risk Factor-Bowel/Bladder Incontinence...<br>b. Assess and treat urine leaks.<br>c. If moisture cannot be controlled use absorbent pads and /or briefs with a quick-drying surface and protect skin with moisture barrier..."<br><br>A facility policy entitled "Quality of Life-Accommodation of Needs (Revised October 2009)" was received and reviewed on 10/28/15 at 3:05 P.M.<br>The policy included but was not limited to,<br>"... Our facility's environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving independent functioning, dignity and well-being...<br>4. In order to accommodate individual needs and preferences, staff attitudes and behaviors must be directed towards assisting residents in maintaining independence, dignity and well-being to | | | |

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| | the extent possible..."<br><br>This Federal Tag related to Complaint IN001840434.<br><br>3.1-38(a)(3)(c) | | | |
| F 0323 SS=D Bldg. 00 | 483.25(h)<br>FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br>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.<br><br>Based on observation, interview, and record review, the facility failed to ensure effective interventions were implemented and supervision was provided to prevent accidents for 2 of 3 residents who met the criteria for review of accidents. (Resident Y, Resident X)<br><br>Findings include:<br><br>1. On 10/27/15 at 11:30 A.M., Resident Y was observed sitting in a recliner in his/her room with extensive bruising on the face. During an interview, at that time, Resident Y indicated he/she had been sitting in a wheel chair, gotten sleepy, nodded off, and fell out of the wheel chair. Resident Y indicated he/she | F 0323 | F – 323 1.) The corrective action taken for those residents found to have been affected by the deficient practice is that the resident identified as resident Y has been re-assessed by nursing and therapy related to the resident's potential fall risks. The care plan has been up-dated to reflect the appropriate interventions that the resident needs and those interventions are in place. No additional falls have occurred. 2.) The corrective action taken for those residents found to have been affected by the deficient practice is that the resident identified as resident X has been reassessed related to fall risks. The care plan has been up-dated to reflect the appropriate interventions that the resident needs and those interventions are in place. No additional falls have | 11/20/2015 |

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| | became aware as he/she was leaning forward, but was not able to correct his/her balance to stop the fall.<br><br>The clinical record of Resident Y was reviewed on 10/27/15 at 12:35 P.M. The record indicated Resident Y was admitted on 7/9/15 with diagnoses including, but not limited to, abnormality of gait/mobility, lack of coordination, muscle weakness, osteoporosis..., hx (history of) of left hip fracture 7/30/15, and below knee amputation 9/29/15.<br><br>The Admission MDS (Minimum Data Set) assessment dated 7/19/15 indicated Resident Y experienced no cognitive impairment, required the limited assistance of two staff for transfers, experienced unsteady balance during transfers and transitions, and had experienced one fall since admission to the facility.<br><br>A Significant Change MDS dated 8/9/15 indicated Resident Y experienced no cognitive impairment, required the extensive assistance of two staff for transfers, experienced unsteady balance during transfers and transitions, and had experienced no further falls.<br><br>The most recent Physician's Order Recap dated 9/3/15 included, but was not | | occurred. *The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that* a housewide audit has been completed on each resident who is at risk for falls. Each resident's safety interventions have been reviewed and revised as needed to ensure the resident's safety. Each resident's care plan has been up-dated to reflect the resident's current safety needs. Each resident is being visually observed to ensure that all fall risk interventions are in place in accordance with their individual plan of care. The measures that have been put into place to ensure that the deficient practice does not recur is that the facility has reviewed its policy on fall prevention. In addition the therapy department has developed a communication tool so that when a safety concern has been identified it is communicated to nursing so that collectively an appropriate intervention can be added to the care plan to ensure resident safety. A mandatory in-service has been provided for all nursing staff on the facility fall prevention program and the implementation of the therapy communication tool. A special emphasis was made on each staff members' responsibility to ensure that each resident's fall risk care plan was in place and appropriate supervision provided to ensure the residents' safety. In | |

