STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 00 B. WING	07/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM CROSSING	200 CONNIE AVE SALEM, IN 47167

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00178704. Complaint IN00178704 - Substantiated. Federal/state deficiencies related to the allegations are cited at F323. Survey dates: July 29 and 30, 2015 Facility number: 000223 Provider number: 155330 AIM number: 100267680 Census bed type: SNF/NF: 83 Total: 83 Census payor type: Medicare: 12 Medicaid: 59 Other: 12 Total: 83 Sample: 4 These deficiencies reflect State findings cited in accordance with 410 IAC	F 0000	Please find the enclosed plan of correction for the survey ending July 30, 2015. Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance; feel free to contact me with any questions.	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	16.2-3.1.			
F 0323 SS=G Bldg. 00	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, record review and interview, the facility failed to provide supervision and care according to standards of practice and the resident's plan of care in order to prevent an avoidable fall for 2 of 4 residents reviewed for falls (Residents B and D), and to identify and treat a fractured hip resulting from a fall in a timely manner (Resident D). This deficient practice resulted in a fractured femur, four spinal fractures, a head laceration requiring 16 staples, and increased pain (Resident B) and a delay in care and treatment for a fractured hip (Resident D). Findings include:	F 0323	1. Resident #B and D no longer reside in facility. 2. All residents have the potential to be affected. All residents care plans were reviewed to ensure they reflect the current ADL needs of the resident and to ensure ADL needs are accurately reflected on the residents' profiles. All residents were assessed to ensure their pain is under control and no indication of injury is noted. 3. The Care Plan, Pain Management, Fall Management, and Change of Condition Policies and Procedures were reviewed with no changes made (See Attachments A, B, C, and D). The Charge Nurse Job Description was reviewed with no changes made (See Attachment E). All nursing staff will be in-serviced on the above policies by the Clinical Education	08/28/2015

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	1. Resident B's clinical record was reviewed on 7/29/2015 at 11:59 a.m. Diagnoses included, but were not limited to, end-stage Alzheimer's disease (for which she was receiving Hospice care), muscle weakness, and pain. Resident B's Quarterly Minimum Data Set (MDS) assessment, dated 4/21/2015, indicated the resident was severely cognitively impaired. The resident was non-ambulatory and required extensive, 2+ person assist for all ADLs (activities of daily living), including bed mobility and transfers. Staff assessment for non-verbal cues of pain was not completed. Resident B was 64 inches tall and weighed 72 pounds. Care Plan for Resident B indicated, "Problem: Resident needs assistance with ADL's [activities of daily living].... Approach: ...Approach Start Date: 9/16/2013 assist of 2 for ADL." Physical Therapy Plan of Care, dated 4/15/2015, indicated, "...Patient is non ambulatory. Pt [patient] needs total assist with rolling, supine to sit, and transfers...." Fall Risk Assessment, dated 7/24/2015, indicated the resident was dependent for		Coordinator by 8-21-15. The licensed nursing staff will be in-serviced on Job Description by 8-21-15. The DNS or designee will review a minimum of 5 care plans and profiles to ensure that it they accurately reflect the resident's needs. The DNS or designee will review incontinent care on 3 residents provided by CNAs to ensure appropriate supervision is provided according to the resident's plan of care. The DNS or designee will assess residents that have had an incident or accident to ensure the resident is free of pain and no indication of injury is noted. If the resident is noted to have pain or injury, the physician will be notified for orders. The DNS or designee will utilize the Nursing Monitoring Tool daily for 4 weeks, then weekly times 4 weeks, then every 2 weeks times 2 months, then quarterly (See Attachment F). 4. The DNS or designee will complete a Fall Management CQI (See Attachment G) weekly times 1 month, then monthly times 6 months, then quarterly. The audits will be reviewed during the facility's CQI meetings and issues will be addressed and the above plan will be altered accordingly if the threshold is not 95% or above.	

