STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	10/16/2015

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dated: October 15, 16, 2015 Facility number: 004904 Provider number: NA AIM number:NA Census Bed Type: Residential: 31 Total: 31 Sample: 7 These State findings are cited in accordance with 410 IAC 16.2-5. Quality review completed by #02748 on October 20, 2015.	R 0000		
R 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of			

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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	induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out. Based on observation, interview, and record review, the facility failed to ensure, employee heath screenings included a two step Mantoux (Tuberculosis skin test), within the required time frame for 2 of 10 employees reviewed. (AD#1, CNA #16)	R 0121	All employees shall receive a health screen including a tuberculin skin test, using the the Mantoux method(5TU,PPD) unless a previously positive reaction can be documented The result shall be recorded in millimeters of induration with the date given, date read, and by	11/30/2015

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	1. The employee file for the facility Activity Director #1 (AD #1) was reviewed on 10/16/15 at 10:22 A.M. The file indicated AD #1 was hired on 8/20/15 and received a first step Mantoux on 8/5/15, read on 8/8/15. A second step Mantoux was documented as given on 8/26/15, no documentation could be provided the second step was read. 2. The employee file for CNA #16 was reviewed on 10/16/15 at 11:00 A.M. The file indicated CNA #16 was hired on 6/12/15, and received a first step Mantoux on 6/12/15, read on 6/15/15. A second step Mantoux was administered on 7/24/15 (42 days after 1st step) which was read on 7/26/15. During an interview with the Clinical Service Manager (CSM) on 10/16/15 at 2:00 P.M.,she indicated no further documentation could be provided in regards to the Mantoux screenings for AD#1 and CNA #16. She further indicated it was the policy of the facility to do a two step Mantoux screening on all new employees that meet the state guidelines. The CMS indicated the current state guidelines was to complete a two step Mantoux screening within 21 days of the employee starting.		whom administered This will be done at time of employment prior to working, or within in 1 month of employment with a two step given if the employee has not had a previous negative Mantoux in the previous 12 months documented. Further TB testing will be done at the risk of infection or yearly thereafter. Chest x ray will be done for any positive reactor to the skin test. A review of all employees was done to confirm that no other employees testing did not follow this policy. Those two employees were given another first step TB test and a 2nd step will follow in the correct time frame and recorded properly. Nursing were re in serviced as to the correct policy for TB testing and requirements by the Care Services Manager Current residents had the potential to be affected by the alleged deficient practice The Care Services Manager is responsible for sustained compliance. The Executive Director and/or designee will audit new employees files within three weeks to ensure the 2- step Mantoux screening is complete with both steps documented with date given, date read and by whom Auditing will be ongoing	

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	A policy titled "TB TESTING" and dated 1/1/2013, was provided by the facility on 10/16/15 at 2:22 P.M. It included, but was not limited to, "... TB testing will be completed per state regulations for residents, staff and volunteers..."			
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.			

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	Based on observation, interview, and record review, the facility failed to ensure supervision was provided or effective interventions were implemented for a resident at risk to experience a fall and the resident experienced 9 falls. This deficient practice resulted in Resident #18 experiencing a traumatic brain injury, a nasal fracture, and a laceration to the right arm requiring 9 sutures. (Resident #18) Findings include: Resident #18 was observed on 10/16/15 at 9:25 A.M., sitting on a couch, in a common lounge, with no staff supervision. The clinical record of Resident #18 was reviewed on 10/15/15 at 12:10 P.M. The record indicated the diagnoses of Resident #18 included, but were not limited to, dementia. The most recent Nursing Comprehensive Evaluation dated 2/5/15 indicated Resident #18 experienced cognitive and gait/balance impairment, had no history of falls, and was not at risk to experience falls. The Service Plan dated 5/7/15 indicated	R 0217	Fall interventions have been implemented on resident#18's care plan Current residents had the potential to be affected by the alleged deficient practice Staff was in serviced on 10/23/2015 by the Care Services Manager and the Executive Director on implementing effective interventions post fall, and post fall documentation The Care Services Manager is responsible for sustained compliance The Executive Director and/or designee will audit care plans post fall for appropriate documentation and intervention on the care plan The audit will be discussed in monthly QA meetings The QA committee will determine if continued auditing is necessary based on 3 consecutive months of full compliance	11/30/2015

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	Resident #18 used a cane, had not experienced a fall in the previous 3 months, required no safety equipment, required no assistance with mobility or transfers, and required safety checks. A Mini-Mental Exam dated 2/05/15 indicated Resident #18 experienced cognitive impairment. The July 2015 Physician's Order Recap lacked any orders related to safety interventions to prevent falls. Fall #1: A Nursing note dated 7/3/15 at 6:30 A.M. indicated, "Reported to writer upon arrival of unwitnessed fall incident. Report states res. slid off couch in her appt [sic] [apartment], landing on buttocks..." The note lacked any documentation to indicate an immediate intervention was implemented to prevent further falls. An untimed Physician's Fax sheet dated 7/3/15 indicated, "Res had unwitnessed fall incident 7/2 at 1923 [7:23 P.M.] Report states res slid off recliner onto buttocks, was able to stand up unassisted..." The sheet lacked any documentation to indicate an immediate intervention was implemented to prevent further falls.			