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| | limited to, orders for, "Activities...up with assist X [times] 1...Safety...PT [Physical Therapy] 3-5 X/weel [sic] for 8weeks [sic] for there [therapeutic] ex [exercises]...to increase safety..."<br><br>A Nursing Admission Assessment dated 7/9/15 indicated Resident Y experienced unsteady gait due to left lower extremity halo device. The assessment lacked any documentation to indicate the risk of Resident Y to experience a fall.<br><br>A Fall Risk Assessment dated 7/10/15 indicated Resident Y was at risk to experience a fall.<br><br>Fall #1: A Nursing Note dated 7/18/15 at 8:40 P.M. indicated, "Res [resident] returned to facility from loa [leave of absence] [sic] with family to [name of store] and reported falling while loa [sic]. Fall occurred while res was transferring self from a motorized w/c [wheel chair] to different one..." The note lacked any documentation to indicate a new intervention had been implemented to prevent further falls.<br><br>An IDT (Interdisciplinary Team) Incident/Accident Review for dated 7/18/15 indicated Resident Y had experienced a fall during a leave of absence from the facility with family. | | addition the nurses were instructed on their responsibility of ensuring that each assessment was documented to accurately reflect the resident's safety risks and needs as well as thorough assessments documented on each fall follow up assessment.<br>*The corrective action taken to monitor to assure compliance is that* a Quality Assurance tool has been developed and implemented to ensure that each residentat risk for falls has the appropriate safety interventions in place and is receiving the level of supervision in accordance with their plan of care to ensure the residents' safety. This tool will be completed by the Director of Nursing and/or her designee daily for one week, then weekly for three weeks, then monthly for three months and then quarterly for three quarters. The outcomes of this tool will be reviewed at the morning QA clinical meetings Monday – Friday to ensure compliance and to address any concerns identified based on the outcome of this tool. | |

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| | The form lacked any documentation to indicate a new intervention was implemented to prevent further falls.<br><br>A Care Plan for "Fall at [name of store] with family" dated 7/18/15 lacked any documentation to indicate a new intervention was implemented to prevent further falls.<br><br>The Nursing Notes from 7/18/15 through 7/20/15 at 7:04 P.M. lacked any documentation to indicate a new intervention had been implemented to prevent further falls.<br><br>A Nursing Note dated 7/20/15 at 7:04 P.M. indicated, "Res was sent [name of hospital] ER [emergency room] d/t [due to] increased pain in L [left] hip today....res has a L hip fracture..."<br><br>A Care Plan dated 7/31/15 for Falls indicated a new intervention of "Up with assist of 1 staff" was implemented. (A new intervention was implemented 13 days after a fall was experienced)<br><br>A Nursing Note dated 8/7/15 at 12:40 P.M. indicated, "Resident readmitted [sic] on 7/27/15 from hospital d/t broken hip..."<br><br>A Care Plan dated 8/10/15 for "The | | | |

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| | resident has a left hip fracture r/t [related to] fall" included the following interventions: "Anticipate and meet needs. Be sure call light is within reach and respond promptly to all request for assistance, Dexa Scan [a test to measure bone density] prior to appt [appointment] on 09/04/15. Fax results to [phone number], Follow MD [physician] orders for weight bearing status. See MD orders and/or PT treatment plan, Monitor limb for swelling and skin changes, Monitor/document pain on a scale of 0 to 10 before and after implementing measures to reduce pain, Monitor/document/report PRN [as needed] s[signs]/sx [symptoms] of hip fracture complications: Contracture formation, Embolism s/sx (cyanosis, pain, petechiae, increased heart rate...achy, difficulty breathing...Infection at surgical site, Impaired mobility, Unrelieved pain, Pneumonia/poor air exchange, incontinence, Monitor/evaluate/provide with/monitor use of adaptive devices PRN: Fracture pan, Gait belt, Abduction pillow, Walker, Wheelchair, Elevated toilet seat, PT/OT [Occupational Therapy] evaluation and treatment per orders, Reposition as necessary to prevent skin breakdown. Prevent 90 degree flexion to prevent circulation problems" | | | |