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	bathing, dressing, feeding, hygiene, toileting, bed mobility, and transfers. Documentation indicated Resident B had 1 fall in the last quarter. A Fall Event Report for Resident B, dated 7/24/2015, indicated, "Event Date: 7/24/2015 05:28 AM. Was fall witnessed: No. Describe what the resident was doing prior to the fall: aide [CNA - Certified Nursing Assistant] was washing resident turned her to side left room to get wash cloth went back in room resident on floor. Describe the position of the resident when first observed after fall: lying on left side...Location of the fall: room. Is the resident in pain and or experiencing difficulty in movement of extremities: Yes - left side of head. Did the resident hit his/her head: Yes...Resident or witness statement of how fall occurred: staff turned resident left room went back in room resident on floor...." Resident Progress Notes, dated 7/24/2015 at 4:45 a.m., indicated, "Called to room per CNA and LPN [Licensed Practical Nurse], upon entering noted res [resident] lying partially on left side on floor between beds facing her bed with large amount bright red bleeding coming from left side of head...instructed LPN to call 911...."			

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Resident Progress Notes, dated 7/24/2015 at 4:59 a.m., indicated, "EMS [Emergency Medical Services] here and assessed res., conversed with ER [Emergency Room] MD [Medical Doctor], decided res to be stat [as soon as possible] flighted to [name of hospital] hospital related to CT scan down at [name of hospital] and severity of head lac [laceration]...."

[Hospital name] Emergency Department Physician Clinical Report, dated 7/24/2015 at 5:53 a.m., indicated, "Chief complaint: Fell...The patient sustained a blow to the head...Patient lives at a nursing home and baseline is noncommunicative and bed bound. Patient had a fall due to unknown cause and struck head with left sided hematoma with bleeding."

Resident B Progress Notes, dated 7/24/2015 at 3:38 a.m., indicated, "Report from [hospital], Resident has L [left] Femur [thigh bone] Fx [fracture], 4 spinal Fx [fractures]; L1 - L3 [lumbar/lower back: 1st , 2nd and 3rd of 5 vertebrae], T4 [thoracic/upper back: 4th of 12 vertebrae]. Staples to head [laceration]...."

Resident B Progress Notes, dated

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	7/25/2015 at 3:06 a.m., indicated, "Resident returned from [hospital].... She has 16 staples in left posterior temple [forehead]...." Resident Progress Notes, dated 7/25/2015 at 8:00 a.m., indicated, "Hospice and MD notified of resident's increased pain level, PRN [as needed] SL [sublingual] morphine [medication for pain] given and not effective...." Resident Progress Notes, dated 7/26/2015 at 11:18 a.m., indicated, "...Grimaces as if in pain, MD and Hospice aware." Interdisciplinary Team Progress Notes, dated 7/27/2015 at 9:08 a.m., indicated, "F/U [follow up] Fall: Resident was found lying on her left side next to her bed by CNA. Nurse called to room...large amount of blood noted on floor. Resident noted with laceration to left side of head.... Resident returned to facility with staples to head and fractures to spine and LLE [left lower extremity]. Interventions: Bed against wall at all times, mat to floor while abed [sic]. Husband aware of interventions and agrees with these. Will continue to observe." During an observation on 7/29/2015 at 12:15 p.m., Resident B was lying on an			

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	air mattress with air bolsters on either side. She was non-responsive to verbal stimuli. The resident had bruising and multiple staples (unable to count due to scabbing/dried blood and hair) to her left temple. On 7/29/2015 at 12:20 p.m., Licensed Practical Nurse (LPN) # 1 indicated Resident B was totally dependent on staff for all transfers and ADLs and that the resident did not move or roll on her own. Resident B's husband was interviewed on 7/29/2015 at 12:56 p.m. He indicated Resident B did not roll on her own. Regarding his wife's fall on 7/24/2015, he indicated facility staff reported to him that "one girl" attempted to turn her in the bed and "they should have had two." The Director of Nursing Services (DNS) was interviewed on 7/30/15 at 9:01 a.m. She indicated she was informed that a CNA was doing a room check on Resident B and turned her. The resident was incontinent and the CNA left the room to get a washcloth. When the CNA returned, she found Resident B on the floor. The DNS indicated the CNA left Resident B on her side when she left the room, stating, "I don't know if she got her too close to the bed. My root cause is possibly due to involuntary movement.			

