

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155461	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/19/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PRAIRIE VILLAGE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 801 S SR 57 WASHINGTON, IN 47501
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
F0000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00102552.</p> <p>Complaint IN00102552-Substantiated, No deficiencies related to the allegations are cited.</p> <p>Survey dates: January 17, 18, and 19, 2012</p> <p>Facility Number: 000302 Provider Number: 155461 AIM Number: 100286510</p> <p>Survey Team: Marla Potts, RN TC Melinda Lewis, RN Sharon Whiteman, RN</p> <p>Census Bed Type: SNF/NF: 63 Total: 63</p> <p>Census Payor Type: Medicare: 8 Medicaid: 53 Other: 2 Total: 63</p>	F0000		

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: 155461	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/19/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PRAIRIE VILLAGE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 801 S SR 57 WASHINGTON, IN 47501
---	--

(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>Sample:15 Supplemental Sample: 3</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2.</p> <p>Quality review completed on January 24, 2012 by Bev Faulkner, RN</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155461		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/19/2012	
NAME OF PROVIDER OR SUPPLIER PRAIRIE VILLAGE NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 801 S SR 57 WASHINGTON, IN 47501			
(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			
F0314 SS=G	<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, interview and record review, the facility failed to ensure a resident at risk of pressure ulcers, was assessed and provided measures to prevent pressure ulcers, with the resident developing a Stage 3 pressure ulcer above her right ear from the oxygen tubing, for 1 of 4 residents reviewed who were at risk of pressure ulcers in the sample of 15. Resident #27</p> <p>Findings include:</p> <p>On 1/17/12 at 8:50 A.M., during the initial tour with RN # 1, she indicated Resident # 27 had a fall with a hip fracture and had been receiving palliative care. She indicated Resident # 27 was doing much better now and was no longer palliative care. She stated Resident # 27 was participating in therapy services. She</p>	F0314	<p>1) A complete skin assessment was completed immediately for res #27. All areas of skin impairment were documented per policy. The responsible party (POA) and physician were notified. Treatment orders were received and implemented. Plan of Care was reviewed and updated as appropriate. 2) A 100% skin assessment was completed on all current in-house residents who are receiving oxygen per nasal cannula. No areas of skin impairment were identified. 3) Re-education will be completed with all Nursing Staff and all Therapy Staff on the "Wound Prevention and Management" policy and procedure. This education will include, but is not limited to "Prevention Strategies", "Proper Assessment" and "Timely Reporting". 4) Skin audits on all residents will be completed weekly x 4 weeks and then a 10% random sample monthly by the Director of Nursing</p>	02/18/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155461		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/19/2012	
NAME OF PROVIDER OR SUPPLIER PRAIRIE VILLAGE NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 801 S SR 57 WASHINGTON, IN 47501			
(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>further indicated Resident # 27 required oxygen per nasal cannula. Resident # 27 was observed to be in a low bed with a mat to the side of the bed. Resident # 27 was observed to be on her back with the head of the bed elevated.</p> <p>On 1/17/12 at 10:15 A.M., Resident # 27 was observed to be in bed on her back with the head of the bed elevated. Resident # 27 was observed to have oxygen per nasal cannula.</p> <p>On 1/17/12 at 10:45 A.M., Resident # 27 was observed to be in bed on her back with the head of the bed elevated. Resident # 27 was observed to have oxygen per nasal cannula.</p> <p>On 1/17/12 at 11:40 A.M., Resident # 27 was observed to be in bed on her back with the head of the bed elevated. Resident # 27 was observed to have oxygen per nasal cannula. PT staff (physical therapy) was observed to be in the room with Resident # 27. PT staff # 1 was observed to remove Resident # 27's nasal cannula and looked at the top of Resident # 27's ear. There was observed to be an open area with a yellow base the size of a dime. The nasal cannula was observed to have a 4 inch by 4 inch piece of gauze taped around the tubing that was resting on this area. There was a moderate</p>		(DON/Designee) to ensure that the "Weekly Skin Audit" performed by the Charge Nurse has accurately identified any areas of compromised skin and that appropriate follow-up has been completed. Identified non-compliance will result in immediate 1:1 re-education with progressive disciplinary action up to and including termination. Results of audits will be presented to the Quality Assurance (QA) Committee on a monthly basis for further review and recommendations as deemed appropriate, for at least 6 months or until the QA Committee determines the issue has been resolved.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155461	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/19/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PRAIRIE VILLAGE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 801 S SR 57 WASHINGTON, IN 47501
---	--

(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>amount of drainage noted on the gauze. PT staff # 1 stated "It doesn't look as bad as I thought it would." PT staff # 1 was then observed to place the nasal cannula with the soiled gauze back on Resident # 27.</p> <p>On 1/17/12 at 12:35 P.M., Resident # 27 was observed to be in bed on her back with the head of the bed elevated. Resident # 27 was observed to have oxygen per nasal cannula.</p> <p>On 1/17/12 at 12:45 P.M., in an interview with RN # 1, she indicated weekly skin checks are done by the charge nurse. She stated the nurse would then document on the treatment sheet either a negative or positive sign. A negative sign meant there was no skin issues. A positive sign meant there was an issue with the skin and the charge nurse would then describe and measure the area and document on a skin sheet.</p> <p>On 1/17/12 at 12:55 P.M., Resident # 27 was observed to be in bed on her back with the head of the bed elevated. Resident # 27 was observed to have oxygen per nasal cannula.</p> <p>On 1/17/12 at 2:10 P.M., Resident # 27 was observed to be in bed on her back with the head of the bed elevated.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155461	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/19/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PRAIRIE VILLAGE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 801 S SR 57 WASHINGTON, IN 47501
