

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155714	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2013
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NAME OF PROVIDER OR SUPPLIER OAK VILLAGE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 200 W FOURTH ST OAKTOWN, IN 47561
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F000000	<p>This visit was for the Investigation of Complaint IN00127593, Complaint IN00127803, and Complaint IN00127828.</p> <p>Complaint IN00127593 - Substantiated, Federal/State deficiencies related to the allegations are cited at F241 and F323.</p> <p>Complaint IN00127803 - Substantiated, Federal/State deficiencies related to the allegations are cited at F241 and F323.</p> <p>Complaint IN00127828 - Substantiated, Federal/State deficiencies related to the allegations are cited at F241 and F323.</p> <p>Survey dates: April 22 and 23, 2013</p> <p>Facility number: 000517 Provider number: 155714 AIM number: 100266770</p> <p>Survey team: Anne Marie Crays RN</p>	F000000	<p>F0000</p> <p>By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective May 1 st , 2013, to the state findings of the complaint survey conducted on 4-23-2013.</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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	<p>Census bed type: SNF/NF: 28 Total: 28</p> <p>Census payor type: Medicare: 3 Medicaid: 17 Other: 8 Total: 28</p> <p>Sample: 4</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on April 24, 2013, by Jodi Meyer, RN</p>			

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F000241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>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 ensure a resident requesting to transfer from a wheelchair to her reclining chair was able to be transferred in a timely manner, for 1 of 4 residents reviewed for dignity, in a sample of 4. Resident A</p> <p>Findings include:</p> <p>On 4/22/13 at 2:55 P.M., the clinical record of Resident A was reviewed. Diagnoses included, but were not limited to, spinal stenosis, neuropathy, and anxiety.</p> <p>A Minimum Data Set [MDS] assessment, dated 3/22/13, indicated the resident scored a 13 out of 15 for cognitive status, with 15 indicating no memory impairment. The MDS assessment indicated the resident required total dependence of two + staff for transfer, and did not ambulate.</p> <p>On 4/23/13 at 10:05 A.M., Resident A</p>	F000241	<p>F241</p> <p>The corrective action taken for those residents found to have been affected by the deficient practice is that Resident A will be transferred to place of her choice, per her request within ten to fifteen minutes of the request.</p> <p>The corrective action taken for other residents having the potential to be affected by the same deficient practice is that all non-ambulatory residents that can make their wants and needs known have the potential to be affected. An audit has been completed to identify those residents. The corrective action for those residents is that all non-ambulatory residents with the ability to make their needs and wants known will have</p>	05/01/2013			

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	<p>was observed sitting in a wheelchair in her room.</p> <p>On 4/23/13 at 11:15 A.M., Resident A was in her electric wheelchair at the nursing station. She indicated to CNA # 2, "Can you put me in my chair?" CNA # 2 looked at the Director of Nursing [DON], who was also standing at the nursing station, and stated, "She wants to go to her chair now. It's 11:15." The DON indicated to the resident, "It's almost lunchtime." The resident responded, "I don't care, I want to go to my chair." The DON indicated, "Well, let's go to your room. We need to look at your leg."</p> <p>On 4/23/13 at 11:25 A.M., as the DON was finishing up a dressing change, Resident A indicated, "I would like to get in my chair." The DON talked to the resident, attempting to get her to agree to go to the dining room. Resident A never really agreed.</p> <p>On 4/23/13, the following was overheard:</p> <p>11:45 A.M.: Resident A indicated, "I want to get in my chair." A housekeeping staff # 1 indicated, "Oh, it's lunchtime. The girls will have to do it, I can't." The housekeeping staff then informed the CNA staff across the hall. An unknown staff member indicated, "She'll just have</p>		<p>transfer requests completed within ten to fifteen minutes of the request.</p> <p>The measures or systemic changes that have been put into place is that a mandatory Nursing in-service was conducted specific to the correct way to relate to residents and to meet their transfer requests in a timely & dignified manner.</p> <p>The action taken to monitor the corrective action is that a PI tool has been developed. All residents will be interviewed weekly by Social Service or her designee to ensure that their transfer requests are being met in a dignified and timely manner. This tool will be completed weekly times three weeks, monthly times three months and quarterly times three quarters. This tool will be reviewed in QA meetings to see if further action is warranted.</p> <p>Completion date: May 1 st , 2013</p>				