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	It's like a mystery." 2. Resident D's closed clinical record was reviewed on 7/30/2015 at 10:10 a.m. Diagnoses included, but were not limited to, dementia with behavior disturbance, anxiety disorder and chronic pain. The resident was admitted to the facility 7/7/2015. Admission MDS assessment, dated 7/14/2015, indicated a Brief Interview for Mental Status (BIMS) of 3; indicating the resident was cognitively impaired. He required extensive, 1-2 person assist for all ADLs. The resident was not steady during transitions (transfers) and walking, and was only able to stabilize with staff assist. MDS assessment indicated Resident D had one fall with an injury (except major) since admission. Nursing Admission Assessment, dated 7/7/2015, indicated Resident D was a fall risk. Resident D's Physical Therapy Plan of Care, dated 7/8/2015, indicated, "...Fall Risk: Current Level: high risk...Underlying impairments Other: 1). Pt [patient] requires verbal and tactile cues to make him hold front wheel walker not using assistive device properly. 2). Once standing, requires			

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	mod assist x 1 to ambulate slow strides. 3). Uneven steps. 4). Might have loss of balance if not holding him. 5). Takes more than 20 seconds to complete 10 feet." A care plan for Resident D indicated, "Problem: 9. Self care deficit related to: dementia, general weakness. Approach: ...Approach Start Date: 7/8/2015 Assist with transfers as needed - 1-2 assist with wheelchair/walker." An ASC Fall Event Report, dated 7/9/2015 at 9:50 p.m., indicated, "Event Date: 7/9/2015 09:30 PM. Was fall witnessed: No. Describe what the resident was doing prior to the fall: Resting abed [sic]. Describe the position of the resident when first observed after fall: Rsd [resident] was found walking with injuries noted...Describe location of the fall: resident's bedroom. Is the resident in pain and or experiencing difficulty in movement of extremities: No. Did the resident hit his/her head: Yes...Describe injuries, if any, and the immediate treatment provided: 1 cm [centimeter] laceration to R [right] forehead, 1 cm s/t [skin tear] to R [right] wrist.... Document any environmental factors observed in area of fall: poor lighting...."			

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	Resident Progress Notes, dated 7/9/2015 at 9:30 p.m., indicated, "Rsd was found walking out of bedroom with forehead bleeding...Head-to-toe assessment done...No edema. MAEW [moves all extremities within normal limits]...." Subsequent Resident Progress Notes indicated Resident D had "no new injuries noted" from the 7/9/2015 fall and no complaints of pain related to the fall. Resident Progress Notes, dated 7/18/2015 at 2:21 p.m. (Recorded as Late Entry on 7/22/2015 at 1:27 p.m.), indicated, "...CNA saying resident was moaning with transfer. Pain assessment done on resident and resident noted to have moaning sound wherever resident was touched. Unable to determine where pain was coming from r/t [related to] resident moaning with each area touched. Skin intact with no discoloration noted. Resident had been in wheelchair most of day with resident to be placed in recliner for comfort upon finishing ADL and toilet care. Resident just recently got routine pain pill, will monitor for effectiveness." The following Resident Progress Notes, dated 7/18/2015 at 3:28 p.m. (Recorded as Late Entry on 7/22/2015 at 1:29 p.m.), indicated, "Resident noted sitting in			