---	--

(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 # 27 was observed to have oxygen per nasal cannula.</p> <p>On 1/17/12 at 3:15 P.M., Resident # 27 was observed to be in bed on her back with the head of the bed elevated. Resident # 27 was observed to have oxygen per nasal cannula.</p> <p>On 1/17/12 at 4:00 P.M., Resident # 27 was observed to be in bed on her back with the head of the bed elevated. Resident # 27 was observed to have oxygen per nasal cannula.</p> <p>On 1/17/12 at 4:30 P.M., in an interview with LPN # 1, she indicated she had been the charge nurse for Resident # 27's hall since 2:00 P.M. She indicated she had received report at that time from RN # 2. She further indicated she had not been given any information regarding Resident # 27 during the report.</p> <p>On 1/17/12 at 4:35 P.M., LPN # 1 was observed to enter Resident # 27's room. LPN # 1 indicated she was not aware there was an area on the top of Resident # 27's right ear. She further stated she was the wound nurse and would stage the area at a stage II. She indicated on the top of the left ear had a scabbed area.</p> <p>The clinical record for Resident # 27 was</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155461		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/19/2012	
NAME OF PROVIDER OR SUPPLIER PRAIRIE VILLAGE NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 801 S SR 57 WASHINGTON, IN 47501			
(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>reviewed on 1/17/12 at 4:50 P.M. and included a Progress Notes, dated 1/17/12 at 1645 (4:45 P.M.), which indicated " noted res [resident] having an area on R [right] top back ear d/t [due to] O2 tubing. 1.5 x [by] 1.0 x < [less than] 0.1 area ...new tubing with padding applied. Tylenol given d/t [due to] discomfort. "</p> <p>The Director of Nursing provided the facility policy and procedure for wound prevention and treatment, dated April 2009, on 1/17/12 at 4:45 P.M. The policy indicated "...Stage III: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss...The depth of a stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear...do not have subcutaneous tissue and stage III ulcers can be shallow...Weekly skin assessment...requires centers to complete a Weekly Skin Assessment. This assessment includes a head to toe visualization of the residents skin..."</p> <p>On 1/17/12 at 5:25 P.M., in an interview with LPN # 1 she indicated she had notified Resident # 27's physician concerning the areas behind each ear. She indicated the physician had given a</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155461	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/19/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PRAIRIE VILLAGE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 801 S SR 57 WASHINGTON, IN 47501
---	--

(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>treatment order for the area to the right ear.</p> <p>The clinical record for Resident # 27 was reviewed on 1/17/12 at 9:30 A.M. The record indicated Resident # 27 had diagnoses that included but was not limited to left hip fracture with open reduction with internal fixation and congestive heart failure. The resident had a phyican's order, dated 1/14/12, for oxygen 4 liters per nasal cannula. The MDS [Minimum Data Set] assessment, dated 11/10/11, indicated Resident # 27 had moderately impaired cognition. Resident # 27 required extensive assistance of two with bed mobility, transfers and toilet use. Resident # 27 had no pressure sores.</p> <p>A care plan, dated 11/15/11 and updated on 1/6/12, indicated a problem of "Skin Integrity Assessment: Prevention and Treatment Plan of Care. Braden Risk Assessment Score At Risk (15-18) Pressure-reduction support surface if bed or chair bound. At risk related to: bowel incontinence, Bladder incontinence, rt [right] hip fracture and repair, PVD [peripheral vascular disease]. Healthy Skin: Clean, well hydrated, normal skin color." The interventions included but were not limited to "complete Braden Scale upon admission and quarterly, and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155461	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/19/2012
NAME OF PROVIDER OR SUPPLIER PRAIRIE VILLAGE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 801 S SR 57 WASHINGTON, IN 47501		
(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>with change of condition, Keep skin clean, dry and free of body wastes, perspiration and wound drainage, and inspect the skin for signs and symptoms of breakdown."</p> <p>The Braden Risk Assessment Scale, dated 1/4/12, indicated a score of 9. The form indicated a score of 0-9 Very High Risk.</p> <p>The January 2012 treatment record indicated a skin assessment was done on Resident # 27 on 1/16/12. No areas were documented to have been red or open.</p> <p>A Pain Data Collection and Assessment, dated 1/17/12, indicated " ...Pain Scale. On a scale of 0-10, with 0 being ' no pain ' and 10 being the " most intense pain imaginable " , what would you rate the severity or intensity of your pain right now? 6...Vocal Complaints of Pain- " ouch " . Facial expressions- wrinkled forehead...Resident Current Conditions: Pressure Ulcer d/t [due to] O2 tubing...Over the past five days, what precipitates/exacerbates pain: pressure from tubing... "</p> <p>3.1-40(a)(1)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155461	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/19/2012
---	--	--	--

NAME OF PROVIDER OR SUPPLIER PRAIRIE VILLAGE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 801 S SR 57 WASHINGTON, IN 47501
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155461	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/19/2012
NAME OF PROVIDER OR SUPPLIER PRAIRIE VILLAGE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 801 S SR 57 WASHINGTON, IN 47501		
(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	
F0315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on interview and record review, the facility failed to ensure a resident who was continent of bladder received services to maintain her continence after a decline in physical condition, in that the resident was readmitted from the hospital with no assessment or plan of care put into place to maintain or improve her urinary function, for 1 of 6 residents reviewed for bladder continence in the sample of 15.</p> <p>Finding include:</p> <p>On 1/17/12 at 8:50 A.M., during the initial tour with RN # 1, she indicated Resident # 27 had a fall with a hip fracture and had been receiving palliative care. She indicated Resident # 27 was doing much better now and was no longer palliative care. She stated Resident # 27 was dependent for care and incontinent of</p>	F0315	<p>1) Assessments and Plans of Care to include but not limited to 3 day Elimination, Comprehensive Bladder Assessment & Alteration in Urinary Incontinence plan of care were immediately updated for res #27. 2) A 100% medical record review was completed on current in-house residents identified by the MDS as having a change of condition, in the past 90 days, to ensure all assessments and care plans including but not limited to 3 day Elimination, Comprehensive Bladder Assessment, and Alteration in Urinary Incontinence plan of care accurately reflected residents current condition. Identified areas were updated as appropriate. 3) Re-education will be completed with Licensed Nurses on policy & procedure for assessing residents having a change of condition to include but not be limited to assessing urinary continence. Re-education will include updating the plans of</p>	02/18/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155461	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/19/2012