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	<p>to wait."</p> <p>11:50 A.M.: The DON indicated to Resident A, "What do you want?" Resident A indicated, "I want to get in my chair. My back hurts." The DON responded, "You'll have to wait. They are getting people up. I can't do it by myself."</p> <p>11:55 A.M.: An unknown staff member answered a call light. Resident A indicated, "I want to get in my big chair. My back hurts." The staff member indicated it was lunch time. Resident A indicated, "I don't care about lunch." The staff member indicated, "I can't move you by myself. She's busy. Hang on."</p> <p>12:00 P.M.: CNA # 1 informed the resident, "They want you to go to the dining room and eat." Resident A indicated, "My back is killing me." CNA # 1 indicated, "They can't get to you because they are busy feeding people. That's how it goes. [Administrator] wants you to go to the dining room. There's a lot of people to care for here. There's not enough people to move you ." Resident A indicated she did not want to eat in the dining room, and that she had food in her room that she could eat.</p> <p>At approximately 12:03 P.M.: CNA # 3 informed Resident A she could be moved</p>			

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	<p>"as soon as we get an available aide. We need to use 2."</p> <p>12:05 P.M.: Resident A informed an unknown staff member, "I've had my d--n light on 4 times. I want to go to my chair." The staff member indicated, "Okay, I'll be back, I promise."</p> <p>12:10 P.M.: The DON informed the resident, "You'll have to wait until after lunch. At 11:25 you told me you would go to the dining room. At 11:45 I told you would have to wait. The staff was already serving trays." Resident A indicated, "That's why I asked before lunch. After lunch, everyone will be busy and won't be able to help me then." The DON continued to argue with the resident. The DON indicated, "There has to be 2." The DON offered a pain pill to the resident, but the resident indicated she had already had a pain pill. The DON offered a pillow to the resident, and then took her to the dining room.</p> <p>12:15 P.M.: Resident A was observed sitting in her wheelchair in the dining room.</p> <p>1:30 P.M.: Resident A was observed sitting in her recliner in her room. CNA # 3 was with her.</p>						

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	<p>On 4/23/13 at 2:15 P.M., during interview with the Administrator, she indicated she was unaware of the resident requesting to transfer to her own chair for approximately 1 hour. The Administrator indicated she was told the resident asked to be transferred at 11:45 A.M., and she did inform the staff to encourage the resident to go to the dining room. The Administrator indicated staff should have just transferred the resident when she requested it.</p> <p>This federal tag relates to Complaint IN00127593, Complaint IN00127803, and Complaint IN00127828.</p> <p>3.1-3(t)</p>				

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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.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident was safely propelled in a wheelchair, causing the resident to fall forward and suffer multiple skin tears and bruising on her right leg, and pain in her foot, resulting in an emergency room visit, for 1 of 3 residents dependent on locomotion, in a sample of 4. Resident A</p> <p>Findings include:</p> <p>1. On 4/22/13 at 11:20 A.M., Resident A was observed sitting in a wheelchair by the nursing station. Her right leg was observed to be wrapped</p> <p>The clinical record of Resident A was reviewed on 4/22/13 at 2:55 P.M. Diagnoses included, but were not limited to, peripheral vascular disease.</p> <p>A Minimum Data Set [MDS] assessment, dated 3/22/13, indicated the resident scored a 13 out of 15 for cognitive status, with 15 indicating no memory</p>	F000323	<p>The corrective action taken for those residents found to have been affected by the deficient practice is that Resident A was evaluated by Therapy and a self-release belt was placed on the wheelchair. Belt to be used only when resident going out to smoke. Resident A is able to release. Two nursing staff members will accompany Resident A to smoking area safely. Resident A will be pulled backward in wheelchair in and out of the doors to give staff more control of the chair when going in or out to smoke. Maintenance personnel has filled in the dipped area where the wheelchair caught and tipped.</p>	05/01/2013	