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	The Service Plan dated 7/3/15 indicated Resident #18 experienced a fall and lacked any documentation immediate, effective interventions were implemented to prevent further falls. Fall #2: A Nursing note dated 7/19/15 at 2:30 P.M. indicated, "Resident had unwitnessed [sic] fall incident @ [at] this time in appt [sic]. States she slid off foot of recliner, landing on buttocks. Call pendant used by resident..." The note lacked any documentation to indicate an immediate intervention was implemented to prevent further falls. An untimed Physician's Fax sheet dated 7/19/15 indicated, "Res. had unwitnessed fall incident @ 1430 [2:30 P.M.] Res states slid from foot of recliner onto buttocks...Able to pull self up to standing position..." The sheet lacked any documentation to indicate an immediate intervention was implemented to prevent further falls. The Service Plan dated 7/19/15 indicated Resident #18 experienced a fall and lacked any documentation immediate, effective interventions were implemented to prevent further falls.			

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	The Service Plan dated 8/5/15 indicated Resident #18 used a cane, experienced no falls in the previous 3 months, required no safety equipment, required no assistance with mobility or transfers, and required safety checks. Fall #3: A Nursing note dated 8/16/15 at 6:30 A.M. indicated, "Reported to writer of 2:53 A.M. unwitnessed fall incident. Report states res emergency pendant alarming. Upon entry to appt [sic] found res on floor with blood on head/nose area. The note lacked any documentation to indicate an immediate intervention was implemented to prevent further falls. A Nursing note dated 8/16/15 at 10:00 A.M. indicated, "Rec'd [received] call...stating res will be kept over noc [overnight] with Dx [diagnosis] of UTI [Urinary Tract Infection] The Service Plan dated 8/16/15 indicated Resident #18 experienced a fall with head injury and lacked any documentation immediate, effective interventions were implemented to prevent further falls. A Nursing note dated 8/19/15 at 8:00 A.M. indicated, "Reported to writer that res ttansferred [sic] to [name of city] for poss [possible] heart cath			

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	[catheterization]." A Hospital Physician Consultation Report dated 8/20/15 indicated, "apparently fell several days ago, I believe on 8-16-15...hit her nose and face and did develop a minimally displaced nasal bone fracture..." A Hospital Physician Progress Note dated 8/30/15 at 1:00 P.M. indicated, "...A. [assessment] ...dementia, Tramatic [sic] brain injury recent (8/20/15)..." A Nursing note dated 9/2/15 at 5:30 P.M. indicated, "...readmitted [sic]..." An untimed Readmission Orders & (and) Plan of Care form dated 9/2/15 indicated Fall #4: A Nursing note dated 9/6/15 at 2:30 P.M. indicated, "...gets up by herself in her room. Staff et [and] family have redirected her each time..." A Nursing note dated 9/6/15 at 3:30 P.M. indicated, "Staff heard alarm et found res sitting on floor in front of her chair, sm [small] skin tear 1/2 " [one half inch] on rt [right] arm...alarm pad in place, call light in reach..." The note lacked any documentation to indicate an immediate intervention was implemented to prevent			

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	further falls. An untimed Physician Fax sheet dated 9/6/15 indicated, "3:30 Staff heard alarm et found res sitting on floor in front of her chair. She stated she was just going over to the dresser et slide [sic] out of my chair. Sm [small] skin tear (1/2 inch) noted on rt [right] arm..." The sheet lacked any documentation to indicated an effective intervention was implemented to ensure the safety of Resident #18. A Nursing note dated 9/10/15 at 10:30 A.M. indicated, "Res up walking in her room alone had O2 [oxygen] tubing wrapped around feet...Res told this nurse "...I'm going to do what I want + [and] when I want so don't bother me." An untimed Physician Fax sheet dated 9/10/15 indicated, "Res [resident] gets very upset with staff for trying to prevent her from doing what she wants to do like up et [and] about alone. May we have up ad lib [at liberty] order? We know she is high risk for falls but she insists..." An untimed Nursing note dated 9/10/15 indicated, "...received new order "up ad lib"..." A Nursing note dated 9/11/15 at 7:00 P.M. indicated, "Res [up] ad lib with			

