

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155139	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/03/2013
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NAME OF PROVIDER OR SUPPLIER NORTH WOODS VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2233 W JEFFERSON ST KOKOMO, IN 46901
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F000000	<p>This visit was for the investigation of Complaint IN00137190.</p> <p>Complaint IN00137190: Substantiated. Federal/State deficiency related to the allegations is cited at F323.</p> <p>Survey dates: October 2 and 3, 2013</p> <p>Facility number: 000064 Provider number: 155139 AIM number: 100288770</p> <p>Surveyor: Janet Stanton, R.N.</p> <p>Census bed type: SNF--17 SNF/NF--135 Total--152</p> <p>Census payor type: Medicare--30 Medicaid--99 Other--23 Total--152</p> <p>Sample: 4</p> <p>This deficiency reflects State findings cited in accordance with</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. This provider respectfully request a face to face IDR due to disagreement with severity. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Survey Review on or after October 18, 2013.</p>	
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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>410 IAC 16.2.</p> <p>Quality Review was completed by Tammy Alley RN on October 8, 2013.</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.</p> <p>Based on observation, interview and record review, the facility failed to ensure a potentially dangerous and unattached wardrobe/cabinet door was immediately removed from a common shower/bathroom, which resulted in 1 resident receiving a laceration and subsequent hematoma to her head when the door fell and hit her. This deficiency impacted 1 of 4 residents reviewed for falls/accidents. (Resident #B)</p> <p>Findings include:</p> <p>The record for Resident #B was reviewed on 10/2/13 at 11:05 A.M. The resident was admitted on 3/7/13. Diagnoses included, but were not limited to, recent history of a cervical spine Level II fracture with a Halo device in place, cervical spine osteoarthritis, osteoporosis,</p>	F000323	<p>F323 Accidents and Supervision It is the practice of this provider to ensure the resident's environment remains as free of accident hazards as is possible. This Provider respectfully request a face to face IDR due to disagreement with severity. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice Resident #B was treated for hematoma for right temple and has fully recovered. Door to cabinet was repaired on 6-20-13 How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken Residents in the facility have the potential to be affected by the alleged deficient practice. All areas throughout this facility have been checked by Maintenance supervisor to ensure the environment is free of hazards and none were</p>	10/18/2013			

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	<p>severe neuroforaminal bilateral compromise at cervical vertebrae C3-C4 with facet arthropathy, severe left neuroforamina narrowing at C4-C5, right rotator cuff tear, non-insulin dependent diabetes, abnormal short term memory, and impaired cognition. The cervical spine injury was healed at the time of the most recent accident and the resident was no longer wearing the halo.</p> <p>A progress note, dated 6/20/13, indicated "Resident hit in head by door. CT [Computerized Tomography] scan negative [for injury]."</p> <p>An "Events History/ Non-pressure wound skin evaluation" report, dated 6/20/13, indicated "New area, hematoma right temple; 4 cm. [centimeter] diameter."</p> <p>On 10/2/13 at 12:45 P.M., the Director of Nursing provided the facility's investigation of the incident. Statements written by the attending nursing staff indicated the following:</p> <p>CNA #1--"On 6/20/13 [name of CNA #2] after lunch asked me to come watch how [Resident #B's name] transferred to bathroom. I went in</p>		<p>found.The facility shall have faulty equipment and/or furnishings in resident area removed from area until repair can be completed. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur The cabinet door was repaired on 6-20-13.Staff were educated by 10-18-13 by the SDC/Designee and/or department managers for removing faulty equipment/furnishings in resident areas until it is appropriately repaired .Daily rounds will be conducted by the housekeeping/maintenance/nursing staff to ensure no faulty equipment/furnishings are present in resident areas .Maintenance Slips will be completed immediately for repair of equipment or furnishings.Any repairs will be discussed at morning supervisor meeting Monday through Friday and with Manager on Duty on the weekends for emergent repairs to be made immediately.Executive/Designee will follow up to ensure emergent repairs are completed. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place A "Facility Environmental Review" CQI tool will be utilized weekly X 4 and monthly there after for at least 6 months.Data will be submitted to</p>		