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| | A Care Plan for Falls dated 8/13/15 indicated an intervention of, "Therapeutic LOA to funeral on 8/12/15 if family has adequate resources to transport safely..."<br><br>A Psychosocial Note dated 9/22/15 at 8:57 A.M. indicated, "Update received from [name of hospital] ...surgery is scheduled for ...the 24th [9/24/15] to amputate...leg..."<br><br>A Fall Risk Assessment dated 9/29/15 indicated Resident Y experienced decreased muscular coordination/jerking movements and was at high risk to experience a fall.<br><br>A Fall Risk Assessment dated 10/23/15 indicated Resident Y experienced decreased muscular coordination/jerking movements and was at high risk to experience a fall.<br><br>Fall #2: A Nursing Note dated 10/23/15 at 10:10 A.M. indicated, "Called to res room at this time by housekeeper. Res lying on floor,left [sic] side, in front of w/c. Res stated that following breakfast res started falling asleep, "nodding off" when res began to fall forward and was unable to catch self before hitting the floor...Res assisted back into w/c via staff and then to recliner. Res did hit head..." | | | |

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| | A Nursing Note dated 10/23/15 at 10:50 A.M. indicated, " Res...to be in recliner instead of w/c while in room if not eating..."<br><br>An untimed PT (Physical Therapy) Eval (evaluation) and Plan of Treatment dated 9/29/15 indicated, "...Sitting Balance Static Sitting=Poor + (maintains balance w [with]/mod [moderate] (A) [assist] and UE [upper extremity support]. Dynamic sitting=Poor +...Assessment Summary Clinical Impressions: Patient present with decreased tolerance to activity, weakness, and increased need for assistance with ADL's [Activities of Daily Living]..."<br><br>An untimed PT Evaluation and Plan of Treatment dated 10/01/15 indicated, "...Sitting balance=Good (maintains balance w/o [without] support against mod resistance) dynamic Sitting=Good ..."<br><br>An untimed OT [Occupational Therapy] Evaluation and Plan of treatment dated 9/29/15 indicated, "Sitting during ADL's= Poor+...Very stiff and struggling to sit edge of bed..."<br><br>An untimed OT Progress Report dated 10/13/15 lacked any documentation to indicate the sitting balance of Resident Y | | | |

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| | was evaluated.<br><br>The Nursing Notes from 9/29/15 through 10/23/15 and lacked any documentation to indicate nursing staff was aware Resident Y experienced deficits in sitting balance.<br><br>During an interview with the DON on 10/28/15 at 9:30 A.M. the DON [Director of Nursing] indicated no documentation could be provided to indicate an immediate intervention was implemented after the fall on 7/19/15 to ensure the safety of Resident Y.<br><br>During an interview on 10/28/15 at 11:30 A.M., OT #1 indicated the therapy documentation dated 9/29/15 and 10/01/15 indicated Resident Y experienced deficits related to sitting balance and then stated, "...[Resident Y] did not have a problem with sitting balance when...in a wheelchair...the wheelchair is the support..." OT #1 further indicated no documentation could be provided between 10/1/15 and 10/23/15 to indicate the sitting balance of Resident Y was evaluated.<br><br>During an interview with the HFA on 10/28/15 at 4:000 P.M., the HFA indicated no documentation could be provided to indicate the nursing staff had | | | |

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| | been notified by PT/OT staff or were aware Resident Y experienced balance deficits while sitting. The HFA further indicated, at that time, if nursing had been aware of the sitting balance deficit, interventions could have been implemented to prevent the fall from the wheelchair on 10/23/15.<br><br>During an interview on 10/28/15 at 11:45 A.M., a handwritten log dated 10/21/15 was provided by the HFA. The log indicated "Transfers & Fall Risk/Balance/Bed Mobility...[Resident Y]...CGA [Contact Guard Assist]..." OT #1 indicated, at that time, CGA meant someone had to be next to Resident Y in case assistance was needed, but Resident Y did not have a problem with balance while sitting. OT #1 then stated, "The fall from the wheelchair was a freak accident, there is nothing we could have done to prevent it." OT #1 then indicated no documentation could be provided to indicate therapy had notified nursing staff Resident Y experienced any deficits with balance while sitting.<br><br>2. During an interview on 10/27/15 at 10:08 A.M. the DON [Director of Nursing] indicated Resident X had a history of falls, was a high risk to experience falls, and had experienced a | | | |