NAME OF PROVIDER OR SUPPLIER PRAIRIE VILLAGE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 801 S SR 57 WASHINGTON, IN 47501		
(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>bowel and bladder.</p> <p>The clinical record for Resident # 27 was reviewed on 1/17/12 at 9:30 A.M. The record indicated Resident # 27 had diagnoses that included but was not limited to left hip fracture with open reduction with internal fixation and congestive heart failure. The MDS [Minimum Data Set] assessment, dated 11/10/11, indicated Resident # 27 had moderately impaired cognition. Resident # 27 required extensive assistance of two with bed mobility, transfers and toilet use. Resident # 27 was always incontinent of bowel and usually incontinent of bladder. The previous MDS, dated 8/17/11, indicated Resident # 27 was independent with all activities of daily living and was always continent of bowel and occasionally incontinent of bladder.</p> <p>A Quarterly Nursing Data Collection and Assessment, dated 8/12/11, indicated "...Incontinent- no. Current toileting plan- no. Change in continence past quarter- no. Toilet habits- toilet..."</p> <p>The clinical record indicated Resident # 27 had fallen on 10/14/11 and sustained a hip fracture.</p> <p>A Nursing Comprehensive Admission Data Collection And Assessment, dated</p>		<p>care for those identified changes. DON/Designee will review physician orders and 24 Hour Report Sheet 5 times weekly to identify residents having a change in condition to include, but not be limited to, urinary continence. Identified residents will be reviewed by the IDT to ensure assessments and plans of care including but not limited to 3 day Elimination, Comprehensive Bladder Assessment, Alteration in Urinary Incontinence plan of care, and Certified Nursing Assistant (CNA) Care Guide, are updated to accurately reflect the residents current status. 4) A medical record audit will be completed on residents identified as having a change in condition weekly x 4 weeks and then monthly ongoing by the DON/Designee to ensure continued compliance. Identified non-compliance will result in immediate 1:1 re-education with progressive disciplinary action up to & including termination. Results of audits will be presented to the QA Committee monthly for further review & recommendations as deemed appropriate, for at least 6 months or until the QA Committee determines the issue has been resolved.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155461	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/19/2012
NAME OF PROVIDER OR SUPPLIER PRAIRIE VILLAGE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 801 S SR 57 WASHINGTON, IN 47501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>10/28/11, indicated "...Incontinence: yes. Toilet habits: Toilet, briefs/pads..."</p> <p>A 3-Day Elimination Tracking Chart Detail, dated 1/1/2012 through 1/5/2012, indicated Resident # 27 was incontinent of bowel and bladder the entire 3 days.</p> <p>The current CNA assignment sheet, last updated 12/19/11, indicated Resident # 27 was continent of bowel and bladder, up ad lib, and did not require any incontinent products.</p> <p>The Director of Nursing provided the facility policy and procedure for Bowel and Bladder Program, dated 1/2009, on 1/19/12 at 11:30 A.M. The policy indicated "...identify resident with urinary incontinence. For suspected incontinence, complete a Three-Day Elimination tracking...Complete a comprehensive bladder assessment using the Bladder Data Collection and Assessment and initiate Alteration in Urinary Continence Plan of Care to manage urinary incontinence...Complete the Three Day Elimination tracking for a resident suspected of having bladder incontinence: upon admission, upon onset of new incontinence, quarterly if change in MDS self control category for incontinence...Significant change of condition...Initiate/Update the Alteration</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155461	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/19/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PRAIRIE VILLAGE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 801 S SR 57 WASHINGTON, IN 47501
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>in Urinary Continence Plan of Care on all resident identified as incontinent of admission, quarterly with change in MDS self control category and residents who become incontinent...Document results of Prompted voiding, scheduled voiding/habit training or scheduled check and change programs..."</p> <p>In an interview with the Assistant Director of Nursing, on 1/17/12 at 4:40 P.M., he indicated they had just missed doing a bowel and bladder assessment and care plan on Resident # 27 when she had a condition change.</p> <p>3.1-41(a)(1)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155461	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/19/2012
---	--	--	--

NAME OF PROVIDER OR SUPPLIER PRAIRIE VILLAGE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 801 S SR 57 WASHINGTON, IN 47501
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155461	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/19/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PRAIRIE VILLAGE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 801 S SR 57 WASHINGTON, IN 47501
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