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	<p>impairment. The MDS assessment indicated Resident A required total dependence of two+ staff for transfer, and did not ambulate.</p> <p>An Occupational Therapy progress report, dated 4/9/13, indicated, "Sitting Balance...Current Level of Function, Patient is...unable to maintain balance without mod/max [moderate/maximum] support...for 3 minutes due to balance dysfunction...."</p> <p>Nurse's Notes included the following notations:</p> <p>4/14/13 at 9:45 A.M.: "Aide was bringing resident back into facility from smoking. Resident was in a regular w/c [wheelchair]. Resident went to the right side aide had a hold of her coat she slide [sic] our of w/c on right side. Hit Rt [right] leg on leg rest as she went to the ground causing 2 skin tears on Rt leg under Rt knee one 3 cm [centimeter] and one 8 cm long by 4.5 cm wide...No c/o [complaints of] pain moves all extremities well...Paged [physician]...Intervention bring resident in and out of building in w/c backwards and to take resident out on front porch to smoke...."</p> <p>4/14/13 at 6:50 P.M.: "Res [resident] c/o [complains of] [left] foot et [and] ankle</p>		<p>The action taken for other residents who have the potential to be affected by the deficient practice is that no other residents were identified.</p> <p>The measures and systemic changes made to ensure that the deficient practice does not recur is that all nursing staff has been in-serviced specifically to the use of the self- release seat belt when taking Resident A out to smoke. Further to pull resident backward in and out of door to give staff more control of the chair. Two staff members must accompany Resident A to the smoking area and then back into the facility when finished. One must be nursing personnel. Maintenance has been in-serviced to observe the dipped area for any needed repairs.</p> <p>The corrective actions will be monitored to ensure the</p>				

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	<p>pain. MD pages et awaiting return call...."</p> <p>4/14/13 at 7:20 P.M.: "[Physician] notified of c/o pain. N.O. [new order] rec'd [received] send to [hospital] ER to [evaluate and treat]...."</p> <p>The resident was transferred to the Emergency Room on 4/14/13 at 7:55 P.M., and returned the same date at 10:55 P.M. A hospital instruction sheet indicated the resident obtained a "hematoma, contusion, bruise."</p> <p>A Nursing Care Plan, dated 4/14/13, indicated: "4/14/13, Problem, Resident fell out of w/c when CNA tried to bring in from smoking...Interventions, Pull Resident backward in w/c in and out of doors. Have maintenance man fix area w/c got caught on. 2 people to assist to get to smoking area safely to and from smoking...."</p> <p>On 4/23/13 at 10:15 A.M., during interview with the acting Director of Nursing [DON], she indicated on 4/14/13, Resident A was coming back in the facility from smoking, there was a dip in the threshold, and the wheelchair tipped forward. The DON indicated CNA # 1 grabbed the resident's coat to keep her from falling hard forward, but that Resident A still hit her leg on the leg rest.</p>		<p>deficient practice will not recur by the implementation of PI tools. These tools will be completed by Nursing Staff daily times one week, weekly times three weeks, monthly times three months and quarterly times three quarters. Maintenance will complete the PI tool for the hazardous sidewalk one time weekly for four weeks, monthly times four months and then quarterly times four. The outcome will be reviewed in QA meetings to see if further action is warranted.</p> <p>Completion date May 1, 2013</p>	

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	<p>The DON indicated that maintenance "fixed it."</p> <p>At that time, the DON demonstrated where Resident A fell from her wheelchair. The DON pointed out where the facility parking lot met the sidewalk, there was a dip in the concrete. She indicated after the resident fell, the area was filled in with asphalt. A rubber mat was observed over this area.</p> <p>On 4/23/13 at 10:20 A.M., during interview with CNA # 1, she indicated on 4/14/13, she was assisting Resident A back in from the outside smoking area. CNA # 1 indicated someone else took Resident A out, and that she did not usually bring "the smokers back in." CNA # 1 indicated there was a dip in the concrete, and the front wheel of the wheelchair got caught in the dip, tipping the resident out. CNA # 1 indicated, "I guess I should have backed her over."</p> <p>On 4/23/13 at 11:25 A.M., a skin assessment was requested. Both lower legs were bruised and discolored. A hematoma and 3 large skin tears with multiple steri strips intact were observed on the resident's right lower leg. Resident A indicated the right leg didn't hurt "as bad as it looks," but that her left foot hurt worse.</p>						

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