

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155689	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2015
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NAME OF PROVIDER OR SUPPLIER COURTYARD HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 COLLEGE AVE GOSHEN, IN 46526
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F000000	<p>This visit was for the Investigation of Complaint IN00165879.</p> <p>Complaint IN00165879 - Substantiated. Federal/State deficiencies related to the allegations are cited at F9999.</p> <p>Survey dates: February 23 & 24, 2015</p> <p>Facility number: 000091 Provider number: 155689 AIM number: 100290080</p> <p>Survey team: Diana McDonald, RN-TC</p> <p>Census bed type: SNF: 149 SNF/NF: 11 Total: 160</p> <p>Census payor type: Medicare: 10 Medicaid: 104 Other: 46 Total: 160</p> <p>Sample: 3</p> <p>The deficiency reflects state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F000000	<p>Please accept this Plan of Correction as our facility's credible allegation of compliance for the complaint survey conducted on February 23-24, 2015.</p> <p>Submission of this plan of correction is not an admission by Courtyard Healthcare Center that the deficiency alleged in the survey are accurate or they depict the quality of nursing care and services provided to the residents of our facility. This plan of correction is being submitted solely because doing so is required by state and federal law. Courtyard Healthcare Center respectfully requests a desk review for this survey. If approved, we would be willing to provide any and all documentation requested including, but not limited to: education records, policies and procedures, checklists, and forms that have been completed, revised, or implemented as a part of the plan of correction.</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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F009999	<p>Quality Review completed on March 1, 2015, by Brenda Meredith, RN.</p> <p>3.1-13 ADMINISTRATION AND MANAGEMENT (g) The administrator is responsible for the overall management of the facility but shall not function as a departmental supervisor, for example, director of nursing or food service supervisor, during the same hours. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Immediately informing the division by telephone, followed by written notice within twenty-four (24) hours of unusual occurrences that directly threaten the welfare, safety, or health of the resident or residents, including, but not limited to, any: (D) major accidents. If the department cannot be reached, such as on holidays or weekends, a call shall be made to the emergency telephone number ((317) 383-6144) of the division.</p> <p>This state rule was not met as evidenced</p>	F009999	<p>F9999 Administration and Management 3.1-13 Corrective Action: Resident A remains at the facility and remains free from unusual occurrences. His plan of care was revised on 2-6-15 to prevent further occurrences. How others are identified: All residents have the potential for unusual occurrences and major accidents. Residents reviewed for reportable events. None were identified. Preventative Measures: Facility management staff has been re-educated on the facility policy regarding reportable events outlined in the "Division of Long Term Care Reportable Incident Policy". An addendum was written which delegates the Administrator as the final decision maker to whether or not an unusual occurrence meets reportable guidelines (Attachment A). In addition the facilities incident/accident checklist for completion was updated requiring the administrator's review and signature (attachment B). Monitoring: The Administrator/Designee will</p>	03/20/2015	

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	<p>by:</p> <p>Based on interview and record review, the facility failed to report a significant injury. Resident A slipped from a Hoyer lift during a transfer with two CNA's which resulted in a hip fracture. This effected one of three residents reviewed for Hoyer lift transfers.</p> <p>Finding includes:</p> <p>Resident A's clinical record was reviewed 2/23/2015 at 1:00 p.m. Resident A's diagnoses include, but were not limited to Parkinson's disease, abnormal posture, muscle weakness and chronic pain. Resident A's Brief Interview for Mental Status (BIMS), dated 1/29/2015, indicated a score of 7, severe impairment. The Minimum Data Set (MDS) assessment, dated 1/29/2015, indicated Resident A's transfer ability was an extensive assistance with two plus person physical assist. The MDS indicates Resident A has no limitation for range of motion of the upper body. He had a loss of voluntary movement for range of motion limitation on both sides of the lower body.</p> <p>A form titled,"[Hospital Name], History and Physical Examination, [Report number]," dated 2/7/2015, indicated</p>		<p>review incidents, accidents and unusual occurrences daily to determine reportable criteria and will report timely when indicated. This will remain as a facility practice. Unusual occurrences will be reported to the Quality Assurance Performance Improvement Committee monthly. Date of Completion: March 20, 2015.</p>				

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	<p>"...He sustained an injury to his right hip this evening after a fall from a Hoyer sling. The patient was noted to have a hairline fracture involving the right femoral subcapital neck without displacement..."</p> <p>During an interview, on 2/23/2015 at 4:35 p.m., CNA #1 indicated "we use to use a full body sling on [Resident A's name], since the fall we use the cross leg sling."</p> <p>During an interview, on 2/23/2015 at 4:37 p.m., CNA #2 indicated "when he does not want to get up he goes straight body. [Resident A's name] the day he slipped from the sling he went straight bodied and had on slippery pants, and he started to slide out of the sling feet first."</p> <p>During an interview, on 2/23/2015 at 4:45 p.m., Unit Manager #1 indicated Resident A goes very stiff when we put him in the Hoyer sling.</p> <p>On 2/24/2015 at 2/24/2015 at 4:15 p.m., the Director of Nursing (DON) provided the policy "Division of Long Term Care Reportable Incident Policy," dated 1/15/2013, and indicated the policy was the one currently used by the facility. The policy indicated, "...(6) SIGNIFICANT INJURIES A) Examples,</p>						

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	<p>but not inclusive of all: 5) serious unusual and/or life threatening injury...."</p> <p>During an interview on 2/24/2015 at 5:15 p.m., the DON indicated she received a phone call from the facility that Resident A had slipped from the Hoyer lift during transfer. The MDS assessment was checked which indicated Resident A was and extensive assist and not totally dependent, interim DON decided not to write an incident report to the state.</p> <p>This State tag relates to Complaint IN00165879.</p> <p>3.1-13(g)(1)(D)</p>						