F0323 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 residents at risk of falls received supervision to prevent falls, in that Resident #12 had experienced a fall resulting in a laceration requiring 3 staples to close and continued to experience repeated falls without new interventions consistently implemented, Resident #49 with repeated falls was left alone in the bathroom without supervision resulting in a fall and Resident #22 lacked the implementation of safety precautions during a transfer resulting in a bruise and skin tear and was left unattended in the bathroom, for 3 of 6 residents reviewed for accidents in the sample of 15.</p> <p>Findings include:</p> <p>1. During the initial tour, on 1/17/12 at 8:50 A.M., RN # 1 indicated Resident # 12 was up in a wheelchair, required assistance of staff with activities of daily living, was confused and had behavior related to falls.</p>	F0323	<p>1) Residents 12, 49 & 22 Safety Assessments, Care Plans, and CNA Care Guides were reviewed by the Interdisciplinary Team (IDT) and updated to accurately reflect residents' current status</p> <p>2) A 100% review by the IDT of Residents Safety Assessments, Care Plans, and CNA Care Guides was completed on current in-house residents. Fall/Injury Assessment: Management/Prevention Plan of Care and CNA Care Guides were updated to accurately reflect residents current status.</p> <p>3) Re-education will be completed with all center staff on policy & procedure for preventing accidents to include but not be limited to fall risk assessment, immediate fall interventions, supervision of residents at risk for falls, & ongoing fall interventions.</p> <p>Licensed Nurses will document on the 24 Hour Report Sheet any resident having a fall on their shift. DON/Designee will review the 24 Hour Report Sheet daily (Mon thru Fri) to identify residents having a fall. The medical record</p>	02/18/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155461	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/19/2012
NAME OF PROVIDER OR SUPPLIER PRAIRIE VILLAGE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 801 S SR 57 WASHINGTON, IN 47501		
(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>The clinical record for Resident # 12 was reviewed on 1/17/12 at 2:00 P.M. The record indicated Resident # 12 has diagnoses that included but were not limited to dementia, Parkinson's disease, and macular degeneration. The MDS [Minimum Data Set] assessment, dated 10/12/11, indicated Resident # 12 had severe cognitive impairment. Resident # 12 required extensive assistance of one with bed mobility, transfers, ambulation and toilet use. Resident # 12 had not fallen since the previous assessment.</p> <p>A Fall/Injury Assessment: Prevention and Management Plan of Care, dated 3/3/11 and updated on 3/21/11, 4/6/11, 4/7/11, 5/2/11, 5/6/11, 5/19/11, 7/6/11, 7/21/11, 8/1/11, and 8/11/11, indicated a problem of "Fall/Injury Risk related to: restless leg syndrome, cardiovascular diagnosis, dementia, MMR [mild mental retardation], hearing HOH [hard of hearing], visual macular degeneration, antianxiety, cardiovascular meds- digoxin, plavix, antidepressant- remeron, antipsychotic- Zyprexa, lithium, Hx [history] of Fall/Injury: 9/29/10 sat on floor no injuries, 11/26/10 found on floor c/o [complaints of] left hip pain, 11/30/10 fall on floor no injury, 1/12/11 fall to floor "ankle gave out" thought to be behavior, 3/21/11 lost balance et [and]</p>		<p>of identified residents will be reviewed by the IDT daily (Mon thru Fri) to ensure immediate interventions, taken by the Charge Nurse, are appropriate, and to determine the most appropriate long term intervention(s). Residents Fall/Injury Assessment: Management and Prevention Plan of Care as well as CNA Care Guide will be updated to accurately reflect interventions and residents current status.</p> <p>4) Utilizing the "Weekly Systems Review Audit" for falls, the DON/Designee will complete a medical record audit on residents having a fall to ensure that the Fall/Assessment Plan of Care is updated & accurately reflects the residents current status with appropriate immediate & long term interventions. The Weekly System Review for falls audit will be completed daily x 2 weeks, weekly x 4 weeks and monthly thereafter. Identified non-compliance will result in immediate 1:1 re-education with progressive discipline up to & including termination.</p> <p>Results of audits will be forwarded to the QA Committee for further review & recommendations as deemed appropriate.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155461		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/19/2012	
NAME OF PROVIDER OR SUPPLIER PRAIRIE VILLAGE NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 801 S SR 57 WASHINGTON, IN 47501			
(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>fell to floor no injuries, 4/5/11 on floor in therapy."</p> <p>An Accident/Incident Report, dated 4/30/11, indicated "...12:30 P.M...res ambulating in B wing hallway res leaned to her left side et fell directly on her left side onto the floor...Immediate action taken to prevent further incidents: encourage res to ask for assist with ambulation..."</p> <p>A Progress Note, dated 5/2/11, no time, indicated "Resident reported fall on 5/1/11. Noted edema and bruising to left hand and elbow. X-ray obtained were negative. Res [resident] cont [continues] on therapy caseload. Staff encourage resident to use w/c that has been provided. She is able to propel self in chair without difficulty but resident refuses chair at times. Res was informed recently of near date of discharge from therapy. IDT [Interdisciplinary Team] concern of continued purposeful falling with previous history of that type of behavior. Will encourage use of w/c while therapy continues to explore options for walker that would assist resident with balance. Resident will not be informed of next upcoming d/c [discharge] date from therapy to the restorative program. Plan will be for resident to not feel need for continued fain of attention from therapy</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155461	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/19/2012
NAME OF PROVIDER OR SUPPLIER PRAIRIE VILLAGE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 801 S SR 57 WASHINGTON, IN 47501		
(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>staff if she recognizes that she will continue to have individualized time with restorative staff. Will monitor for safety."</p> <p>The fall care plan was updated on 5/2/11 to include the intervention of "xray obtained (neg) [negative]. On therapy caseload staff to encourage use of w/c for mobility."</p> <p>An Accident/Incident Report, dated 5/6/11, indicated "...12:40 P.M...Res ambulating past A wing desk fell onto buttocks et [and] hit back of head on floor sustaining laceration top back of scalp 3.2 mm...Immediate action taken to prevent further incidents: (blank)..."</p> <p>In an interview with the Director of Nursing, on 1/19/12 at 9:45 A.M., he provided the second page of the accident/incident report, dated 5/6/11, which indicated "...May still be behavior but unable to control fall, recent med changes, 3 staples, alarming lap belt..."</p> <p>The fall care plan was updated on 5/6/11 to include the intervention of "Out to ER for evaluation cont on therapy case load, SRALB [self release alarming lap belt], ambulation 1 assist and transfer 1 assist."</p> <p>A Progress Note, dated 5/6/11, no time, indicated "IDT met to review due to fall</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155461	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/19/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PRAIRIE VILLAGE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 801 S SR 57 WASHINGTON, IN 47501
---	--

