

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155684	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/19/2014
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NAME OF PROVIDER OR SUPPLIER  SOUTHFIELD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 6450 MIAMI CIR SOUTH BEND, IN 46614
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey date: December 15, 16, 17, 18 &amp; 19, 2014</p> <p>Facility number: 002662 Provider number: 155684 AIM number: 200315930</p> <p>Survey team: Shauna Carlson, RN Julie Baumgartner, RN Pamela Williams, RN Amy Miller, RN</p> <p>Census bed type: SNF: 16 SNF/NF: 38 Residential: 49 Total: 103</p> <p>Census payor type: Medicare: 10 Medicaid: 25 Other: 19 Total: 54</p> <p>Residential Sample: 7</p>	F000000	This plan of correction constitutes the written allegation of compliance for the deficiencies cited. The submission of this Plan of Correction is not an admission that a deficiency exists or that a deficiency was cited correctly. This Plan of Correction is being submitted to meet the requirements established by state and federal law	

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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F000241 SS=D	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed on December 23, 2014, by Brenda Meredith, R.N.</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview and record review, the facility failed to provide a dignity cover for a Foley catheter bag for 1 of 1 residents observed. (Resident #6)</p> <p>Finding includes:</p> <p>On 12-15-2014 at 3:48 p.m., Resident #6 was observed laying in bed. The Foley catheter bag was suspended from the bed frame without a dignity cover to conceal the contents.</p> <p>On 12-16-14 at 9:49 a.m., Resident #6</p>	F000241	<p>Resident #6's Foley catheter bag has been placed in a cover. Only one other resident currently has a Foley catheter and the drainage bag is covered. All nursing staff have been in-serviced regarding the policy for covering urinary drainage bags at all times. Licensed nurses will be responsible to monitor this each shift.</p> <p>The Resident Life Enrichment Committee, a subcommittee of the quality assurance program, will randomly monitor once per week, for four weeks. This will continue until 100% compliance is achieved in four consecutive weeks.</p>	01/18/2015

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F000323	<p>was observed laying in bed. The Foley catheter bag was suspended from the bed frame without a dignity cover to conceal the contents.</p> <p>On 12-17-14 at 10:00 a.m., the clinical record for Resident #6 was reviewed. The diagnoses included, but was not limited to: multiple sclerosis, neurogenic bladder and depression.</p> <p>On 12-19-14 at 9:40 a.m., an interview with the Director of Nursing (DON) was conducted. She indicated Resident #6 does have a Foley catheter, "...yes, a bag should cover the catheter no matter if they're in the chair or the bed...it should always be on...."</p> <p>On 12-19-14 at 9:45 a.m., review of the Catheter care and Management policy, received from the DON at this time, indicated "...Drainage Bag Management...Cover the bag with a bag cover...."</p> <p>3.1-3(t)</p> <p>483.25(h)</p>				

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SS=E	<p><b>FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</b></p> <p>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.</p> <p>Based on observation and interview, the facility failed to ensure that chemicals and razors were stored properly and out of reach of the residents for 2 of 3 spa areas. (100 hall and 200 hall)</p> <p>Finding includes:</p> <p>On 12-15-2014 at 10:35 A.M., an observation was made of the 200 hall spa room (a shower room) with the door standing open. A 6 drawer dresser inside the spa room had one drawer with a bottle of antiseptic mouthwash, 2 bottles of baby powder, a tube of antifungal cream, a bottle of Purell (alcohol based hand sanitizer), 3 bottles of shampoo and body wash and a bottle of periwash.</p> <p>On 12-15-2014 at 10:48 A.M., an observation was made of the 100 hall spa room with the door standing open. A 3 drawer dresser inside the spa room had a drawer with a bottle of antiseptic mouthwash, a bottle of baby powder, 2 cans of (name) shaving cream, a bottle of deodorant, a tube of toothpaste and a bag of 8 razors.</p>	F000323	The toiletries have been removed from all spas. An environmental audit has been conducted to assure that no other items, that could be harmful to residents are present. All staff have been in-serviced regarding maintaining a safe environment. The Environment Enrichment Committee, a subcommittee of the quality assurance program, will conduct weekly inspections until 100% compliance is achieved for four consecutive weeks. Once this threshold is obtained, the Environment Enrichment Committee will continue to monitor once per month	01/18/2015

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	<p>On 12-16-2014 at 9:35 A.M., 12-17-2014 at 10:13 A.M. and 12-18-2014 at 11:05 A.M., the spa rooms for the 100 hall and 200 hall dresser drawers were observed to be the same as above.</p> <p>On 12-19-2014 at 2:00 P.M., an observation of the spa rooms with the DON (Director of Nursing) was made and the dresser drawers were observed to be the same. An interview was conducted with the DON at this time. The DON indicated, "...no, that should not be in there...the CNA's (Certified Nursing Assistance) clean up the room after showers and if they don't know who the products belong too, they must place them in the drawers...they should throw them out...we have locked cabinets on the wall for personal care products...."</p> <p>On 12-19-2014 at 2:40 P.M., the Executive Director indicated, "...we do not have a policy for storage of personal care items in common areas...."</p> <p>3.1-45(a)(1)</p>				

