

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155473	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CHALET VILLAGE HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1065 PARKWAY ST BERNE, IN 46711
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	<p>This visit was for the Investigation of Complaint IN00144645.</p> <p>Complaint IN00144645 Substantiated. Federal/ state deficiencies related to the allegations are cited at F 309 and F 514.</p> <p>Survey date: March 17, 2014</p> <p>Facility number: 000546 Provider number: 155473 AIM number: 100267370</p> <p>Survey team: Christine Fodrea, RN</p> <p>Census bed type: SNF/NF: 33 Total: 33</p> <p>Census payor type: Medicare: 3 Medicaid: 22 Other: 8 Total: 33</p>	F000000	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.	

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155473	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CHALET VILLAGE HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1065 PARKWAY ST BERNE, IN 46711
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000309 SS=D	<p>Sample: 4</p> <p>These deficiencies reflect state findings in accordance with 410 IAC 16.2.</p> <p>Quality review completed on March 18, 2014 by Randy Fry RN. 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on interview and record review the facility failed to adequately assess for injuries after a fall for 1 of 3 residents reviewed with falls in a sample of four. (Resident # M)</p> <p>Findings include:</p> <p>Resident #M's record was reviewed 3-17-2014 at 10:02 AM. Resident #M's diagnoses included, but were not limited to, diabetes, GERD, and left above the knee amputation.</p>	F000309	<p>F 309-</p> <ol style="list-style-type: none"> Assessment was completed for resident M with no injuries noted. Physician was notified accordingly. The medical records of those residents who have incurred falls within the last 30 days were reviewed to assure accurate, complete assessments were performed. Licensed nurses were re-educated on the policy for adequate assessment for injuries, post fall. Licensed Nursing staff were re-educated regarding policy and procedures for assessment post fall. The DON and/or her designee will monitor/review all falls on 	03/27/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155473		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/17/2014	
NAME OF PROVIDER OR SUPPLIER CHALET VILLAGE HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1065 PARKWAY ST BERNE, IN 46711			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Nurse's notes dated 3-8-2014 at 4:00 AM indicated Resident #M fell out of bed during bedcheck. The notes indicated there was no injury noted.</p> <p>A incident accident monitoring sheet dated 3-8-14 indicated to monitor the resident through day one if there was no injury. The documentation on the form for 3-8-14 at 1:25 PM and 6:00 PM indicated vital signs were taken, but there was no description of the right or left leg.</p> <p>Nurse's notes documentation dated 3-8-2014 at 1:25 PM indicated there were no signs or symptoms of injury or of discomfort.</p> <p>On 3-9-2014 at 6:00 PM, an incident/ accident monitoring sheet entry indicated there were no signs or symptoms of injury.</p> <p>On 3-10-2014 at 9 AM, an incident/accident monitoring sheet entry indicated there were no signs or symptoms of injury.</p> <p>On 3-13-2014, a physician's order was given to obtain x-rays of the right knee and foot and of the left stump.</p>		<p>scheduled work days, to assure proper assessment post fall, and to assure documentation is complete and accurate. (Attachment A) Should concerns be identified, re-education will be completed immediately.</p> <p>4. As a means of Quality Assurance, the DON will share the results of her aforementioned reviews and any corrective actions taken with the monthly QAA committee. Revisions to the plan will be made, if warranted.</p> <p>5. 3-25-14</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155473	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CHALET VILLAGE HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1065 PARKWAY ST BERNE, IN 46711
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>A Radiology report dated 3-13-2014 indicated arthritic changes in the left knee, and degenerative arthritis in the left foot. The resident was a left above the knee amputee. The report additionally indicated there was a possible fracture in the shaft of the left femur.</p> <p>A review of Nurse's notes did not indicate the facility returned to assess Resident #M's left femur for bruising or deformity.</p> <p>In an interview on 3-17-2014 at 2:47 PM, LPN #1 indicated if the area had been assessed, then there would have been documentation.</p> <p>This federal tag relates to IN00144645.</p> <p>3.1-37(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155473		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/17/2014	