(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>from 5/6/11. Res received staples in the ER [emergency room] at (hospital name) and was returned. Res cont to have unsteady gait and is non-compliant with use of w/c due to decreased safety awareness. Res in w/c and res agreeable with self releasing alarming lap belt to promote her to remember to allow staff to assist with ambulation and transfers. Cont to be on therapy. Neuro checks continue. Wound care to be done as ordered to staples."</p> <p>The fall care plan was updated on 5/10/11 to include the intervention of "chair alarm."</p> <p>An Accident/Incident Report, dated 7/5/11, indicated "...11:45 A.M...Resident stood from w/c to sit in chair in lobby and fell onto L [left] side. c/o L hip pain...Tab alarm sounding. Noted resident laughing at incident...Immediate action taken to prevent further incidents: Encourage resident to ask for assist with transfers ambulation..."</p> <p>The fall care plan was updated on 7/5/11 to include the intervention of "continue with behavior plan."</p> <p>A Progress Note, dated 7/6/11, no time, indicated "IDT met to review fall from 7/5/11. Res found in floor shortly after</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155461		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/19/2012	
NAME OF PROVIDER OR SUPPLIER PRAIRIE VILLAGE NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 801 S SR 57 WASHINGTON, IN 47501			
(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>she tried to get from DR [dining room]. Res denied injury and was laughing about putting self on floor. Behavioral intervention cont will monitor as needed."</p> <p>An Accident/Incident Report, dated 7/20/11, indicated "...1445 (2:45 P.M.)...Res up w/c (sic) propelling self down hallway. Laying on floor left side...1 cm x 1 cm abrasion L [left] knee...Immediate action taken to prevent further incidents: Enc [encourage] request assist from staff to be up. Placed in nsg [nursing] direct supervision..."</p> <p>An Accident/Incident Report, dated 7/31/11, indicated "...11:00 A.M...sat easily onto floor et stated I fell then layed (sic) over et started crying no fall no injuries...Immediate action taken to prevent further incidents: placed direct nsg supervision enc call for assist..."</p> <p>An Accident/Incident Report, dated 7/31/11, indicated "...1300 (1:00 P.M.)...amb [ambulated] hallway. Sat easily down onto floor et cryed (sic) I fell...Immediate action taken to prevent further incidents: placed direct nsg supervision. Enc call for assist..."</p> <p>In an interview with the Director of Nursing, on 1/19/12 at 9:50 A.M., he indicated the alarm did sound to alert staff</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155461	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/19/2012
NAME OF PROVIDER OR SUPPLIER PRAIRIE VILLAGE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 801 S SR 57 WASHINGTON, IN 47501		
(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 # 12 was up unassisted.</p> <p>A Progress Note, dated 8/1/11, no time, indicated "IDT met to review ongoing behavior. Resident observed easing herself to the floor x [times] 2 over the weekend then claiming she fell. This is ongoing pattern of behavior. noted that resident has long history of self injurious behavior when wanting attention. Will ensure psychiatrist is aware of recent behavior."</p> <p>An Accident/Incident Report, dated 8/8/11, indicated "...12:30 P.M...res alarm sounded CNA entered room. Res lost her balance when rising from bed fell onto floor. Landing on L hip...Immediate action taken to prevent further incidents: Assisted res to bed, alarms reapplied, call light in place..."</p> <p>A Fall/Injury Assessment: Prevention and Management Plan of Care, dated 8/11/11, indicated "Fall/Injury Risk related to: restless leg syndrome, cardiovascular diagnosis, dementia, MMR [mild mental retardation], hearing HOH [hard of hearing], visual macular degeneration, antianxiety- ativan, cardiovascular meds- digoxin, plavix, antidepressant- remeron, antipsychotic- Zyprexa, lithium, Hx [history] of Fall/Injury: 3/21/11 fall, 4/5/11 fall, 4/6/11 fall, 5/1/11 fall, 5/6/11</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155461		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/19/2012	
NAME OF PROVIDER OR SUPPLIER PRAIRIE VILLAGE NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 801 S SR 57 WASHINGTON, IN 47501			
(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>fall, 7/5/11 fall, 7/20/11 fall, 7/31/11 fall, 7/31/11 fall and 8/8/11 fall."</p> <p>An Accident/Incident Report, dated 10/22/11, indicated "...12:15 P.M...Resident was ambulating in room (number) unassisted. Stated she lost her balance fell onto her bottom before staff could get to her...Denied pain. No injury noted...Immediate action taken to prevent further incidents: Encourage resident to ask for assistance when ambulating..."</p> <p>A Progress Notes, dated 10/24/11, no time, indicated "IDT met to review. Res had fall on 10/22/11. She fell after removing her bed tabs alarm while attempting to ambulate no injury noted. Currently on therapy caseload. Will receive balance test on 10/26/11. Will request order for Lithium level. Continue current safety plan and restorative walking program. Will cont to monitor for pattern of behaviors and review as needed..."</p> <p>An Accident/Incident Report, dated 11/9/11, indicated "...1330 (1:30 P.M.)...Resident was found on floor in bathroom in sitting position. Resident had removed tabs alarm herself and whet to bathroom. No apparent injury Denies any pain...Immediate action take to prevent further incidents: Assisted resident up and</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155461		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/19/2012	
NAME OF PROVIDER OR SUPPLIER PRAIRIE VILLAGE NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 801 S SR 57 WASHINGTON, IN 47501			
(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>back to bed. Tab alarm secured to clothing on residents back diff [difficult] to reach and remove..."</p> <p>A Progress Note, dated 11/10/11, no time, indicated "IDT met to review. Res sat self in floor on 11/9/11 no injuries noted. Staff report res removed alarm and unhooked...Alarms adjusted to prevent tampering. Res has ongoing pattern of behavior and placing self on floor. Therapy reports res gait is steady. Will cont to monitor and review as needed."</p> <p>An Accident/Incident Report, dated 11/15/11, indicated "...1930 (7:30 P.M.)...This nurse head alarm sounding found resident on floor next to recliner...no apparent injuries. Assisted back to chair x [times] ii [two] assist sensor alarm in recliner...immediate action taken to prevent further incidents: continued sensor alarm in recliner et close monitoring..."</p> <p>An Accident/Incident Report, dated 12/24/11, indicated "...0615 (6:15 A.M.)...CNA saw res leaning forward in w/c in A wing lounge attempting to pick up trash CNA called res to lean back at that time res fell forward onto floor hitting R [right] side of forehead causing a 1.7 x 0.2 abrasion area cleansed bandaid applied neuro checks started after res</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155461	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/19/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PRAIRIE VILLAGE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 801 S SR 57 WASHINGTON, IN 47501
