

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155769	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/09/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MORRISON WOODS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 4100 N MORRISON RD MUNCIE, IN 47304
--	---

(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 IN00141691.</p> <p>Complaint IN00141691-Substantiated. Federal/State deficiencies related to the allegations are cited at F323.</p> <p>Survey dates: January 7, 8, and 9, 2014</p> <p>Facility number: 011596 Provider number: 155769 AIM number: 200901690</p> <p>Survey team: Betty Retherford, RN TC (1/8, 9, 2014) Karen Lewis, RN (1/7, 8, 2014)</p> <p>Census bed type: SNF/NF: 9 SNF: 40 Residential: 35 Total: 84</p> <p>Census payor type: Medicare: 15 Medicaid: 5 Other: 64 Total: 84</p>	F000000	<p>Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Complaint Survey (IN00141691) on January 9, 2014. Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</p>	
---------	---	---------	---	--

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: 155769	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/09/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MORRISON WOODS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 4100 N MORRISON RD MUNCIE, IN 47304
--	---

(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
F000323 SS=D	<p>Sample: 4</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed by Debora Barth, RN.</p> <p>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, interview, and record review, the facility failed to ensure residents identified at risk for falls had interventions in place and/or had care provided in accordance with their plan of care to prevent falls for 2 of 4 residents reviewed for falls. (Resident #B and #C)</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #C was reviewed on 1/8/14 at 10:25 a.m.</p>	F000323	F 323 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #B and #C are confidential as part of the complaint survey. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: Review of all residents identified as at risk for falls to ensure interventions are in place and/or have care provided in accordance with their plan of care to prevent falls. Measures put in place and systemic changes made to ensure the alleged deficient	02/08/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155769		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/09/2014	
NAME OF PROVIDER OR SUPPLIER MORRISON WOODS HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 4100 N MORRISON RD MUNCIE, IN 47304			
(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>Diagnoses for the resident included, but were not limited to, chronic pain; right hip fracture, non-operative; and senile dementia.</p> <p>The clinical record indicated the resident was admitted to the facility on 6/18/13 with a non-operative fracture of the right hip. An "Individual Plan Report", revised 12/13/13, indicated the resident was comfort measures only and receiving hospice services. The report indicated the resident was at risk for falls and required a bed alarm as a safety measure.</p> <p>During an observation on 1/8/13 at 10:10 a.m., Resident #C was lying in bed on his back with the head of his bed slightly elevated. An alarm box was in place on the outer siderail of the resident's bed and was blinking indicating it was on and in working order. A cord (similar to a telephone cord with a clear plastic clip on the end) was connected to the bottom of the alarm box with the plastic clip inserted into the box. The other end of the cord went to a pressure pad located underneath the resident. When the alarm was in place and functioning, the alarm box would sound an alarm when pressure was removed from the pad under the</p>		<p>practice does not recur: DHS or designee will re-educate the Nursing staff on the following campus guidelines: 1). Fall Management Program 2). Gait belt use How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations will be conducted by the DHS or designee 2 times per week times 4 weeks, then monthly times 5 months to ensure compliance: Review of 5 residents per hallway identified as at risk for falls to ensure interventions are in place and/or have care provided in accordance with their plan of care to prevent falls. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155769		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/09/2014	
NAME OF PROVIDER OR SUPPLIER MORRISON WOODS HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 4100 N MORRISON RD MUNCIE, IN 47304			
(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>resident.</p> <p>A recapitulation of physician's orders, signed 12/3/13, included the following order: "Bed alarm on bed at all times to alarm staff of transfers".</p> <p>A nursing note entry made by LPN #4, dated 12/15/13, at 2 a.m., indicated she had been summoned to Resident #C's room by CNA #5. The note indicated the resident had been found on the floor by his bed and had abrasions to both knees and his left elbow. The resident was assessed, vital signs taken, and a lift was used to put the resident back into bed. The note indicated "res [resident] unable to state why he is on floor."</p> <p>A "Fall Circumstance Investigation and Intervention" report, dated 12/16/13, indicated the resident's fall had been reviewed. The report indicated the resident had tried to get up without assistance and was found on the floor. The report indicated the resident's safety equipment had not been in place and functioning at the time of the fall. The report indicated the pressure pad plug was broken and lying on the floor. The report</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155769	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/09/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MORRISON WOODS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 4100 N MORRISON RD MUNCIE, IN 47304
--	---

