

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155681 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 09/16/2014 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER AUTUMN WOODS HEALTH CAMPUS | STREET ADDRESS, CITY, STATE, ZIP CODE 2911 GREEN VALLEY RD NEW ALBANY, IN 47150 |
|--|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|--|---------------|---|----------------------|
|--------------------|--|---------------|---|----------------------|

| | | | | |
|---------|--|---------|--|--|
| F000000 | <p>This visit was for the Investigation of Complaint IN00155939.</p> <p>Complaint IN00155939-Substantiated. Federal/State deficiencies related to the allegations are cited at F-223.</p> <p>Survey date: September 16, 2014.</p> <p>Facility number: 002657 Provider number: 155681 AIM number: 200308930</p> <p>Survey Team: Jenny Sartell, RN-TC Gwen Pumphrey, RN Trudy Lytle, RN Josh Emily, RN</p> <p>Census bed type: SNF: 43 SNF/NF: 40 Total: 83</p> <p>Census payor type: Medicare: 16 Medicaid: 34 Private: 33 Total: 83</p> <p>Sample: 4</p> | F000000 | | |
|---------|--|---------|--|--|

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: 155681 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 09/16/2014 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER AUTUMN WOODS HEALTH CAMPUS | STREET ADDRESS, CITY, STATE, ZIP CODE 2911 GREEN VALLEY RD NEW ALBANY, IN 47150 |
|--|---|

| (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 |
|--------------------|---|---------------|---|----------------------|
| F000223 SS=D | <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on September 19, 2014 by Randy Fry RN.</p> <p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on observation, interview and record review the facility failed to ensure residents were protected from physical abuse by a staff member. This deficient practice affected 1 of 4 residents reviewed for abuse. (Resident A).</p> <p>Findings include:</p> <p>On 9/16/14 at 9:45 a.m., the reportables to the Indiana State Department of Health (ISDH) were reviewed. A reportable involving Resident A indicated a Certified Nursing Assistant (CNA) was observed hitting the resident in the abdominal area on 9/7/14.</p> | F000223 | <p>The submission of this Plan of Correction does not indicate an admission by Autumn Woods that the findings contained herein are accurate and true representations of the quality of care and services provided to the residents of Autumn Woods. This facility recognized it's obligation to provide legally and medically necessary care and services to it residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities (Title 18/19 programs.) to this end; this plan of correction</p> | 10/16/2014 |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155681 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 09/16/2014 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER AUTUMN WOODS HEALTH CAMPUS | STREET ADDRESS, CITY, STATE, ZIP CODE 2911 GREEN VALLEY RD NEW ALBANY, IN 47150 |
|--|---|