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>placed back in chair alarm did sound...immediate action taken to prevent further incidents: res placed in view of nurse..."</p> <p>An Accident/Incident Report, dated 12/24/11, indicated "...1930 (7:30 P.M.)...Resident found on floor by bed. Abrasion from earlier fall reopened. Bleeding stoped (sic) et bandaid re-applied...Immediate action taken to prevent further incidents: monitored for rest of shift and while in bed. Assured that pressure alarm working..."</p> <p>A Progress Note, dated 12/27/11, no time, indicated "IDT met to review res fell x 2 on Christmas eve while attempting to self transfer. Received a hematoma on forehead. Neuro checks completed with no abnormalities noted. Res cont to exhibit falling behaviors at this time. Noted dx [diagnosis] of borderline personality disorder. Dr (name) on call for Dr (name) over the weekend. He was updated on falls with new orders received to obtain CBC, BMP and Lithium levels. Awaiting results. Will cont to monitor for safety and review as needed. Res denies pain."</p> <p>On 1/19/12 at 10:00 A.M., the Director of Nursing indicated the alarm had malfunctioned and was replaced following this fall.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155461		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/19/2012	
NAME OF PROVIDER OR SUPPLIER PRAIRIE VILLAGE NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 801 S SR 57 WASHINGTON, IN 47501			
(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>2. Resident #49 was identified on the initial tour of the facility on 1/17/12 at 8:45 A.M., with the Assistant Director of Nursing, as having Downs syndrome, walking with assistance and also using a wheelchair.</p> <p>Resident #49 was observed on 1/18/12 at 11:00 A.M., to ambulate with assistance of 2 staff members and a gait belt, her gait was slow and steady. She was observed to have alarms in the chairs to alert staff of unassisted movement.</p> <p>Resident #49's clinical record was reviewed on 1/17/12 at 1:00 P.M. The most recent Minimum Data Set, dated 12/7/11, indicated the resident was cognitively impaired and required extensive assistance with transfers and ambulation, and had a fall since the last assessment.</p> <p>An "Accident Incident Report," dated 8/21/11 at 12:50 P.M., indicated "Resident was crossing rec (recreation) room floor when she stumbled and went down on left knee...requires no assist with transfers, immediate action was to monitor resident when ambulating and make sure pathways clear."</p> <p>Nurses notes indicated on 9/19/11 the</p>	F0323	<p>1) Residents 12, 49 & 22 Safety Assessments, Care Plans, and CNA Care Guides were reviewed by the Interdisciplinary Team (IDT) and updated to accurately reflect residents' current status</p> <p>2) A 100% review by the IDT of Residents Safety Assessments, Care Plans, and CNA Care Guides was completed on current in-house residents. Fall/Injury Assessment: Management/Prevention Plan of Care and CNA Care Guides were updated to accurately reflect residents current status.</p> <p>3) Re-education will be completed with all center staff on policy & procedure for preventing accidents to include but not be limited to fall risk assessment, immediate fall interventions, supervision of residents at risk for falls, & ongoing fall interventions.</p> <p>Licensed Nurses will document on the 24 Hour Report Sheet any resident having a fall on their shift. DON/Designee will review the 24 Hour Report Sheet daily (Mon thru Fri) to identify residents having a fall. The medical record of identified residents will be reviewed by the IDT daily (Mon thru Fri) to ensure immediate interventions, taken by the Charge Nurse, are appropriate, and to determine the most appropriate long term intervention(s). Residents</p>	02/18/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155461	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/19/2012
NAME OF PROVIDER OR SUPPLIER PRAIRIE VILLAGE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 801 S SR 57 WASHINGTON, IN 47501		
(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 started crying in pain, stating her abdomen hurt and refusing to ambulate. The resident was sent to the hospital were she was found to have a fracture of her proximal left humerus (upper arm) and had surgical repair on 9/20/11.</p> <p>During interview with the Director of Nursing on 1/17/12 at 1:30 p.m., he provided an investigation concerning the fracture and indicated at that time the resident could have fallen and gotten up on her own without staff having been aware. The facility was unable to determine what had happened to cause the fracture.</p> <p>A care plan for fall/injury assessment:prevention and management plan of care, dated 8/23/11, indicated 8/21 fall, 7/17/11 fall, 10/6 fall and 10/13/11 fall. Interventions included but were not limited to: ambulate and transfer with 1 assist, 10/5/11 alarms to all seats, 10/6/11 alarms to couch, 1 assist, 10/13 attempt self release alarming seat belt, 12/12/11 continue safety plan CNA educated.</p> <p>The accident/incident reports, included as part of the nurse's notes indicated the following:</p> <p>10/5/11 1850 (6:50 p.m.) recreation room- stood up for wheelchair and as she</p>		<p>Fall/Injury Assessment: Management and Prevention Plan of Care as well as CNA Care Guide will be updated to accurately reflect interventions and residents current status.</p> <p>4) Utilizing the "Weekly Systems Review Audit" for falls, the DON/Designee will complete a medical record audit on residents having a fall to ensure that the Fall/Assessment Plan of Care is updated & accurately reflects the residents current status with appropriate immediate & long term interventions. The Weekly System Review for falls audit will be completed daily x 2 weeks, weekly x 4 weeks and monthly thereafter. Identified non-compliance will result in immediate 1:1 re-education with progressive discipline up to & including termination.</p> <p>Results of audits will be forwarded to the QA Committee for further review & recommendations as deemed appropriate.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155461	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/19/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PRAIRIE VILLAGE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 801 S SR 57 WASHINGTON, IN 47501
---	--

