

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155154	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/18/2014
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NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260
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F000000	<p>This visit was for the Investigation of Complaint #IN00156322.</p> <p>Complaint #IN00156322- Substantiated. Federal/State deficiencies related to the allegation are cited at F323.</p> <p>Survey date: September 18, 2014</p> <p>Facility number: 000074 Provider number: 155154 AIM number: 100290050</p> <p>Survey team: Michelle Carter, RN</p> <p>Census bed type: SNF- 17 SNF/NF- 94 Total- 111</p> <p>Census payor type: Medicare- 22 Medicaid- 67 Other- 24 Total- 111</p> <p>Sample- 6</p>	F000000	<p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p> <p>This provider respectfully requests a Desk Review in Lieu of a Revisit and that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Survey Review on or after October 9, 2014.</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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F000323 SS=D	<p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review was completed by Tammy Alley RN on September 25, 2014.</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 record review and interview, the facility failed to follow a care plan for transfers and ensure safe transfers with the use of the correct transfer equipment for 1 of 5 residents reviewed for transfers in a sample of 6. (Resident B)</p> <p>Findings include:</p> <p>The medical record for Resident B was reviewed on 9/18/2014. Diagnoses for Resident B included, but were not limited to, history of cerebrovascular accident, right sided hemiplegia, anemia, high blood pressure, type 2 diabetes mellitus, history of venous thrombosis (blood clot) to the left lower extremity, debility, and cognition decline.</p>	F000323	<p>F323 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. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident B no longer resides in this facility. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Pull statement from last POC and put in the as the</p>	10/09/2014

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	<p>Nursing event notes, dated 7/11/14 at 3:03 p.m., indicated Resident B was assisted to the floor, during a transfer with a mechanical lift, because Resident B started to slip. No injury was noted after assessment was completed. The family and physician were notified. The notes indicated "immediate intervention was staff education on two person transfers for mechanical lifts."</p> <p>An IDT (Interdisciplinary Team) note, dated 7/14/14 at 10:03 p.m., indicated on 7/11/14, staff was assisting Resident B with care and attempted to transfer Resident B with a mechanical stand up lift. Resident B began to slide and the staff member lowered Resident B to the floor. IDT recommended to provide continued education with staff related to proper use of mechanical lifts, per guidelines.</p> <p>A care plan for self care deficit, included an intervention, "Hoyer lift for all transfers," dated 1/22/14.</p> <p>A fall risk care plan intervention, dated 1/23/14, indicated "Transfer using Hoyer lift."</p> <p>A CAA (Care Area Assessment) worksheet for the 6/8/2014 MDS</p>		<p>firstsentence.</p> <ul style="list-style-type: none"> ·All residents have the potential to be affected bythe alleged deficient practice. ·Nursing staff will be in-serviced on ensuring planof care is followed for each resident by October 9, 2014. ·Nursing staff will be in-serviced on ensuring safetransfers with the use of correct transfer equipment by October 9, 2014. ·Allresidents using mechanical lift transfers will have their care plans reviewedby DNS/Designee to ensure they accurately reflects the type of mechanicaltransfers are to be used. <p>What measures will be put into place or what systemicchanges will you make to ensure that the deficient practice does not recur.</p> <ul style="list-style-type: none"> ·Nursing staff will be in-serviced by SDC/Designee onensuring plan of care is followed for each resident by October 9, 2014 ·Nursing staff will be in-serviced by SDC/Designee onensuring safe transfers with the use of correct transfer equipment by October9, 2014. ·DNS/Designee will make rounds to ensure that plansof care are being followed and proper mechanical lifts are used duringtransfers. <p>How will the corrective action(s) be monitored toensure the deficient practice will not recur, i.e., what quality assuranceprogram will be put</p>	

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	<p>(Minimum Data Set) Assessment report indicated Resident B required the extensive assistance of 2 or more people for transfers and ADL's (activities of daily living). An assessment for "seated to standing position" was marked as "activity did not occur." Assistance was required for care 100% of the time. Due to hemiplegia, poor balance and weakness, Resident B was unable to stand.</p> <p>During an interview on 9/18/2014 at 1:50 p.m., the Director of Nursing (DON) indicated Resident B was improperly transferred on 7/11/14. The CNA that assisted Resident B used a mechanical stand lift, without additional staff assistance. Two staff members and a Hoyer lift should've been used. The CNA did not use the Hoyer lift and this transfer resulted in a witnessed fall.</p> <p>This Federal tag relates to Complaint #IN00156322.</p> <p>3.1-45(a)(2)</p>		<p>into place</p> <ul style="list-style-type: none"> ·A MechanicalLift CQI tool will be utilized weekly x 4, monthly x 6, and quarterlythereafter. ·A CarePlan Update CQI tool will be utilized weekly x 4, monthly x 6, and quarterlythereafter. ·Ifthreshold of 95% is not achieved, an action plan will be developed to achieve desiredthreshold. ·Datawill be submitted to the CQI Committee for review and follow up. <p>Compliance date: October 9, 2014</p>				