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	recliner with no moaning noted at this time...." The following Resident Progress Notes, dated 7/19/2015 (Recorded at Late Entry on 7/22/2015 at 1:33 p.m.), indicated, "...No moaning or s/s [signs or symptoms] of pain noted at this time." The following Resident Progress Notes, dated 7/20/2015 at 4:10 a.m., indicated, "While doing skin assessment, noted to have a bright purple discoloration to right inner thigh. Skin to area is intact. RLE [right lower extremity] is noted to be shortened and externally rotated. Will cont. [continue] to observe area." The following Resident Progress Notes, dated 7/20/2015 at 5:25 a.m., indicated, "MD notified of edema to R [right] lower extremity, increased pain, shortening and external rotation of R [right] lower extremity. N.O. [new order] written: Send to [hospital name] to eval [evaluate] & tx [treat]." EMS Patient Care Report, dated 7/20/2015, and provided by the Director of Nursing Services (DNS) on 7/30/2015 at 1:10 p.m., indicated, "Arrived at Patient: 7/20/2015 at 5:26 a.m. Chief Complaint: PAIN x 11 days. Anatomic Location: Extremity - Lower. Narrative:			

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	Rec'd [received] call...pt [patient] with hip fracture. Upon arrival found male pt laying in bed unresponsive...Bruising noted to right inside thigh. Edema noted to both feet. Nursing staff advised pt may have fallen eleven days ago. EMS asked about pt being in current condition of unresponsive, was advised by nurse pt is normally this way. Advises pt c/o [complained of] pain. Asked how pt was able to advise of pain, was told 'just was'...." Resident D's Hospital Progress Notes, dated 7/22/2015, indicated, "Hospital Course: "...by report of the poa [Power of Attorney]/companion, when he entered the [facility] he was ambulatory. she [sic] reports that shortly after entering he had 3 falls, and he remained wheelchair bound after that. she [sic] states she saw him on the day prior to admission [to hospital] and he was very somnolent.... in the er [Emergency Room] he was found to be unresponsive.... he was noted to have R [right] intertrochanteric [hip/upper femur] fx [fracture] of unknown duration...." On 7/30/2015 at 10:15 a.m., the Director of Nursing Services (DNS) provided a report indicating, "All Falls for Facility (Start Date: 4/30/2015. End Date: 7/30/2015)." The document indicated			

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	Resident D had one fall on 7/9/2015. On 7/30/2015 at 10:34 a.m., The DNS indicated Resident D had only the fall documented on 7/9/2015 while in the facility. She indicated the resident's plan of care prior to the fall on 7/9/2015 included ambulation without assistance and that the resident's care plan changed to "ambulate with assist" after the fall on 7/9/2015. Resident D's significant other and Power of Attorney (POA) was interviewed on 7/30/2015 at 11:40 a.m. She indicated Resident D fell three times from the date of his admission to the facility on 7/7/2015 to his discharge on 7/20/2015. She could not recall dates or names, but indicated, "The nurse said she just forgot to report it", regarding the second fall. On 7/30/2015 at 1:10 p.m., the DNS indicated there was "no other documentation" by the facility related to Resident D's unresponsiveness and decline as indicated in EMS and hospital documentation. On 7/30/2015 at 1:55 p.m., the DNS and Executive Director were interviewed. The DNS indicated CNA's reported concerns about Resident D's right leg/hip to "both nurses on duty" (LPN # 1 and			

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	RN # 4) on 7/18/2015. The DNS indicated, "We found the CNAs had reported it to both nurses on Saturday [7/18/2015]. Neither [nurse] followed up or called the doctor. Nothing was done in that case...." The Executive Director provided documentation of statements by CNAs on duty 7/18/2015 that they notified nursing staff of Resident D's increased right leg/hip pain and shortening of the right leg. A current copy of the Fall Management Program Policy and Procedure, provided by the Corporate Nurse Consultant, on 7/29/2015 at 1:13 p.m., indicated, "POLICY: It is the policy of American Senior Communities to ensure residents residing within the facility will maintain maximum physical functioning through the establishment of physical, environmental, and psychological guidelines to prevent injury related to falls." This Federal tag relates to the Investigation of Complaint IN00178704. 3.1-45(a)(2)			

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