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	slow steady gait using RW [rolling walker]..." A untimed Nursing note dated 9/16/15 indicated, "...has been found ambulating in hall per self..." Fall #5: A untimed Nursing note dated 9/19/15 indicated "...noted hallway outside of res rooms flooded with moderate amt [amount] of water. Upon investigation noted resident sitting on tolet [sic] seat, on top of RW with tank of commode busted et running everywhere..." The note lacked any documentation to indicate an immediate intervention was implemented to prevent further falls. An untimed Physician Fax sheet dated 9/19/15 indicated, "...Resident had unwitnessed fall incident this pm [evening] @ [at] 1900 [7:00 P.M.]..." The sheet lacked any documentation to indicated an effective intervention was implemented to ensure the safety of Resident #18. Fall #6: A Nursing note dated 9/27/15 at 12:10 P.M. indicated, "Called to res appt [sic] per daughter. Noted res. lying supine in front of doorway. Res appears to have been ambulating in room unassisted. The			

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	note lacked any documentation to indicate an immediate intervention was implemented to prevent further falls. An untimed Physician Fax sheet dated 9/27/15 indicated, "...Res had unwitnessed fall incident @ 1210 [12:10] pm [P.M.] this date. Found in appt [sic] [apartment] lying flat on back..." Fall #7: A Nursing note dated 9/29/15 at 1:45 P.M. indicated, "...found setting [sic] on floor by W/C + AC. Noted laceration on outer palm of rt hand ...skin tear rt for arm [sic]...Daughter came et transported res to E.R. Pt alert et denies hitting head. A Nursing note dated 9/29/15 at 5:00 P.M. indicated, "Returned from [name of hospital] ER. 9 sutures in rt hand..." An untimed Physician Fax sheet dated 9/29/15 indicated, "...Res fell in her room next to W/C [wheel chair] + [and] AC [air conditioner]...Has laceration on left hand [arrow down] [below] little finger palm side 3/4 " [three quarters of an inch] X [by] .5 " [half an inch], skin tear left fore arm [sic] [arrow down] side 2.75 " Daughter took res to ER [emergency room]..." The sheet lacked any documentation to indicate an immediate intervention was implemented to prevent			

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	further falls. An Emergency Room Transfer record dated 9/29/15 indicated, "...R elbow lac [laceration S/T [skin tear]/R hand lac...9 sutures R hand..." An untimed Physician Fax sheet dated 9/29/15 indicated, "...Returned to facility...orders received from ER [emergency room]...9 sutures..." A Nursing note dated 10/1/15 at 7:00 P.M. indicated, "...continues to transfer self unassisted. Daughter aware et requested ad-lib order from MD [physician]. The note lacked any documentation to indicate an immediate intervention was implemented to prevent further falls. Fall #8: A Nursing note dated 10/2/15 at 1530 indicated, "Responded to alarm sounding in appt [sic]. Upon entering noted res lying supine [on back] near doorway. Res unable to give details of incident...small raised hematoma posterior head...Baby monitor for closer monitoring." The note lacked any documentation to indicate an effective intervention was implemented to prevent further falls.			

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	An untimed Physician Fax sheet dated 10/2/15 indicated, "...Res [resident] had another unwitnessed fall incident @ [at] 1530 [3:30 P.M.] this day. Small abrased area R [right] elbow. Raised hematoma (small) post [posterior] head..." A Nursing note dated 10/5/15 at 7:00 P.M. indicated, "...Bed in low position @ all times. Seat/bed alarm et baby monitor as safety intervention..." A Nursing note dated 10/8/15 at 12:00 P.M. indicated, " Bed alarm and baby monitor seems to be effective so far. When awake res is almost 1-1 [one to one supervision] or sets [sic] in lounge close to N.S. [nursing station] Fall #9: A Nursing note dated 10/10/15 at 10:15 A.M. indicated, "Alarm sounding in appt [sic].Upon entering room, noted res. sitting in supine position in bathroom. Res unable to verbalize specifics of incident...:The note lacked any documentation to indicate a new intervention was immediately implemented to prevent further falls and lacked any documentation to indicate which alarm was sounding or if the baby monitor was in use at the time of the fall. During an interview on 10/15/15 at 3:00			

