

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 04/30/2013
--	---	--	---

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 IN00127945.</p> <p>This visit was in conjunction with the Recertification and State Licensure survey.</p> <p>Complaint IN00127945, Substantiated. Federal/state deficiency related to the allegations is cited at F323.</p> <p>Survey dates: April 23, 24, 25, 26, and 29, 2013</p> <p>Facility number: 011596 Provider number: 155769 AIM number: 200901690</p> <p>Survey team: Karen Lewis, RN, TC Ginger McNamee, RN Toni Maley, BSW Linn Mackey, RN</p> <p>Census bed type: SNF/NF: 52 Residential: 33 Total: 85</p> <p>Census payor type: Medicare: 28 Medicaid: 7</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 Annual Recertification and State Licensure Survey in conjunction with Complaint (IN00127945) Survey on April 29, 2013. Please accept this plan of correction as the provider's credible allegation of compliance.</p> <p>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 04/30/2013
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>Other: 50 Total: 85</p> <p>This deficiency also reflects state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed by Debora Barth, RN.</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 04/30/2013
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>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 and interview, the facility failed to ensure wheel chair brakes were locked during resident care for 2 of 6 residents reviewed for resident care which potentially caused the residents to fall. (Resident #B and #C)</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #B was reviewed on 4/29/13 at 12:21 p.m.</p> <p>Diagnoses for the resident included, but were not limited to, gastrointestinal bleeding, weakness, and hypertension.</p> <p>A nurses note, dated 3/15/13 at 4:55 p.m., indicated the resident arrived to the facility with her husband and daughter in a car. The entry further indicated the resident was alert and oriented.</p> <p>The next entry, dated 3/15/13 at 5:15 p.m., indicated the resident was being</p>	F000323	<p>F 323</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #B and #C are confidential as part of complaint survey.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: For all residents requiring assist with transfer, the DHS or designee will observe transfers of residents to ensure wheel chair brakes are locked for safety.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Nursing Team on the following campus guidelines: Transporting a resident safely in a wheelchair</p> <p>How the corrective measures will be monitored to ensure the</p>	05/30/2013	

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 04/30/2013
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>weighed, stood up, and fell.</p> <p>A "FALL CIRCUMSTANCE, ASSESSMENT AND INTERVENTION," dated 3/15/13, indicated the wheels on the resident's wheelchair were not locked at the time of the fall.</p> <p>2.) During an interview with Resident #C on 4/23/13 at 3:58 p.m., she indicated CNA #2 had assisted her to the bathroom and during the assist CNA #2 told Resident #C it was not necessary to lock the wheelchair brakes during the transfer from the wheelchair to the toilet. The resident told the CNA therapy wanted the wheelchair locked during transfers. CNA #2 replied to the resident if she [the CNA] let someone fall she could just go get another job. The resident indicated CNA #2 was very casual and nonchalant towards her.</p> <p>During an interview with CNA #2 on 4/29/13 at 2:10 p.m., the CNA indicated she had told the resident it was not necessary to lock the wheelchair because she was holding the back of the wheelchair while the resident stood up. She indicated Resident #C did lock the brakes on the wheelchair before standing. She indicated she should not have told the</p>		<p>alleged deficient practice does not recur: The following observations for 5 residents will be conducted by the DHS or designee 2 times per week times 4 weeks, then monthly times 5 months to ensure compliance: observe transfers of residents to ensure wheel chair brakes are locked for safety.</p> <p>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 04/30/2013	
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 to not lock the wheelchair brakes.</p> <p>3.) The undated "Transporting a Resident Safely in a Wheelchair" policy was provided by the RN Consultant on 4/29/13 at 9:46 a.m. The policy indicated the wheelchair brakes should be securely locked for transfers to and from the chair.</p> <p>This Federal tag relates to Complaint IN00127945.</p> <p>3.1-45(a)(2)</p>						