| (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 report indicated Resident A had some bruising to the left antecubital area (bend of the elbow) and was transferred to the hospital for evaluation.</p> <p>The report indicated the facility initiated and completed an investigation immediately. The investigation included but was not limited to: staff interviews, resident skin assessments, staff reeducation, and notification of law enforcement.</p> <p>The facility notified ISDH of the incident in a timely manner.</p> <p>On 9/16/14 at 10:55 a.m., Resident A was observed sitting in a reclining chair in the activity area of Legacy Lane. The resident was interacting with staff and residents appropriately. The resident did not have any evidence of physical or psychological distress.</p> <p>Resident A's clinical record was reviewed on 9/16/14 at 11:00 a.m. The resident had diagnoses including, but not limited to dementia, high blood pressure, and arthritis. The record lacked documentation of Resident A having any behaviors before, during, or after the incident.</p> | | <p>shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statue only.</p> <p>1. Resident A was immediately assessed by licensed nurse on 9/07/14, including a full skin assessment. Resident A was transported to the emergency room for further evaluation by a physician. Cat scan of the abdomen was performed on 9/07/14 with normal findings. Resident A returned to the campus with no new orders.</p> <p>Responsible party of resident A was notified immediately of the incident. ISDH was immediately notified of the incident on 9/7/14 by the ED. Law enforcement was notified on 9/7/14by the ED. Resident A was monitored daily by licensed nurse to assess for any signs of physical or psychological distress and none were noted. CRCA involved was immediately supervised and escorted from the campus by the Legacy Lane Director.</p> <p>2. Resident skin assessments were conducted on all residents</p> | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155681 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 09/16/2014 |
|--|--|---|--|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER AUTUMN WOODS HEALTH CAMPUS | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2911 GREEN VALLEY RD NEW ALBANY, IN 47150 | | |
| (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 Minimum Data Set [MDS] Assessment dated 5/17/14 indicated the resident was severely cognitively impaired and required extensive assistance with activities of daily living.</p> <p>Resident A was transferred to the emergency room on 9/7/14 at 9:50 a.m. A physician progress note indicated,"impression-physical abuse/assault". The physician progress note indicated Resident A had no injuries related to the incident. Resident A returned to the facility on 9/7/14 with no new orders.</p> <p>On 9/16/14 at 11:10 a.m., Resident A was observed during a transfer from a reclining chair to a wheelchair. Resident A did not exhibit guarding, fearfulness or stress towards staff.</p> <p>On 9/17/14 at 1:45 p.m., LPN#1 was interviewed. She indicated Resident A was completely dependent. LPN#1 indicated the resident was non-verbal, very frail, and had no aggressive behaviors. Regarding the incident, the LPN#1 stated, "I saw the CNA hit Resident A three times on 9/7/14. I immediately had a housekeeper stay with the resident and notified my supervisor. The CNA was escorted out of the building by my supervisor. The resident looked scared, but I don't think [named</p> | | <p>on the Legacy Lane Unit by the licensed nurses. No unusual findings were noted. Interviews were conducted with all staff members and no issues were identified. Families of residents on Legacy Lane unit were contacted by the Legacy Lane Director and no concerns were identified.</p> <p>3. All staff received reeducation on the abuse policy, abuse prevention, and staff burnout. This was initiated by the ED, DHS, ADHS on 9/7/14 and completed on 9/9/2014. Campus will continue to conduct background checks and check abuse registry per regulatory requirements.</p> <p>4. The DHS/ADHS will conduct random staff interviews for 10 staff weekly for 4 weeks then 5 staff weekly for 8 weeks, and then 5 staff monthly for 3 months to verify ongoing understanding and compliance with abuse policy, prevention and staff burnout. All new staff will be educated on the abuse policy, prevention and staff burnout and Hand-in-Hand dementia training upon hire. Annually all staff will be re</p> | | |

| | | | | | | | |
|--|---|---|--|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155681 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 09/16/2014 | |
| NAME OF PROVIDER OR SUPPLIER AUTUMN WOODS HEALTH CAMPUS | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2911 GREEN VALLEY RD NEW ALBANY, IN 47150 | | | |
| (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] knew what happened. I assured [named resident] that this would not happen again."</p> <p>Resident A was unable to be interviewed due to cognitive impairment.</p> <p>The policy titled, "Abuse and Neglect Procedural Guidelines" was received from the Director of Nursing on 9/16/14 at 9:30 a.m. It included, but was not limited to the following: "...to ensure the prevention....of suspected or alleged resident abuse and neglect...implemented processes in an effort to provide a comfortable and safe environment...assure that prevention techniques are implemented in the campus..."</p> <p>This federal tag is related to Complaint IN00155939.</p> <p>3.1-27(a)1</p> | | <p>educated on the abuse policy, prevention and burnout. Resident skin assessments will continue to be reviewed by the DHS/ADHS 10 per week for 4 weeks, then 5 per week for 4 weeks, and then monthly for 3 months to aid in monitoring for any unusual findings. Nursing staff will conduct skin assessments weekly and monitor for any unusual findings. DHS/ADHS will be notified of any unusual findings. Results of these audits will be presented by the DHS to the QA committee for further recommendations and continue until the Quality Assurance team determines substantial compliance has been achieved.</p> <p>5. Compliance Date: October 16, 2014</p> | | | | |