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	P.M., the Care Services Manager indicated no documentation could be provided to indicate when the chair alarm was implemented. An untimed Physician Fax sheet dated 10/10/15 indicated, "...Resident had another unwitnessed fall incident @ 1015 [10:15 A.M.] this day. AROM [Active Range of Motion]/PROM [Passive Range of Motion] WNL [within normal limits] for res [resident]. No new skin alterations noted. Denies pain/ disc[discomfort]..." The sheet lacked any documentation to indicated an effective intervention was implemented to ensure the safety of Resident #18. A Short Term Monitoring Log dated 8/2/15 through 10/10/15, provided by the Care Services Manager on 10/15/15 at 3:00 P.M. indicated Resident #18 experienced falls on 7/2/15, 7/19/15, 9/6/15, 9/21/15, 9/24/15, 10/2/15, and 10/10/15. The log lacked any documentation to indicate Resident #18 experienced falls on 8/16/15, 9/19/15, 9/27/15, 9/29/15, and 10/12/15. The form lacked any documentation to indicate immediate, effective interventions were implemented to ensure the safety of Resident #18. The Policy and Procedure for Falls Risk			

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		A. BUILDING 00 B. WING	10/16/2015

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	Assessment provided by the Care Service Manager on 10/15/15 at 2:45 P.M. indicated, "...III. Appropriate interventions to help decrease the risk for falls will be determined, put in place and noted on the Negotiated Service Plan..."			
R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on interview and record review, the facility failed to ensure the emergency information file contained complete allergy information, for 2 of 5 residents, diagnoses for 2 of 5 residents, and	R 0356	An emergency binder will be complete with all required information and kept updated on all residents to ensure compliance with R 356 Residents # 18,1, and #3 have had their emergency files completed	11/30/2015

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	resuscitation status for 3 of 5 residents who met the criteria for review of emergency file information. (Resident #18, Resident #1, Resident #3) 1. The clinical record of Resident #18 was reviewed on 10/15/15 at 12:10 P.M. The most recent Physicians Order Recap dated 7/30/15 indicated the diagnoses of Resident #18 included, dementia, vitamin D deficiency, hypothyroidism, electrolyte [sic] imbalance, chronic dehydration, pernisious [sic] anemia, chronic, [sic] anxiety, depressive disorder, hypertensive disorder, and urge incontinence of urine. The Physician's Order Recap included, but was not limited to, an order for, "...Do not resuscitate..." and indicated Resident #18 experienced medication allergies to Aspirin and Iodinated contrast media-IV. A Hospital Discharge Summary dated 8/22/15 indicated Resident #18 experienced an, "...allergic reaction to barrium [sic]..." The emergency file lacked any documentation related to the diagnoses, code status, or to indicate Resident #18 experienced allergies to aspirin or barium.		correctly A review of all resident's emergency binders were completed by the Executive Director and all are complete Staff were in serviced on the completion of emergency files, including updates as necessary by the Care Services Manager and Executive Director on 10/23/2015 Current Residents had the potential to be affected by the alleged deficient practice The Care Services Manager is responsible for sustained compliance The Executive Director and /or designee will audit random resident emergency files for compliance by auditing 5 files per week for 1 month, then 5 files every other week for 1 month, and then 5 files for 1 month Audit results will be discussed in monthly QA meetings The QA committee will determine if audit is necessary after 3 consecutive months of compliance.	

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	2. The clinical record of Resident #1 was reviewed on 10/15/15 at 10:45 A.M. A Living Will Declaration of Resident #1 dated 5/21/10 indicated, "...If at any time my attending physician certifies in writing...the use of life-prolonging procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld..." The most recent Physician's Order Recap dated 9/2/15 lacked any order related to the resuscitation status of Resident #1. A State of Indiana Out Of Hospital Do Not Resuscitate Declaration and Order dated 8/20/15 included, but was not limited to an order for, "...I order...not to initiate or continue cardiopulmonary resuscitation procedures..." The emergency file lacked any documentation to indicate the code status of Resident #1. 3. The clinical record of Resident #3 was reviewed on 10/15/15 at 11:30 A.M. The most recent Physician's Order Recap dated 9/30/15 indicated the diagnoses of Resident #3 included, "A fib [sic] [atrial fibrillation], CKD [chronic kidney disease, anemia, painful left knee, and DJD [degenerative joint disease] of L			

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	[left] knee. The Physician's Order Recap included, but was not limited to, an order for, "...Do not resuscitate..." and indicated Resident #3 experienced medication allergies to Clonidine and Bactrim. The emergency file lacked any documentation related to the diagnoses, code status or to indicate Resident #3 experienced allergies to Clonidine. During an interview on 10/15/15 at 10:30 A.M., LPN #5 indicated she was not aware of the existence of an emergency binder. She further indicated, at that time, in the event of an emergency she would use the resident charts. During an interview on 10/15/15 at 2:35 P.M. the Care Services Manager indicated no policy could be provided related to an emergency binder, but it should be usual facility practice to maintain an emergency binder with complete accurate information including, but not limited to, diagnoses, code status, and allergies.			