(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>was falling pushed a side table away then came down slowly on right side then landed or ended up on bottom all the time hold her left arm with right arm...immediate action to prevent further incidents "brought wheelchair closer to myself."</p> <p>10/6/11 1230 PM in recreation room, witnessed by a visitor, Res stood up from couch in rec room, takes few steps away from seat and stumbles lands on buttocks then rolls to side and lays down on left side...immediate action-will review resident for use of mobility monitor at meal times until safe to ambulate by self again..."</p> <p>10/13/11 2000 (8 p.m.) lounge area. sitting in wheelchair, stood up from wheelchair then sat down onto floor on buttocks , exhibiting behavior symptoms just before the incident, yes several attempts to get up unassisted, immediate action to prevent further incidents- keep direct supervision, required 2 assist to get up..</p> <p>12/11/11 1310 (110 p.m.) rec room bathroom, Resident was toileting and CNA turned around to cabinet to get new brief when resident apparently slid from toilet to floor on right side between toilet and wall.. This fall was unwitnessed</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155461		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/19/2012	
NAME OF PROVIDER OR SUPPLIER PRAIRIE VILLAGE NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 801 S SR 57 WASHINGTON, IN 47501			
(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>The bathroom in the recreation room was observed on 1/18/12 at 11:00 A.M. An area has been set up in front of the bathroom with several cabinets of supplies and a curtain, which leads to the actual bathroom. The cabinets are outside the actual bathroom door and a resident could not be seen from the cabinet area while sitting in the bathroom.</p> <p>During interview on 1/18/12 at 11:00 A.M. with the Assistant director of nursing, he indicated the alarms were started on 10/6/11 not 10/5/11, as the interdisciplinary team would not have met until 10/6 following the 10/5/11 fall. He further indicated documentation was lacking as to if the alarm was in place on 10/13/11 or if it had rang.</p> <p>3. On 01/18/12 at 9:00 a.m., Resident #22 was observed in a shower room to be seated sideways on a commode. The Resident was observed to be unattended by staff. The resident was noted to whimper and attempt to button her robe. After a few minutes, the resident started mumbling, "Wonder why nobody's come to help me." The resident was observed to have a reddened skin tear on her lower right leg which was held together with steri-strips. At 9:15 a.m., the resident indicated, "Guess I'll ring the bell." The resident then pulled the call light string.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155461	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/19/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PRAIRIE VILLAGE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 801 S SR 57 WASHINGTON, IN 47501
---	--

(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>At 9:16 a.m., CNA # 1 and CNA # 2 entered the shower room. Using a gait belt, the CNA's assisted the resident to stand and after providing incontinence care, the CNA's were observed to transfer the resident from the commode to her wheelchair. During the incontinence care, the resident's bottom was observed to be reddened and to have an indentation on her outer buttocks from sitting on the commode.</p> <p>During interview of LPN #2 (Nurse working floor Resident #22 resided on) on 01/18/12 at 10:00 a.m., indicated LPN #2 was not certain how Resident #22 was supposed to be transferred. LPN #2 indicated the last she heard was that Resident #22 was to be evaluated by Physical Therapy for transfers, but she was not sure whether or not this had been done.</p> <p>Review of Resident #22's clinical record on 01/18/12 at 9:40 a.m. indicated the following:</p> <p>Resident #22 had diagnoses which included, but were not limited to, Schizophrenia, Anxiety Disorder, Post Traumatic Stress Syndrome, and Chronic Obstructive Pulmonary Disease.</p> <p>A quarterly MDS [Minimum Data Set]</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155461	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/19/2012
NAME OF PROVIDER OR SUPPLIER PRAIRIE VILLAGE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 801 S SR 57 WASHINGTON, IN 47501		
(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>assessment, dated 11/25/11, indicated the resident had severe cognitive impairment, was unable to recall 3 words, was frequently incontinent of bladder, and required extensive assistance of staff for toileting and transfers.</p> <p>An "Accident/Incident Report," dated 12/03/11 at 7:20 p.m., indicated, "During transfer from toilet to w/c [wheelchair], Res [Resident #22] eased to sitting position onto floor per CNA's. 0 [No] injury sustained. Denies pain....Immediate Action Taken To Prevent Further Incidents: Use stand up lift to enable secure transfers...." The report indicated the resident was being transferred by 2 CNA's and with assist of a gait-belt at the time of the incident.</p> <p>An "Accident/Incident Report," dated 12/23/11 at 10:00 a.m., indicated, "Res [Resident #] bumped hand on bathroom rail during transfer. Noticed bruise dark purple and black 5.5 x 5 across nuckles (sic). 0 [No] s/s [signs or symptoms] pain. 0 changed ROM [range of motion]." The "Reason" section of the report had not been filled out. The report indicated the resident was not compliant with assistive devices.</p> <p>An IDT [Interdisciplinary Team] progress note, dated 12/27/11, indicated, "IDT met</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155461	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/19/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PRAIRIE VILLAGE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 801 S SR 57 WASHINGTON, IN 47501
---	--

(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>to review Res [Resident #22] noted to have bruising to knuckles on her left hand. Res had bumped it on the handrail in the bathroom. Hand was x-rayed to R/O [rule out] fx [fracture] c [with] results being negative. Denies c/o [complaint of] pain or discomfort. Will monitor for healing & review as needed."</p> <p>A physician's telephone order, dated 01/03/12, indicated, "PT [Physical Therapy] eval [evaluation] done. Pt [Resident #22] not appropriate for skilled PT at this time.</p> <p>A physician's telephone order, dated 01/04/12, indicated, "OT [Occupational Therapy] eval on 1/3/12 - No indication for OT intervention at this time.</p> <p>An "Accident/Incident Report," dated 01/14/12 at 11:45 a.m., indicated, "Three CNA's attempting to transfer resident from recliner to w/c [wheelchair]. Resident's feet slid under the bed and shin was injured on underside of bed frame....Immediate Action Taken To Prevent Further Incidents: CNA's educated to use mechanical lift for all future transfers of this resident until therapy can evaluate needs. The report indicated the resident sustained a 4 centimeter skin tear to her lower leg. The report indicated the resident was wearing</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155461		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/19/2012	
NAME OF PROVIDER OR SUPPLIER PRAIRIE VILLAGE NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 801 S SR 57 WASHINGTON, IN 47501			