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| | fall with injury in the last 3 months.<br><br>Resident X was observed on 10/27/15 at 12:15 P.M. sitting in a wheelchair at the dining room table eating lunch in no apparent distress.<br><br>The clinical record of Resident X was reviewed on 10/27/15 at 1:30 P.M. The record indicated the diagnoses of Resident X included, but was not limited to, dementia, abnormal posture, history of subdural hematoma, history of yelling.<br><br>A Care Plan for Falls dated 6/9/15 included, but was not limited to, an intervention of, "...utilize pull tab alarm..."<br><br>A Post-Fall note dated 8/1/15 indicated Resident X experienced a fall at 4:36 P.M. The note lacked any specific detail related to the fall.<br><br>A Nurse Manager Post incident/Accident Review dated 8/1/15 at 4:10 P.M. indicated "Resident sitting in doorway of rm [room] Reaching for something on floor. Fell forward striking head. Alarm did not sound. Resident having increased restlessness and variable moods...Immediate intervention [arrow up] supervision q [every] 15 min [minutes]...Alarm cord shortened..." | | | |

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| | A Post-Fall note dated 8/23/15 at 6:53 P.M. indicated, "...Res seen by this nurse falling in doorway of room from bed. landing on left side of head. heard res head hit floor. res noted to have injuries as stated above. res with no change in mental status. unable to obtain vital signs at this time as res was noncompliant res was yelling out d/t being pain..."<br><br>An IDT (Interdisciplinary Team) Incident/Accident Review dated 8/23/15 at 4:15 P.M. indicated, "...Fall with hematoma L [left] forehead laceration anterior left hand; bottom lip and left elbow...Nurse saw resident attempting to get out of bed on R [right] side of bed; alerted CNA to assist resident the left rm [room]. CNA assisted resident to lay down and then went to get assistance to get resident up as she requires 2 assist. Nurse walking down hall, saw resident fall from bed on L side with head by doorway. Alarm (pull tab) had been on resident when nurse saw her earlier was detached at time of fall...Pressure alarm to bed immediate intervention. When up in w/c constant staff visual supervision, Visual check q 15 minutes in bed..."<br><br>During an interview on 10/27/15 at 2:15 P.M., the DON (Director of Nursing) indicated, the pull tab chair alarm did not | | | |

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| | function properly on 8/1/15 because the cord was too long to activate the alarm and Resident X experienced an unwitnessed fall.<br><br>During an interview on 10/27/15 at 2:20 P.M., the HFA (Health Facilities Administrator) indicated staff should not have left Resident X unattended and the safety alarm should be been activated on 8/23/15.<br><br>The Policy and Procedure for High Risk Fall Protocol Fall Prevention Program provided by the HFA on 10/28/15 at 2:00 P.M. indicated,<br>"...To establish a facility wide program to properly identify, evaluate [sic] and supervise residents who are at risk for fall.<br>The goal of this program is to prevent falls, reduce both the incident of falls, and the injuries that may accompany falls...<br>Procedure:...4. If a fall occurs the nurse will implement a new intervention on the care plan in an effort to decrease the risk of future falls...Intervention Options for Fall Prevention ...A new intervention must be put in place immediately following a fall. Following is a list of options:...<br>2. Keep in high traffic area, easily viewed by staff and frequently passed by staff | | | |

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| | members...<br>18. Alarms...bed and/or pull tab alarms..."<br><br>This Federal Tag relates to Complaint IN00181005.<br><br>3.1-45(a)(2) | | | |
| F 0514<br>SS=D<br>Bldg. 00 | 483.75(l)(1)<br>RES<br>RECORDS-COMPLETE/ACCURATE/ACCESSIBLE<br>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.<br><br>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.<br><br>Based on interview and record review, the facility failed to ensure the clinical record contained therapy documentation for 2 of 3 residents who met the criteria for review of accidents. (Resident Y, Resident X)<br><br>Findings include: | F 0514 | F – 514 1.) The corrective action taken for those residents found to have been affected by the deficient practice is that the resident identified as resident Y has had their clinical record reviewed. The clinical record now contains copies of all therapy notes while the resident was receiving therapy. 2.) The corrective action taken for those | 11/20/2015 |