(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>indicated the resident's alarm had been replaced.</p> <p>LPN #4 was interviewed on 1/8/14 at 11:35 a.m. LPN #4 indicated she had been summoned to the resident's room early in the morning on 12/15/13 by CNA #5 who had found Resident #C on the floor. LPN #4 indicated the resident's bed alarm had not sounded when the resident got out of bed and fell. She indicated the alarm clip was broken and lying on the floor and was not connected to the alarm box. LPN #4 indicated this would prevent the alarm box from sounding when pressure was removed from the pressure pad.</p> <p>2.) The clinical record for Resident #B was reviewed on 1/8/14 at 8:46 a.m.</p> <p>Diagnoses for Resident #B included, but were not limited to, hypertension, orbital cancer, dementia, and Parkinson's Disease.</p> <p>A "Monthly Nursing Assessment & Data Collection" form, dated 11/16/13, indicated the resident was a risk for falls with the need for bed and wheelchair alarms due to a history of falls.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155769	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/09/2014
NAME OF PROVIDER OR SUPPLIER MORRISON WOODS HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 4100 N MORRISON RD MUNCIE, IN 47304		
(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 quarterly Minimum Data Assessment, dated 11/22/13, indicated Resident #B required extensive assistance of two or more staff members for transfers, dressing, personal hygiene and toilet use.</p> <p>A health care plan problem, dated 10/24/13, indicated the Activities of Daily Living (ADLs) for Resident #B required the extensive assistance from two staff. The health care plan for Resident #B indicated the resident had a history of frequent falls and a personal alarm was to be used when the resident was in the chair. The health care plan was updated on 11/13/13, indicating the need to use a gait belt when transferring Resident #B.</p> <p>The clinical record indicated Resident #B had falls on 11/13/13, 12/12/13, and 12/25/13.</p> <p>A Fall Investigation Report created for the 11/13/13 fall indicated the resident had been assisted to the bathroom by CNA #2. The resident became weak and CNA #2 was unable to hold the resident in position on the toilet and the resident slid to the floor. The incident report lacked any</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155769	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/09/2014
NAME OF PROVIDER OR SUPPLIER MORRISON WOODS HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 4100 N MORRISON RD MUNCIE, IN 47304		
(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>documentation of CNA #2 having used a gait belt while assisting the resident. The report indicated the resident was being toileted by one staff instead of two staff as indicated in the resident's health care plan.</p> <p>A Fall Investigation Report created for the 12/12/13 fall indicated the resident was being assisted to the bathroom by LPN #3 when he lost balance and was lowered to the floor by LPN #3. LPN #3 indicated to the Director of Nursing that she did not use a gait belt when she assisted Resident #B to the bathroom. The report indicated the resident was being toileted by one staff instead of two staff as indicated in the resident's health care plan.</p> <p>A Fall Investigation Report for the 12/25/13 fall indicated a visitor informed the Assistant Director of Nursing of Resident #B "sitting on floor" while attempting to transfer himself in the library. The report lacked any documentation of a wheelchair alarm sounding.</p> <p>During an interview with the Assistant Director of Nursing on 1/8/14 at 10:54 a.m., she indicated on 12/25/13 she entered the library and found the resident sitting on the</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155769	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/09/2014
NAME OF PROVIDER OR SUPPLIER MORRISON WOODS HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 4100 N MORRISON RD MUNCIE, IN 47304		
(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>floor between the couch and the wheelchair. She was not sure if the resident was attempting to transfer from the wheelchair to the couch or from the couch to the wheelchair. She further indicated the alarm on the wheelchair was not sounding. A new alarm was placed on the wheelchair after caring for the resident. The ADoN did not indicate why the alarm did not sound.</p> <p>3.) Review of the current undated facility procedure, titled "GUIDELINES FOR GAIT BELT USE," provided by the RN Consultant on 1/8/14 at 1:30 p.m., included, but was not limited to,</p> <p>"Purpose: To ensure safety for the resident and staff during transfers and mobility activities.</p> <p>Procedure:</p> <p>1. Gait belts should be used according to the plan of care for the individual resident. If there is a question of whether or not to use a gait belt it is best to be on the safe side and use the gait belt...."</p> <p>4.) Review of the current facility policy, revised 3/08, titled "Falls Management Program Guidelines", provided by the RN Consultant on</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155769	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/09/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MORRISON WOODS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 4100 N MORRISON RD MUNCIE, IN 47304
--	---

(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>1/8/14 at 9:55 a.m., included, but was not limited to, the following:</p> <p>"Purpose:</p> <p>Trilogy health services (THS) [corporate initials] strives to maintain a hazard free environment, mitigate fall risk factors and implement preventative measures....</p> <p>Procedure:</p> <p>...b. Care plan interventions should be implemented that address the residents' risk factors...."</p> <p>3.1-45(a)(2)</p>			