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F009999	<p>3.1-14 PERSONNEL</p> <p>(a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Specific inquires shall be made for prospective employees. The facility shall have a personnel policy that considers references and an convictions in accordance with IC 16-28-13-3.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure pre employment screening references was complete for 3 of 10 employee records reviewed. (Employee # 3, #4, and # 5).</p> <p>Finding includes: On 12/19/14 at 2:20 P.M., review of the employment records for Employee #3 with hire date of 11/14/14, Employee #4 with hire date of 9/15/14, and Employee # 5 with hire date of 11/14/14, indicated the "Pre Employment Reference Checks" was missing from the files. During an interview on 12/18/14 at 2:40 P.M., the Human Resource Director</p>	F009999	The references for the three employees cited have been requested. An audit of all other employee files has been conducted and references are available or have been requested if missing. Staff have been in-serviced on the facility's policy regarding references and offers of employment. The Staff Enrichment Committee, a subcommittee of the quality assurance program, will monitor all new hire's personnel files for 90 days or until 100% compliance is achieve, which ever is later. Once the 100% threshold is obtained, audits will be conducted quarterly	01/18/2015	

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R000000	<p>indicated, "... no references done yet ... yes they are working on the floor...."</p> <p>During an interview on 12/18/14 at 2:52 P.M., the DON (Director of Nursing) indicated, "... all three have worked the floor...."</p> <p>During an interview on 12/19/14 at 9:20 A.M., the ED (Executive Director) indicated "...we do not have a new hire policy...."</p> <p>3.1-14(a)</p>	R000000	This plan of correction constitutes the written allegation of compliance for the deficiencies cited. The submission of this Plan of Correction is not an admission that a deficiency exists or that a deficiency was cited correctly. This Plan of Correction is being submitted to meet the requirements established by state and federal law		
R000214	<p>410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to</p>				

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	<p>admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident.</p> <p>Based on interview and record review, the facility failed to complete a semi annual evaluation for 2 of 7 residents reviewed. (Resident #2 and Resident #3)</p> <p>Finding includes:</p> <p>On 12-16-14 at 1:20 P.M., review of Resident #2's record was conducted. Resident #2 was admitted on 3-20-14. The documentation did not indicate a semi annual evaluation was completed within the last 6 months.</p> <p>On 12-16-14 at 1:50 P.M., review of Resident #3's record was conducted. Resident #3 was admitted on 3-20-14. The documentation did not indicate a semi annual evaluation was completed within the last 6 months.</p> <p>On 12-16-14 at 2:50 P.M., the Executive Director was interviewed. He indicated the semi annual evaluations had not been completed.</p>	R000214	Residents #2 and #3's semi-annual evaluations have been completed. All other residents' semi-annual evaluations have been audited and are complete. Staff have been in-serviced regarding the facility's policy and completing semi-annual evaluations. The Resident Wellness Committee, a subcommittee of the quality assurance program, will assure all semi-annual evaluations are completed timely for the next 90 days. At the end of the 90 day period, if a 100% threshold is obtained, the monitoring will end	01/18/2015

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R000216	<p>410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility.</p> <p>Based on interview and record review, the facility failed to complete a weight on admission and/or semi-annually for 4 of 7 residents reviewed. (Resident #3, Resident #5, Resident #6 and Resident #4)</p> <p>Finding includes:</p> <p>On 12-16-14 at 1:50 P.M., review of Resident #3's record was conducted. Resident #3 was admitted on 3-20-14. No documentation to indicate a weight on admission and semi-annually was completed.</p>	R000216	Resident's #3, #4, #5 and #6's weights have been taken. An audit has been conducted for all other residents and their weights are present and accurate. Staff have been in-serviced on the facility's policy for obtaining weights on admission and at a minimum of semi-annually. The Resident Wellness Committee, a subcommittee of the quality assurance program, will assure all weights are completed timely for the next 90 days. If at the end of 90 days, a 100% threshold is obtained, the monitoring will end	01/18/2015

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R000217	<p>On 12-16-14 at 2:20 P.M., review of Resident #5's record was completed. Resident #5 was admitted on 10-5-14. No documentation to indicate a weight on admission was completed.</p> <p>On 12-16-14 at 2:50 P.M., review of Resident #6's record was completed. Resident #6 was admitted on 9-4-14. No documentation to indicate a weight on admission was completed.</p> <p>On 12-16-14 at 3:00 P.M., review of Resident #4's record was conducted. Resident #4 was admitted on 12-1-14. A weight was not completed until 12-16-14.</p> <p>On 12-16-14 at 2:50 P.M., an interview with the Executive Director was conducted. He indicated the weights had not been done.</p> <p>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</p>				