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| | 1. The clinical record of Resident Y was reviewed on 10/27/15 at 12:35 P.M. The record indicated Resident X was admitted on 7/9/15 and lacked any documentation related to Physical or Occupational Therapy.<br><br>The most recent Physician's Order Recap dated 9/3/15 included, but was not limited to orders for, "...PT [Physical Therapy] 3-5 X/weel [sic] for 8weeks [sic] for ther [therapeutic] ex [exercises]...to increase safety..."<br><br>2. The clinical record of Resident X was reviewed on 10/27/15 at 1:30 P.M. The record lacked any documentation related to Physical or Occupational Therapy after 4/17/15.<br><br>During an interview on 10/27/15 at 1:35 P.M., comprehensive, complete therapy documentation was requested of PTA #1. PTA #1 indicated, at that time, Resident X and Y had received Physical and Occupational Therapy services at various times in the last few months. PTA #1 then indicated, therapy documentation was located in a separate therapy computer system and was not part of the resident's facility clinical record. PTA #1 further indicated, the nursing staff did not have access to the therapy documentation | | residents found to have been affected by the deficient practice is that the resident identified as resident X has had their clinical record reviewed. The clinical record now contains copies of all therapy notes while the resident was receiving therapy. *The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that* a housewide audit has been completed. Any resident that has received or is currently receiving therapy services has the therapy evaluation, progress notes and discharge notes/instructions on their clinical record.<br>The measures that have been put into place to ensure that the deficient practice does not recur is that the therapy department has implemented a new practice in that each week all therapy evaluations, progress notes and discharge notes/instructions are placed on the respective residents'clinical records. The therapy department has also implemented a communication tool in that when any safety concern or resident need is identified this information is immediately forwarded to the nursing department and collectively they will determine an appropriate intervention to meet that resident's need. The care plan and CNA assignment sheets will also be up-dated as warranted. | |

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| | unless they asked the Therapy Manager, because the documentation had to be signed by the physician first.<br><br>During an interview on 10/27/15 at 2:10 P.M., LPN #4 indicated she did not know how to access therapy documentation and did not know the current therapy plan of care.<br><br>During an interview on 10/27/15 at 4:00 P.M., the Therapy Manager provided therapy documentation for Resident Y dated from 7/10/15 through 12/27/15 and for Resident X dated from 9/17/15 through 12/15/15. The Therapy Manager indicated, at that time, the therapy documentation was lacking in the clinical record because the volunteer who did the filing was off work.<br><br>During an interview on 10/28/15 at 1:00 P.M., the HFA (Health Facilities Administrator) indicated no specific policy could be provided related to clinical records, but it was the usual facility practice for the clinical record to be complete and the therapy notes should be part of the resident clinical record.<br><br>This Federal Tag relates to Complaint IN00181005.<br><br>3.1-45(a)(2) | | *The corrective action taken to monitor to assure compliance is that* a Quality assurance tool has been developed and implemented to ensure that all therapy documentation is placed in the residents' clinical record weekly. In addition the tool will monitor to ensure that any concerns that are identified by therapy are reported to nursing immediately to ensure that appropriate interventions have been put in place to address those needs/concerns. This tool will be completed by the Director of Nursing and/or her designee daily for one week, then weekly for three weeks,then monthly for three months and then quarterly for three quarters. The outcomes of this tool will be reviewed at the morning QA clinical meetings Monday– Friday to ensure compliance and to address any concerns identified based on the outcome of this tool. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155539 | A. BUILDING 00<br>B. WING | 10/28/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BERTHA D GARTEN KETCHAM MEMORIAL CENTER | 601 E RACE ST<br>ODON, IN 47562 |

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