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	<p>bathroom. [CNA #3] shut the door and a broken closet door fell and hit [resident's name] in front right side of head."</p> <p>CNA #2--"We were taking [resident's name] into shower room to toilet her. We didn't realize that the shower cabinet door was propped up behind our shower door. The door fell and hit [resident's name] in the right temple."</p> <p>CNA #3--"We were in the restroom and as we shut the door, there was a closet door that had been leaned up behind the bathroom door that we didn't know was there. So when the door shut, the loose door fell over and hit [resident' name] on the top right side of her head."</p> <p>LPN #4--"At 11:50 A.M., [Resident #B's chart number] was taken into shower room by CNAs to toilet; soon after resident was taken into shower room, CNAs called out that a "door had hit resident in the head." Went into shower room and noted swelling hematoma to right temple that was bleeding freely. Applied immediate pressure and ice to right temple. Bleeding from temple ceased after a few minutes. Resident is alert and oriented; speech clear. PERLA</p>		<p>the CQI committee for review and follow up. An action plan will be developed for identified issues if 95% compliance is not achieved. Compliance date: 10-18-13</p>				

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	<p>[Pupils equal, react to light and accommodation]. Paged NP [Nurse Practitioner] who was in facility's parking lot and immediately assessed resident and gave order to send resident to ER [Emergency Room]. NP then called MD who ordered for resident to go to [name of hospital] ER to have CT of head. Called 911... Attempted to notify POA [Power of Attorney]... unable to reach him... left voice mail... After resident transferred out learned form CNAs that door that hit resident's temple was one of the doors of a closet in shower room that had broke off the hinges and was leaning against the wall behind shower room door. That closet door had fell over and hit resident's temple. After learning this, notified ED [Executive Director], DON [Director of Nursing], and UM [Unit Manager]; UM stated that staff X [times] 2 including her had notified Maintenance of door needing fixed early this morning and Maintenance slip had been filled out and placed in appropriate box. Maintenance called after resident's transfer and door was fixed immediately."</p> <p>In an interview on 10/3/13 at 12:00 P.M., the DON indicated the incident had been reported to the Indiana</p>			

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	<p>State Department of Health. She believed a housekeeper initially found the door off the cabinet and leaned it against the wall behind the hall door to the bathroom, then left to get Maintenance to fix it. The housekeeper apparently filled out a Maintenance repair slip. The DON was not sure if the CNAs knew the door was off, but shortly after took the resident into the shower room to toilet her. She was not sure exactly how the incident happened, but thought maybe a breeze from the hall door, as it closed, caused the closet door to fall forward and hit the resident.</p> <p>In an interview on 10/3/13 at 2:15 P.M., the ADON (Assistant Director of Nursing) indicated she thought the door had come off on the midnight shift, about 7:7:30 A.M. When she got to the facility that morning, a Maintenance repair slip had already been made out, but Maintenance had not yet arrived for work.</p> <p>In an interview on 10/3/13 at 2:15 P.M., the ED indicated the Maintenance department picked up repair request slips one time a day. Staff were able to call the department for any immediate</p>			

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	<p>issues.</p> <p>In an interview on 10/3/13 at 2:15 P.M., the DON indicated she and the ADON had actually found out about the door when they returned from their lunch break, about 11:45 AM-12:00 PM. She thinks the housekeeper found the door off first, and was pretty sure she turned in a repair slip. She was unsure of the time frame. The DON indicated one of the CNAs in the room actually caught the door on her arm as it was falling, but was not able to keep the door from hitting the the resident's head.</p> <p>At 2:20 P.M., the shower/bathroom in question was observed. The door from the hallway opened inward to the room, from the left to the right. A 6-foot wardrobe-type cabinet, with 2 doors that opened out, was positioned immediately to the right in the room. The hall door had clearance between the edge of the door and the near end of the cabinet. One of the 6 foot doors had hit the resident in the head.</p> <p>In an interview on 10/3/13 at 2:50 P.M., the ED indicated she has spoken with the Maintenance department. They reported they had</p>			

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	<p>not received any repair slips for the door, but did fix the door about noon on 6/20/13. She indicated that nursing staff and the housekeeper reported they had turned in repair slips. She indicated removing equipment and items that required repair and/or was potentially unsafe was not a subject that staff had received training on.</p> <p>No documentation was provided to explain the actual time the door was first found or why the door was not removed from the shower/bathroom area until it could be fixed.</p> <p>This Federal tag relates to Complaint IN00137190.</p> <p>3.1-45(a)(1)</p>			