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	<p>follows:</p> <p>(1) The services offered to the individual resident shall be appropriate to the:</p> <p>(A) scope;</p> <p>(B) frequency;</p> <p>(C) need; and</p> <p>(D) preference;</p> <p>of the resident.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>Based on interview and record review, the facility failed to develop a service plan for 2 of 7 residents reviewed. (Resident #3 and Resident #4)</p> <p>Finding includes:</p> <p>On 12-16-14 at 1:50 P.M., review of Resident #3's record was conducted. Resident #3 was admitted on 3-20-14. No documentation to indicate a service plan had been completed.</p>	R000217	Residents #3 and #4's Service Plans have been completed. An audit has been conducted and all other residents' have appropriated Service Plans in place. Staff have been in-serviced regarding the facility's policy for Service Plans. The Resident Wellness Committee, a subcommittee of the quality assurance program, will assure all Service Plans are completed for the next 90 days. If at the end of 90 days, a 100% threshold is obtained, the monitoring will end.	01/18/2015	

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R000356	<p>On 12-16-14 at 3:00 P.M., review of Resident #4's record was conducted. Resident #4 was admitted on 12-1-14. No documentation to indicate a service plan had been completed.</p> <p>On 12-16-14 at 2:50 P.M., the Executive Director was interviewed. He indicated there was no service plans for these residents.</p> <p>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 include hospital preference, photo, living will information</p>	R000356	Residents #2, #3, #4, #5 and #6's emergency files have been updated to include all required	01/18/2015

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	<p>and/or physician in the current emergency file for immediate access for 5 of 7 residents reviewed.</p> <p>Finding includes:</p> <p>On 12-16-14 at 1:20 P.M., review of Resident #2's record was completed. Resident #2 was admitted on 3-20-14. No documentation to indicate a hospital preference and the residents photo.</p> <p>On 12-16-14 at 1:50 P.M., review of Resident #3's record was completed. Resident #3 was admitted on 3-20-14. No documentation to indicate a hospital preference and the residents photo.</p> <p>On 12-16-14 at 2:20 P.M., review of Resident #5's record was completed. Resident #5 was admitted on 10-5-14. No documentation to indicate a hospital preference and the residents photo.</p> <p>On 12-16-14 at 2:50 P.M., review of Resident #6's record was completed. Resident #6 was admitted on 9-4-14. No documentation to indicate the residents photo.</p> <p>On 12-16-14 at 3:00 P.M., review of Resident #4's record was completed. Resident #4 was admitted on 12-1-14. No documentation to indicate living will</p>		<p>information. An audit of all other residents' emergency files have been conducted and all pertinent information is included. The staff have been in-serviced regarding the facility's policy about the content of the emergency file. The Environmental Enrichment Committee, a subcommittee of the quality assurance program, will monitor the emergency file with each new admission for the next 90 days. If at the end of 90 days, a 100% threshold is obtained, the monitoring will end</p>		

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R000410	<p>information, hospital preference, physician of record and the residents photo.</p> <p>On 12-16-14 at 3:30 P.M., an interview with the Executive Director was conducted. He indicated he was unaware of missing emergency file information and explained the residents photos could be printed off at the computer in an emergency case.</p> <p>410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents 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 within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155684		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/19/2014	
NAME OF PROVIDER OR SUPPLIER  SOUTHFIELD VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 6450 MIAMI CIR SOUTH BEND, IN 46614			
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	<p>laboratory examinations in order to complete a diagnosis.</p> <p>Based on interview and record review, the facility failed to complete a tuberculin Mantoux (TB) testing within 3 months prior to admission or on admission for 5 of 7 residents reviewed. (Resident #2, Resident #3, Resident #5, Resident #6, and Resident #4)</p> <p>Finding includes:</p> <p>On 12-16-14 at 1:20 P.M., review of Resident #2's record was completed. Resident #2 was admitted on 3-20-14. The first TB testing was initiated on 6-5-14.</p> <p>On 12-16-14 at 1:50 P.M., review of Resident #3's record was completed. Resident #3 was admitted on 3-20-14. The first TB testing was initiated on 7-16-14.</p> <p>On 12-16-14 at 2:20 P.M., review of Resident #5's record was completed. Resident #5 was admitted on 10-5-14. The first TB testing was initiated on 11-19-14.</p> <p>On 12-16-14 at 2:50 P.M., review of Resident #6's record was completed. Resident #6 was admitted on 9-4-14. The</p>	R000410	Residents #2, #3, #4, #5 and #6's tuberculin (TB) skin tests are now current utilizing the two step method. An audit has been conducted of all other residents and all now have appropriate chest x-rays and TB skin tests on file. Staff have been in-serviced regarding the facility's policy on testing and monitoring for TB. The Resident Wellness Committee, a subcommittee of the quality assurance program, will monitor all new admissions for the next 90 days to assure the facility's policy regarding TB testing is being followed. If at the end of 90 days, a 100% threshold is achieved, the monitoring will end.	01/18/2015			

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	<p>first TB testing was initiated on 11-19-14.</p> <p>On 12-16-14 at 3:00 P.M., review of Resident #4's record was completed. Resident #4 was admitted on 12-1-14. No documentation to indicate TB testing had been initiated.</p> <p>On 12-16-14 at 1:00 P.M., an interview with the Director of Nursing (DON) was conducted. The DON indicated if the documentation was not on the electronic chart, it had not been done.</p>				