(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>"socks only" at the time of the incident. The report indicated the socks were not "gripper socks."</p> <p>An IDT progress note, dated 01/18/12, indicated, "IDT met to review-discussed fall for 12/3/11. Safety plan was ii [2] person assist for transfer. Res cont [continues] to show increased difficulty c transfers. Res noted to have another recent fall that resulted in a skin tear - this also during transfer. PT to re-eval [re-evaluate] for safe transfer & evaluate appropriateness of mechanical lift. Will continue to monitor and review as needed. The IDT did not meet until 4 days after the resident's fall on 01/14/12.</p> <p>Documented interviews from two of the CNA's were provided by the DON on 01/18/12 at 2:30 p.m. Both interviews indicated Resident #22's feet were slipping & slipped under the bed and the bed railing cut the resident's leg.</p> <p>A "Fall/Injury Assessment/Prevention and Management Plan of Care," dated 08/30/11 with updates of 11/29/11 and 12/23/11, indicated the resident was a fall risk related to pain, osteoarthritis, osteoporosis, poor weight bearing, fall history, and severe thoracic (curvature of the spine). The plan of care listed several interventions to prevent falls such as</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155461	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/19/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PRAIRIE VILLAGE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 801 S SR 57 WASHINGTON, IN 47501
---	--

(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>non-skid socks and non-skid strips to floor. No interventions on the list were check marked as being implemented. Hand written on the last page of the plan of care was, "Encourage resident to use gait belt but allow her to choose." This intervention was dated 10/02/10.</p> <p>No additional plans/interventions to prevent the resident from being injured during transfers were provided by the facility.</p> <p>3.1-45(a)(2)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155461	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/19/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PRAIRIE VILLAGE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 801 S SR 57 WASHINGTON, IN 47501
---	--

(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
F0465 SS=D	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORT ABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to ensure tile was in good repair, failed to ensure an exit door was properly sealed, failed to ensure a utility door was free from rust, failed to ensure posts surrounding a lounge area were free from chips and marred areas, failed to ensure hall way cove base was in good repair, and failed to ensure the ceiling of a recreation room was free of yellowed and dingy colored paint.</p> <p>Findings Include:</p> <p>During observation tour on 01/19/12 at 8:50 a.m., with the Maintenance Supervisor and Laundry Supervisor present, the following observations were made:</p> <p>1. The exit door to the smoke shack was observed to have chipped and broken floor tile on the inside of the door and a opening/crack at the bottom of the door was observed to have daylight showing through and cold air could be felt coming through the opening.</p> <p>2. The door of the water softener room</p>	F0465	<p>It is the Policy and Procedure of Prairie Village to ensure a Safe/Functional/Sanitary/Comfort able Environment.Areas identified as needing repaired or replaced will be addressed accordingly: 1) Exit Door to Smoke Shack will be repaired by entirely replacing the door and door frame with a new like model.The adjacent chipped and broken floor tiles will be replaced with new floor tiles to prevent daylight and cold air entry. This will be completed on or 2/18/12. 2) The rust on the bottom edge of the wooden door of the water softener room will be properly removed,treated and painted. The rust locatedon the bottom of the metal door framewill be removed, treated with rustoleum. The entire door frame will be painted. Thiswill be completed on or before 2/18/12. 3) The ceiling of the large resident recreation room will be painted tocover the dingy/yellowed color nowpresent. This will be completed on orbefore 2/18/12. 4) The chipped and marred post located in the resident lounge on 200 Hall will berepaired and painted. This will be completedon or before 2/18/12. 5) The cove based located in 200 Hall will be</p>	02/18/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155461	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/19/2012
NAME OF PROVIDER OR SUPPLIER PRAIRIE VILLAGE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 801 S SR 57 WASHINGTON, IN 47501		
(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>was observed to be rusted along the bottom edge of the door.</p> <p>3. The large resident recreation room was observed to have a dingy/yellowed color.</p> <p>Interview of the Maintenance Supervisor on 01/19/12 at 9:10 a.m., indicated the large recreation room used to be used for a smoking room for residents residing at the facility.</p> <p>4. A resident lounge area was observed to have posts surrounding the area. The posts were observed to be chipped and marred.</p> <p>5. On the same hall as the resident lounge, cove based was observed to be loose and missing.</p> <p>3.1-19(f)</p>		<p>repaired or replaced as needed. This will be completed on or before 2/18/12. The Maintenance Director has conducted a complete 100% audit of the center's other ingress/egress doors, service room doors, all other lounge areas and cove based located within the center. The audit will be completed on or before 2/18/12. The areas identified as needing repairs or replacement will be placed on a project completion list and will be completed within 90 days of discovery. The Maintenance Director and Health Facility Administrator will conduct a 'Maintenance' Rounds audit 1 x per week x 3 months, then 1 x per month x 3 months to identify areas needing repairs or replacement. Areas identified as needing repairs/replacement will be placed on the Maintenance Director's project list. To ensure the Environment will be maintained the Maintenance Director will conduct 'Preventative Maintenance' Rounds audits on a monthly basis thereafter. The areas identified as needing repairs and/or replacement will be placed on the Maintenance Director's project list and will be reported to the Administrator. The Administrator will report the findings to the Quality Assurance Committee. The needed repairs and/or replacements will be completed within 90 days of</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155461	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/19/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PRAIRIE VILLAGE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 801 S SR 57 WASHINGTON, IN 47501
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
			discovery. The 'Preventative Maintenance' Rounds audits will be 'on-going'.	