NAME OF PROVIDER OR SUPPLIER CHALET VILLAGE HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1065 PARKWAY ST BERNE, IN 46711			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F000514 SS=D	<p>483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE 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.</p> <p>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.</p> <p>Based on interview and record review, the facility failed to document physician notification of radiology report concerns for 1 of 1 residents reviewed with radiology report concerns (Resident #M); the facility further failed to document neurological checks for 1 of 1 residents reviewed with neurological checks in a sample of 4 (Resident #L)</p> <p>Findings include:</p> <p>1. Resident #M's record was reviewed 3-17-2014 at 10:02 AM. Resident #M's diagnoses included, but were not limited to, diabetes, GERD, and left above the knee amputation.</p>	F000514	F 514- 1. Resident M physician was notified. DON re-educated to assure documentation present regarding physician notification. Resident L Neurological checks were located in the miscellaneous section of the residents' record. 2. The medical records of those residents who have incurred falls within the last 30 days were reviewed to assure proper physician notification is documented as well as complete, accurate medical records are maintained for falls. Licensed Nursing staff re-educated concerning the maintenance of complete, accurate assessment post fall, as well as proper documentation of physician notification. 3. Licensed Nursing staff re-educated concerning the maintenance of complete,	03/27/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155473	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/17/2014
NAME OF PROVIDER OR SUPPLIER CHALET VILLAGE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1065 PARKWAY ST BERNE, IN 46711		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>On 3-13-2014, a physician's order was given to obtain x-rays of the right knee and foot and of the left stump.</p> <p>A Radiology report dated 3-13-2014 indicated arthritic changes in the left knee, and degenerative arthritis in the left foot. The resident is a left above the knee amputee. The report additionally indicated there was a possible fracture in the shaft of the left femur. The radiology report indicated the physician had been faxed a copy of the report on 3-13-2014 at 11:00 PM.</p> <p>A review of Nurse's notes did not indicated the physician had been contacted to clarify whether he had seen the report of if further actions were necessary.</p> <p>In an interview on 3-17-2014 at 12:22 PM, the Director of Nursing indicated she had called the physician on Friday (3-14-2014) and had questioned the results and if there would be any further actions he would like taken. The Director of Nursing further indicated she should have documented the call.</p> <p>In an interview on 3-17-2014 at</p>		<p>accurate assessment post fall, as well as proper documentation of physician notification.</p> <p>The DON and/or her designee will monitor/review all falls on scheduled work days, to assure proper physician notification and documentation of the same, as well as proper maintenance of complete accurate medical records. (Attachment A) Should concerns be noted, re-education will be completed immediately.</p> <p>4. As a means of Quality Assurance the DON will share the results of her aforementioned reviews and any corrective actions taken with the monthly QAA committee. Revisions to the plan will be made, if warranted.</p> <p>5. 3-25-14</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155473		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/17/2014	
NAME OF PROVIDER OR SUPPLIER CHALET VILLAGE HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1065 PARKWAY ST BERNE, IN 46711			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>12:25 PM, LPN #2 indicated he had called the physician on the morning of 3-17-2014, but had not had a response from him regarding the x-ray yet.</p> <p>2. Resident #L's record was reviewed 3-17-2014 at 1:47 PM. Resident #L's diagnoses included, but were not limited to, dementia, diabetes, and heart failure.</p> <p>A nurse's note dated 2-21-2014 at 9:00 PM indicated Resident #L had fallen and hit her head. The note indicated Resident #L was reviewed in emergency room and returned to the facility.</p> <p>A nurse's note dated 2-22 at 2:30 AM indicated neurological checks were continuing.</p> <p>In an interview on 3-17-2014 at 2:10 PM, the Director of Nursing indicated neurological checks had been completed, but the facility was unable to locate the documentation.</p> <p>This Federal tag relates to complaint IN00144645.</p> <p>3.1-50(a)(1)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155473	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/17/2014
---	--	--	--

NAME OF PROVIDER OR SUPPLIER CHALET VILLAGE HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1065 PARKWAY ST BERNE, IN 46711
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE