

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155139	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/20/2015
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NAME OF PROVIDER OR SUPPLIER NORTH WOODS VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2233 W JEFFERSON ST KOKOMO, IN 46901
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: February 16, 17, 18, 19, and 20, 2015</p> <p>Facility number: 000064 Provider number: 155139 AIM number: 100288770</p> <p>Survey Team: Bobette Messman, RN-TC Maria Pantaleo, RN Rita Mullen, RN Tammy Alley, RN (February 17, 18, 19, and 20, 2015)</p> <p>Census bed type: SNF: 13 SNF/NF: 142 Total: 155</p> <p>Census payor type: Medicare: 27 Medicaid: 103 Other: 25 Total: 155</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F000000	<p>March 5, 2015</p> <p>Ms. Kim Rhoades Indiana State Department of Health 2 North Meridian St. Indianapolis, Indiana 46204</p> <p>Dear Ms. Rhoades:</p> <p>Please accept this 2567 Plan of Correction for the Recertification and State Licensure Survey ending February 20, 2015, as our Letter of Credible Allegation and we respectfully request a Desk Review in lieu of a post survey revisit on or after March 20, 2015.</p> <p>Thank you for your time in reviewing our plan of correction and please call with any questions.</p> <p>Sincerely,</p> <p>Cathy S. Greene Executive Director North Woods Village</p> <p>Enclosure</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.

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F000257 SS=D	<p>Quality Review was completed by Tammy Alley RN on February 25, 2015.</p> <p>483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F</p> <p>Based on observation and interview, the facility failed to ensure resident room temperatures were maintained above 71 degrees Fahrenheit (F) and as the resident desired for 2 of 40 rooms (Room 241 and 261) observed for temperature impacting 3 residents. (Resident # 252, #257, and # 82)</p> <p>Finding include:</p> <p>During an initial interview on 2/17/14 at 11:24 a.m., Resident # 252 indicated her room was too cold.</p> <p>On 02/19/2015 at 9:49 a.m., during an observation of room 241 and interview,</p>	F000257	<p>The creation and submission of this Plan of Correction doesnot constitute an admission by this provider of any conclusion set forth in thestatement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan ofCorrection be considered the Letter of Credible Allegation and respectfullyrequests Desk Review in lieu of a Post Survey Review on or after March 20, 2015. F257 Comfortable& Safe Temperature Levels It is the practice of this provider to provide comfortableand safe temperature levels. What corrective action(s) will be accomplished for thoseresidents found to have been affected by the deficient practice.</p>	03/20/2015

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	<p>Resident # 253 indicated her "room is so cold, my nose is froze." She indicated she had been at the facility since Friday and had told people about the cold room. The resident's nose was very cold to touch. The temperature in room was checked and it was 68.5 F. The heating unit was set on high heat and the knob was all the way over to the end of the "warmer" side. The window was plastic sealed.</p> <p>On 02/19/2015 at 9:59 a.m., during an observation in room 241 and interview, Resident # 257 also indicated her room was very cold.</p> <p>Maintenance was summonsed to this room at this time. The Maintenance supervisor arrived at 10 a.m. He checked the heat blowing out of the heater and it registered 78 degrees F. He indicated he had placed a heater in the hall way 3 months ago to help keep the rooms warm. He indicated he had checked the hallway heater that was in close proximity to room 241 this morning and the heating unit had been turned off by the staff. He indicated he might have to put a lock on the hall unit thermostat so they staff could not turn it off.</p> <p>On 2/17/15 at 10:51 a.m., Resident # 82 indicated her room was too cold. She</p>		<p>·In the wall heating unit was installed on 2-17-15 above the entry room doors and the rooms and checked at a temperature of 72 degrees F, and hallway thermostats were checked and on, by the Maintenance Man. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.</p> <p>· Residentson Magnolia and Birch Hall have the potential to be affected by room temperatures.</p> <p>·All other rooms were checked for appropriate temperatures and all were at the comfortable and safe levels for the other residents by maintenance man on 2-17-15. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.</p> <p>·Room temperatures will be checked on a preventive maintenance schedule weekly and during extreme weather changes of temperature below 10 degree F and above 80 degree F daily, by Maintenance Man</p> <p>·Customer Care Representatives and weekend managers will ask residents daily if room temperature is comfortable, if no heating units will be adjusted and /or Maintenance will be notified to obtain comfortable temperatures.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what</p>		

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F000279 SS=D	<p>resided in room 261.</p> <p>During and observation on 02/19/2015 at 10:08 a.m., in room 261 with the Maintenance Supervisor, he indicated the heat coming out of heating unit was 83, but the temperature in the room was 68.9 degrees F. The hallway heater was set at 72 and he turned it up to 76.</p> <p>On 2/19/15 at 2 p.m., room 241 and 261 were rechecked. A heating unit had been installed above the entry room doors and the rooms checked at a temperature of 72 degrees F.</p> <p>3.1-19(h)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under</p>		<p>quality assurance program will be put into place.</p> <ul style="list-style-type: none"> Room temperatures will be checked weekly X 4weeks, monthly X 6 and quarterly thereafter per preventive maintenance and CQI tool "Facility Environmental Review". The CQI committee will review the data. If the threshold for compliance of 100% is not met appropriate action will be taken and an action plan will be developed. <p>Compliance date; 3-20-15</p>		

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	<p>§483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to develop a Plan of Care for inappropriate sexual behaviors for 1 of 5 residents reviewed for unnecessary medications (Resident #19).</p> <p>Findings include:</p> <p>The clinical record of Resident #19 was reviewed on 2/20/15 at 9:00 a.m.</p> <p>Diagnoses included, but were not limited to, dementia with delusional features, chronic respiratory failure, depression and anxiety.</p> <p>A Physician's order, dated 2/18/14, indicated Depo-Provera (a female hormone use to suppress male sexual urges) 150 mg (milligrams) injection on the 27th of the month at bedtime.</p> <p>A review of the current Plans of Care, on 2/20/15 at 1:30 p.m., did not include a Plan of Care for inappropriate sexual behaviors.</p> <p>During an interview with Unit Manager #1, on 2/20/15 at 11:00 a.m., she indicated he gets anxious with daily care, he will start to shake and become resistive. "He had sexual behaviors when</p>	F000279	<p>F279 Comprehensive Care Plans</p> <p>It is the practice of this provider to develop, review and revise the resident's comprehensive plan of care.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice</p> <ul style="list-style-type: none"> Resident#19 had a Care Plan developed for the Depo-Prevera and the Psychiatrist reviewed the resident for the use of Depo-Prevera at which time the Psychiatrist discontinued the use of the medication and a care plan and behavior tracking is in place. In November 2014 a GDR was requested at which time the Physician declined to decrease or discontinue. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</p> <ul style="list-style-type: none"> Residents who need a revision to their care plan have the potential to be affected by the alleged deficient practice. No other residents at this time are on Depo-Prevera, if one is admitted or receives an order for this medication a care plan will be developed at that time and a behavior monitoring will be developed. 	03/20/2015			

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	<p>he first got here and about the time for another Depo-Provera injection he starts making sexual remarks to the staff."</p> <p>3.1-35(a)</p>		<p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</p> <ul style="list-style-type: none"> No other residents at this time are on Depo-Provera, if one is admitted or receives an order for this medication a care plan will be developed at that time and a behavior monitoring will be developed The Interdisciplinary Team reviews behaviors in clinical morning meeting, Monday-Friday excluding holidays and updates resident care plans and resident need sheets to include current interventions. On weekend and holidays Director of Nursing Services (DNS)/Designee will be contacted if resident exhibits behavior when interventions are not effective, then the DNS will provide guidance for appropriate interventions. The IDT was re-educated 3-3-15 by Staff Development Coordinator/Designee on the behavior program and updating the care plan as needed. (SDC) Residents comprehensive care plans will be developed upon admission and reviewed at least quarterly by the IDT and updated as needed. The care plan will be completed as indicated based on the issues identified with the completion of the comprehensive MDS/RAP process. 		

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F000314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, record review and interview the facility failed to provide treatment to a pressure ulcer to prevent possibility of infection for 1 of 3</p>	F000314	<ul style="list-style-type: none"> The MDS Coordinator is responsible to ensure resident's plan of care is an accurate reflection of residents needs and was re-inserviced on 3-3-15 by SDC/ designee. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place A "CarePlan" CQI tool will be utilized weekly x 4, and monthly X 6 and quarterly thereafter, to monitor compliance with care plan process. The CQI committee will review the data. If the threshold for compliance of 95% is not met, an action plan will be developed. <p>Compliance date: 3-20-15</p> <p>F314 Pressure Sores It is the practice of this provider to ensure that a resident who enters the facility without pressure sores does not develop pressure sores</p>	03/20/2015

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	<p>residents reviewed for pressure ulcers. (Resident # 2)</p> <p>Findings include:</p> <p>The clinical record of Resident #2 was reviewed on 2/19/2015 at 10:30 a.m. Diagnoses included, but were not limited to, Congestive Heart Failure, Hypertension, anxiety, depression, osteoporosis, osteoarthritis, restless leg syndrome, and mild intellectual disabilities.</p> <p>A Physician order dated 2/11/2015 indicated cleanse 5th metatarsal with normal saline, apply wounddress to wound bed, cover with dressing and wrap daily once a day 6:00 a.m. to 2:00 p.m.</p> <p>During an observation on 2/20/2015 at 11:53 a.m., Resident # 2 was sitting on the toilet seat with her feet and legs bare, no wound dressing was on the residents left foot. CNA #1 and CNA #2 were attempting to lift the resident to a standing position utilizing a standing lift. CNA #1 placed a stocking over the resident's left foot without a wound dressing.</p> <p>During an interview with CNA #1 and CNA #2, on 2/20/2015 at 11:55 a.m., CNA #1 indicated she did not know if the</p>		<p>unless the individual's clinical condition demonstrates thatthey were unavoidable; and a resident having pressure sores receives necessarytreatment and services to promote healing, prevent infection and prevent newsores from developing.</p> <p>What corrective action(s) will be accomplished for thoseresidents found to have been affected by the deficient practice</p> <ul style="list-style-type: none"> Resident#2 had wound assessed and dressing applied immediately per wound nurse on2-20-15 NotifiedPhysician and family the treatment not completed per order. C.N.A. #1and #2 was educated on 2-20-15 and 3-3-15 by Director of Nursing Services(DNS)/Designee about the importance of notifying nurse about dressing that arenot on. <p>How will you identify other residents having the potentialto be affected by the same deficient practice and what corrective action willbe taken</p> <ul style="list-style-type: none"> Residentswith wounds residing at facility are at risk for this alleged deficientpractice. <p>All residents with wounds were assessed forappropriate dressing application on 2-20-15 by the Wound Nurse.</p> <p>What measures will be put into place or what systemicchanges you will make to ensure that the deficient practice does not recur</p>		

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	<p>resident needed a wound dressing , and CNA #2, went to get the unit manager to inquire about the wound dressing.</p> <p>The Wound Care Nurse on 2/20/2015 at 12:05 p.m., applied the appropriate wound dressing to the resident's left foot and the resident was lifted into the wheel chair from the toilet seat.</p> <p>Wound tracking documents for Resident #2 indicated the following measurements:</p> <p>Event Report: dated 2/16/2015 at 9:38 a.m., indicated wound measurement 0.5 cm (centimeters) x 0.7 cm x 0.1 cm.</p> <p>During an interview on 2/20/2015 at 12:00 p.m., the Wound Care Nurse indicated the resident should have had a dressing in place on her left foot at all times.</p> <p>During an interview on 2/20/2015 at 2:25 p.m., the Wound Care Nurse indicated the residents dressing became soiled during morning care and was removed, the resident was then dressed for activities with only socks and no wound dressing was applied.</p> <p>3.1-40(a)(2)</p>		<ul style="list-style-type: none"> Wound rounds completed weekly by wound nurse and DNS/Designee. Weekly wound rounds completed by department managers. Nurses reinsert service immediately and on 3-3-15 by SDC/Designee to appropriate dressing changes. C.N.A's were instructed to notify nurse of any soiled dressings immediately on 2-20-15 and 3-3-15 by SDC/Designee All residents assessed for risk of skin breakdown and preventions put in place, upon admission and by weekly wound rounds by Wound nurse. <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</p> <ul style="list-style-type: none"> A "Skin Management Program" CQI tool will be utilized weekly x 4, and monthly X 6 and quarterly thereafter, to monitor compliance with care plan process. The CQI committee will review the data. If the threshold for compliance of 100% is not met, an action plan will be developed. <p>Compliance date: 3-20-15</p>				

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F000323 SS=G	<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 record review, observation and interview, the facility failed to implement care planned transfer mode for 1 of 1 resident (Resident #196) resulting in a hospital transfer with a femur fracture, failed to revise current fall prevention interventions for 1 of 1 resident (Resident # 222) with a subsequent fall and hospital transfer with a hip fracture, and failed to perform a mechanical lift transfer in a safe manner to prevent the possibility of injury for 1 of 3 residents (Resident # 255) reviewed for accidents.</p> <p>Findings Include:</p> <p>1. The record review for Resident #196 was completed on 2/18/15 at 1:30 p.m.</p>	F000323	<p>F323 Free of Accident Hazards/Supervision/Devices It is the practice of this provider to ensure that the resident environment remains as free of accident hazards as is possible. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?</p> <ul style="list-style-type: none"> Resident #196, MDS, Care Plan and resident profile sheet had appropriate transfer information at time of accident and C.N.A. had been trained appropriately upon hire and orientation for the use of hoist and profile sheets, C.N.A was clocked out and terminated for not following proper procedure . Resident #222 did not return 	03/20/2015

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	<p>Current diagnoses included, but were not limited to, Cerebral Palsy, osteomyelitis, chronic right ankle and foot, and mild intellectual disabilities.</p> <p>Physician orders dated 10/23/14 indicated an order "Positioning/Devices: Transfer with Hoyer lift with assistance of 2 staff members."</p> <p>A plan of care dated 10/23/14 indicated the resident had a self care deficit, with approaches that included, but were not limited to, Hoyer lift and assist of two staff for transfers.</p> <p>A "Resident Profile" for Resident # 196 indicated the resident was a Hoyer transfer with 2 assist.</p> <p>Nursing progress notes indicated the following: 10/23/14: requires 2 person or Hoyer for transfer 10/25/14: total assist with transfers per Hoyer lift 11/2/14: Hoyer lift to transfer to wheelchair 11/11/14: Hoyer lift 11/19/14: extensive assist with transfers with Hoyer lift 12/1/14: Hoyer lift for all transfers 2/10 /15: total assist with transfers per Hoyer</p>		<p>to this facility following hospital stay, the resident had been identified as alert and oriented and was non-compliant per nursing notes through out stay.</p> <p>Resident #255 was assessed and had no injury and states that the Hoyer lift did not hit her.</p> <ul style="list-style-type: none"> Certified Nursing Assistant (C.N.A) was immediately clocked out and terminated. Other C.N.A's were re-instructed on transfers and the use of the resident profile sheet on 2-11-15 by DNS/designee and on 3-3-15 in service by SDC/designee. How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken All Resident's MDS, Care Plan and resident profile sheets were audited to ensure appropriate transfer information was correct. Nursing staff will be re-educated on following MDS, Care Plan and profile sheets for resident transfers by the SDC or designee by 3-3-2015. Other C.N.A's were re-instructed on transfers and the use of the resident profile sheet on 2-11-15 by DNS/designee and on 3-3-15 in service by SDC/designee. <p>A Hoyer skills validation was completed for all C.N.A.'s by 3-20-15 by SDC/Designee. What measures will be put into</p>				

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	<p>2/11/15: Resident was sent out to the hospital due to a fall in the resident's room. Right lower extremity was bent at a 90 degree angle and she was in pain.</p> <p>An "Observation" form dated 2/11/15 indicated the resident was sent to the emergency room due to a fall with a Right lower extremity deformity. The form indicated the resident's usual mental status was "alert, disoriented, but cannot follow simple instructions," was non-ambulatory.</p> <p>A "Name of Hospital" emergency room report indicated the resident was dropped at the extended care facility while transferring from a wheelchair. Resident was having pain in right knee and lower thigh.</p> <p>A "Name of Hospital" X-ray report indicated the resident had a "...comminuted fracture of the distal femur...."</p> <p>On 02/20/2015 at 9:40 a.m., during interview, the DON indicated she was called at home the night of 2/11/15 regarding Resident # 196's accident with injury. She indicated a newly hired CNA who had completed her orientation was assigned to this resident. She indicated</p>		<p>place or what systemic changes you will make to ensure that the alleged deficient practice does not recur</p> <ul style="list-style-type: none"> · All Resident's MDS, Care Plan and resident profilesheets were audited to ensure appropriate · DNS/Designee will conduct round on each shift to ensure nursing staff is providing transfers per plan of care and resident profile sheet. • Certified Nursing Assistant (C.N.A) was immediately clocked out and terminated, other C.N.A were re-instructed on transfers and the use of the resident profile on 2-11-15 by DNS/designee and on 3-3-15 in service by SDC/designee. • Upon admission and during the Care Plan review process, Care Plans, MDS and Resident profile sheets will be reviewed to ensure appropriateness for each resident. How the corrective action(s) will be monitored to ensure the deficient practice will not recur? i.e., what quality assurance program will be put into place • The CQI tool "Fall Management" will be completed weekly X 4, monthly X 6, and then quarterly until compliance is maintained for two consecutive quarters. • The CQI Team will review the data. If the threshold of 100% for compliance is not met then an action plan will be developed. Compliance date: 3-20-15 	

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	<p>earlier in the shift the CNA had gotten the Resident up with the Hoyer. The DON provided a written statement dated 2/11/15 and signed by CNA # 20 that indicated the CNA was trying to get the resident to bed and the other 2 CNA's on the unit were busy and she could not find the Hoyer lift. The CNA indicated she lifted the resident to try to put her to bed and the resident fell to the floor. The DON indicated the CNA was instructed to clock out and go home and was subsequently terminated. An "Employee Communication Form" dated 2/13/15 indicated the CNA was terminated for transferring Resident # 196 manually by herself when the resident was a Hoyer transfer and the CNA dropped the resident resulting in a fracture of the right lower extremity.</p> <p>On 02/20/2015 at 11:00 a.m., during interview, CNA # 21 indicated her first day of training was with the Staff Development Coordinator (SDC). She indicated the SDC went through all the policies including transfers. She indicated the SDC showed her the lifts and how they were used. She also indicated she was trained on the computer system so she could retrieve the resident profiles that told how to take care of each resident. She indicated when she was oriented with the floor</p>			

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	<p>staff, she was shown more intensively how to use the lifts, gait belts and care for the residents. She indicated she had a good orientation. She also indicated CNA # 20 was in her orientation.</p> <p>During an interview with CNA # 23, she indicated the computer had resident profiles that indicated how each resident transferred. She also indicated there was a Activities of Daily Living book at the nursing station that could also be reviewed for care.</p> <p>2. The record for Resident #222 was reviewed on 02/19/2015 at 10:56 a.m. Current diagnoses included, but were not limited to, fracture of pubis, Parkinson's disease, and Myasthenia Gravis.</p> <p>The Hospital "History and Physical" form dated 9/18/14 indicated the resident had a right superior and inferior pubic rami fracture.</p> <p>9/29/14 plan of care: Resident required frequent toileting program due to frequently incontinent of bladder and needed assist with transfers, toileting, was cooperative with care, and was on a toileting program that consisted of toilet upon rising, before and after meals, at bed time and check and change through the night as needed.</p>			

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	<p>9/22/14 plan of care: At risk for fall due to fall with fracture, impaired balances, uses walker and wheelchair. Approaches included, but were not limited to, 9/22/14 bed alarm, 9/22/14 assist with transfers, 10/14/14 chair alarm check function, 10/14/14 moved closer to the nursing station, call light in reach, non-skid footwear and therapy.</p> <p>Progress notes indicated: 9/24/14: extensive assist with transfers and able to make needs known.</p> <p>10/4/14: limited assist with transfers, makes needs known.</p> <p>10/9/14: found on the floor in front of the television area in her room. She was bleeding from the top of her head, she indicated she wanted to put her clothes away the family had brought. She could not recall what she hit her head on. She was sent to the emergency room and received 19 sutures.</p> <p>10/10/14 bed and chair alarms applied, resident compliant IDT (Interdisciplinary Team) educated to call for assistance when needed. She had turned off her bed pad alarm at times.</p>			

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	<p>10/13/14 late entry for 10:04 a.m., heard alarm going off, resident had transferred self from the wheelchair to the chair, alarm was sounding and call light was not on. She was reminded by CNA to use call light for assistance and not to transfer self without help present.</p> <p>10/14/14 son approved room move to 120 closer to nurses station and this was completed.</p> <p>10/14/14 at 2:03 p.m., responded to the alarm and found the resident transferring self to the toilet. She had not turned her call light on. She was educated to use her call light to ask for help and not to transfer herself. The resident stated she "doesn't need help." "Res [Resident] does not seem open to education."</p> <p>10/14/14 at 10:24 p.m., the resident turned off bed alarm two times and was educated on safety of alarms, stated she understood but did not like it.</p> <p>10/17/14 at 7:20 a.m., alarm was sounding and found resident on the toilet, educated on using the call light for help for safety.</p> <p>10/17/14 at 10:09 a.m., the alarm was sounding, found the resident on the floor on her buttocks and her back up against</p>			

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	<p>the wall. The call light was not on. The resident complained of right hip pain and the right hip was rotated outward and noted to be shorter. 911 was called and the resident went to the hospital.</p> <p>10/17/14 admitted to the hospital with a fracture of the right hip.</p> <p>On 02/20/2015 at 9:30 a.m., during an interview with the Director Nursing, she indicated the resident was being treated for a urinary tract infection when she was admitted until 9/29/14. She also indicated the resident was on a toileting plan as indicated in her plan or care. She indicated the resident was again treated for a urinary tract infection from 10/10-17/2015. The resident was in Physical and Occupational Therapy. She also indicated bed alarm and chair alarms were applied and the resident was educated on use of call light and safe transfers. The DON also indicated the resident's bed had transfer rails to assist the resident to transfer and there were grab bar was on toilets and that would help if a resident was noncompliant to call for help. The DON indicated she was aware the resident had removed her alarms, had indicated she did not like them, had been resistive to education and had continued to transfer herself. She indicated no other intervention had been</p>			

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	<p>attempted to assist with monitoring the resident was unsafe transfers or that she was moving about in her room.</p> <p>A Policy titled "Fall Risk Interventions (not all inclusive-use as a reference tool)" was provided by the DON on 2/20/15 at 10 a.m., and deemed as current. The policy indicated: "...Equipment interventions....", that included, but were not limited to, wedge cushions, drop seats, hipsters, motion sensor, self-release belt, and pommel cushion.</p> <p>3. The record for Resident # 255 was reviewed on 02/20/2015 at 9:04:05 a.m. Diagnoses included, but were not limited to, diabetes, obesity, debility, ambulation of the toes on the right foot.</p> <p>A Physician order dated 2/18/15 indicated the resident was a Hoyer transfer with assist of 2 staff members.</p> <p>A Plan of care dated 2/17/14 indicated the resident was a Hoyer transfer with two person assist.</p> <p>On 02/19/2015 at 1:28 p.m., a Hoyer transfer of Resident # 255 was observed. As CNA # 22 attempted to position the mechanical lift to transfer the resident from the wheelchair to the bed, the CNA was watching the base of the lift and</p>			

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F000329 SS=D	<p>bumped the resident in the head with the upper lift mechanism. At that time the CNA indicated she was sorry and had been watching the positioning of the base of the lift.</p> <p>3.1-45(a)(2)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review, the facility failed to monitor and track sexually inappropriate behaviors for 1 of</p>	F000329	F329 Unnecessary Drugs It is the practice of this provider to ensure that theresident's drug regimen is free from unnecessary	03/20/2015

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	<p>5 residents reviewed for unnecessary medications (Resident #19).</p> <p>Findings include:</p> <p>The clinical record of Resident #19 was reviewed on 2/20/15 at 9:00 a.m. Diagnoses included, but were not limited to, dementia with delusional features, chronic respiratory failure, depression and anxiety.</p> <p>A Physician's order, dated 2/18/14, indicated Depo-Provera (a female hormone use to suppress male sexual urges) 150 mg (milligrams) injection on the 27th of the month at bedtime. There was no diagnosis related to the use of Depo-Provera.</p> <p>A review of the current Plans of Care, on 2/20/15 at 1:30 p.m., did not include a Plan of Care for inappropriate sexual behaviors.</p> <p>A review of the behavior monitoring records for the months of November 2014, December 2014, January 2015 and February 1- 20, 2015, did not indicate Resident #19 was being monitored for inappropriate sexual behaviors. Nor was sexual inappropriateness noted in the Nursing notes during the same time period.</p>		<p>drugs in excessive dose,excessive duration, without adequate indications for use and in the presence ofadverse consequences, which indicate the dose, should be reduced.</p> <p>What corrective action(s) will be accomplished for thoseresidents found to have been affected by the deficient practice</p> <ul style="list-style-type: none"> Resident #19's Medication order for Depo-Provera was evaluated by Psychiatrist and medicationorders discontinued. The resident alsohad a Care Plan and behavior managementprogram put in place for monitoring inappropriate sexual behavior immediately. Nonegative outcome to the alleged deficient practice. How will you identify other residents having the potentialto be affected by the same deficient practice and what corrective action willbe taken No otherresidents found to use or be affected by the use of Depo-Provera. Will have care plan developed and resident placed on behavior monitoringprogram if a resident is admitted with this medication or if a new order isreceived. <p>*If a resident is prescribed Depo-Provera a GDR will berequested of the physician if warrented By DNS/SS.</p> <ul style="list-style-type: none"> GradualDose Reduction will be recommended if medication is ordered will be completedby 				

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	<p>During an interview with Unit Manager #1, on 2/20/15 at 11:00 a.m., she indicated Resident #19 came from another facility and had the order for the Depo-Provera. He had sexual behaviors when he first got here, he would make remarks to the staff while he was getting a shower.</p> <p>During an interview with (name of psychiatrist) on 2/20/15 at 10:55 a.m., he indicated he had taken over Resident #19's case and would be stopping the Depo-Provera.</p> <p>3.1-48(a)(3) 3.1-48(a)(4)</p>		<p>DNS/Designee/Social Service .</p> <ul style="list-style-type: none"> Pharmacyreviews monthly all psychotropic medication to determine if GDR is warrantedand DNS/Designee/SSD will follow up with recommendation. InserviceInterdisciplinary Team and nurses oncorrect documentation for care plans and behavior monitoring plan on 3-3-15 bySDC/designee. <p>What measures will be put into place or what systemicchanges you will make to ensure that the deficient practice does not recur</p> <ul style="list-style-type: none"> InserviceInterdisciplinary Team and nurses oncorrect documentation for care plans and behavior monitoring plan on 3-3-15 bySDC/designee. <p>*Social Service Designee SSD will be monitored by SSDirector/Interdisciplinary team (IDT) for appropriate intervention, care plansand behavior monitoring for inappropriate sexual behavior</p> <ul style="list-style-type: none"> All neworders for medications and behaviors reviewed in morning meeting by InterdisciplinaryTeam (IDT) 5 days a week and weekend manager on weekends, to ensure properdocumentation for care plans and behavior monitoring plan. <p>How the corrective action(s) will be monitored to ensure thedeficient practice will not recur, i.e., what quality assurance program will beput into place</p> <ul style="list-style-type: none"> A"Behavior Management" 		

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F000371 SS=E	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the facility failed to ensure the dry storage area was maintained in a clean sanitary manner. This deficient practice had the potential to affect 154 of 155 residents receiving food from 1 of 1 kitchen.</p> <p>Findings include:</p> <p>During the initial tour of the kitchen with the Dietary Manager, on 2/16/15 at 8:00 a.m., the following were observed,</p> <p>The floors in the dry storage area were littered with dry tracked in leaves, and there was build up of dirt behind the wire</p>	F000371	<p>and "Unnecessary Medications" CQI tool will be utilized weekly x 4, and monthly X 6 and quarterly thereafter, to monitor compliance with care plan process.</p> <ul style="list-style-type: none"> The CQI committee will review the data. If the threshold for 95% compliance is not met, an action plan will be developed. <p>Compliance date: 3-20-15</p> <p>F371 Food Procure,Store, Prepare/Serve-Sanitary It is the practice of this facility to Procure food from sources approved or considered satisfactory by Federal, State or local authorities and store, prepare, distribute and serve food under sanitary conditions. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice</p> <ul style="list-style-type: none"> No residents were affected by this practice. The floor was cleaned and the boxes removed immediately from store room by dietary staff. <p>How will you identify other residents</p>	03/20/2015	

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	<p>storage racks. There were four cardboard boxes unopened on the floor in the dry storage area.</p> <p>During an interview with the Dietary Manager and the Executive Director on 2/20/15 at 10:30 a.m., the Dietary Manager indicated the dry storage area did not meet the standard for cleaning</p> <p>Review of the policy titled Infection Control dated 2/02 with a revision date of 01/14 stated "all local, state and federal standards and regulations are followed in order to assure a safe and sanitary dietary department....3. Food Storage...b. The food that is stored in the stockroom is placed on clean racks at least 6" above the floor. The room is clean, dry and cool."</p> <p>3.1-21(i)(2)</p>		<p>having the potential to be affected by the same deficient practice and what corrective action will be taken</p> <ul style="list-style-type: none"> Residents who reside in the facility have the potential to be affected by the alleged deficient practice. The dry storage unit was cleaned appropriately immediately by dietary staff. Dietary Staff has been re-educated on proper cleaning of kitchen floors immediately and on 3-3-15 by SDC/Dietary Manager/Designee.. Failure to follow interventions by dietary staff will result in disciplinary action up to and including termination. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</p> <ul style="list-style-type: none"> Dietary Staff has been re-educated on proper cleaning of kitchen floors immediately and on 3-3-15 by SDC/Dietary Manager/Designee.. The Dietary Manager/Kitchen Manager will monitor to ensure the kitchen floor is kept clean and boxes off the floor, daily. Failure to follow interventions by dietary staff will result in disciplinary action up to and including termination. Floor care employee will deep clean floors twice a month. 		

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NAME OF PROVIDER OR SUPPLIER NORTH WOODS VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2233 W JEFFERSON ST KOKOMO, IN 46901
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(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
F000372 SS=E	<p>483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. Based on observation and interview, the facility failed to cover the trash containers in the kitchen while not in use. This deficient practice had the potential to affect 154 of 155 residents receiving food from 1 of 1 kitchen.</p> <p>Findings include:</p> <p>During the initial kitchen tour on 2/16/15 at 8:00 a.m., the following was observed:</p> <p>1. All the trash cans in the kitchen were</p>	F000372	<p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</p> <ul style="list-style-type: none"> A "Kitchen Sanitation/Environment Review" CQI tool will be utilized weekly x 4, monthly x 6 and then quarterly thereafter for at least 6 months to monitor compliance with covering and dating stored food. The CQI committee will review the data. If compliance of threshold of 90% is not met, an action plan will be developed. Compliance date: 3-20-15 <p>F372 Sanitary Conditions It is the practice of this provider to dispose of garbage and refuse properly. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? ·No residents were affected by the deficient practice, however the kitchen trash can lids shall be kept on trash cans when not in use. ·Trash can lids were obtained and placed on trash cans by</p>	03/20/2015

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	<p>observed without lids, the trash cans were not being used at the time of the observation.</p> <p>2. A followup observation on 2/16/15 at 2:00 p.m., the trash cans again did not have lids and were not being used.</p> <p>During an interview with the Dietary Manager and Executive Director on 2/20/15 at 10:15 a.m., the Dietary Manager indicated he were aware the trash cans were required to have lids when not in use.</p> <p>3.1-21(i)(5)</p>		<p>dietary staff.</p> <p>How will you identify other residents having the potentialto be affected by the same deficient practice and what corrective action willbe taken?</p> <ul style="list-style-type: none"> ·All residents have the potential to be affected by the deficient practice. · The trashcan lids shall remain on when not in use. · Trash canlids were obtained and placed on trash cans by dietary staff. <p>What measures will be put into place or what systemicchanges you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> ·All dietary staff was in serviced 2-16-15 and3-4-15 keeping the trash can lids onwhen not in use by dietary manager/SDC. ·Dietary Manager/Cook will monitor kitchen trashcans to ensure lids are appropriately applied during each meal. <p>How will the corrective action be monitored to ensure thedeficient practice will not recur, i.e., what quality assurance program will beput into place?</p> <ul style="list-style-type: none"> • A“Kitchen Sanitation/Environment Review” CQI tool will be utilized weekly x 4,monthly x6 and then quarterly thereafter for at least 6 months to monitorcompliance with covering and dating stored food. • The CQI committee will review thedata. If compliance of threshold of 90%is not met, an 	

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