

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155684	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SOUTHFIELD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 6450 MIAMI CIR SOUTH BEND, IN 46614
--	---

(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 IN00155530.</p> <p>Complaint IN00155530 - Substantiated. Federal/State deficiencies related to the allegations are cited at F323.</p> <p>Survey Dates: September 22, 23, &amp; 24, 2014</p> <p>Facility number: 002662 Provider number: 155684 AIM number: 200315930</p> <p>Survey team: Diana McDonald, RN-TC</p> <p>Census bed type: SNF: 23 SNF/NF: 31 Residential: 48 Total: 102</p> <p>Census payor type: Medicare: 9 Medicaid: 25 Other: 68 Total: 102</p> <p>Sample: 3</p>	F000000	This Plan of Correction constitutes the written allegation of compliance for the deficiency cited. The submission of this Plan of Correction is not an admission that a deficiency exists or that a deficiency was cited correctly. This Plan of Correction is being submitted to meet the requirements established by State and Federal law.	

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:  155684	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SOUTHFIELD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 6450 MIAMI CIR SOUTH BEND, IN 46614
--	---

(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
F000323 SS=G	<p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed on October 2, 2014, by Brenda Meredith, R.N.</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review and interview, the facility failed to identify Resident A's risk of an accident. The resident fell from her bed which resulted in a right femur fracture and an extended hospital stay. This affected 1 out of 1 resident, Resident A.</p> <p>Finding includes:</p> <p>Resident A's clinical record was reviewed on 9/22/2014 at 1:45 p.m. Resident A's diagnoses include, but were not limited to multiple sclerosis, abnormal involuntary movements, obesity, and muscle spasms. Resident A's Brief Interview for Mental Status (BIMS), dated 9/8/2014, indicated a score of 15, cognitively intact. The</p>	F000323	<p>Nursing personnel have been in-serviced on the functionality of the specialty air bed and the change to the Specialty Air Mattress policy and procedure. Additionally, for the affected resident, her CNA Assignment Sheet and Plan of Care have been revised to include " Must have two staff members to assist any time involving any turning or repositioning". All other residents that utilize a specialty air mattress have also had their CNA Assignment Sheets and Plans of Care revised to include "Must have two staff members to assist any time involving any turning or repositioning". Systemically, the Specialty Air Mattress policy and procedure has been revised to require two</p>	10/10/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155684		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/24/2014	
NAME OF PROVIDER OR SUPPLIER  SOUTHFIELD VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 6450 MIAMI CIR SOUTH BEND, IN 46614			
(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>Minimum Data Set (MDS) assessment dated 9/8/14, indicated Resident A hygiene care was an extensive assistance with two plus person physical assist.</p> <p>A nursing note, dated 4/2/14 at 4:32 p.m., indicated "...2 assist required for transfers which are accomplished using Hoyer lift. Assistance required for all ADL's [Activities of Daily Living]...."</p> <p>Review of an incident report indicated "On August 20, 2014 at 10:45 AM, staff member was providing care to resident who was lying on a pressure relieving air mattress. The mattress was set on the firm setting to allow staff to re-position the resident as necessary. After 15 minutes, the mattress automatically deflates to the softer setting to prevent future skin breakdown. This occurred while the staff member was still providing care. The staff member pushed the button for the mattress to return to the firm setting causing the resident to roll out of bed." The report further indicated the resident was assessed for potential injury. The resident complained of right hip pain. The physician was notified and the resident was sent to the hospital for evaluation. The resident sustained a fractured right hip.</p> <p>The Admission Register, 8/21/2014 thru</p>		<p>staff members to be present when repositioning a resident on any air bed in addition to, when being transferred. The Fall Committee, which is a sub-group of our Quality Assurance and Performance Improvement process will be responsible to monitor all specialty air beds. At the time an order is received for a specialty air bed, The Fall Committee will assure the CNA Assignment Sheet and Plan of Care have been updated to include two staff members to reposition and transfer. Additionally, The Fall Committee will visually inspect the resident and their air bed weekly to assure the staff are following the proper protocols and procedures including the use of a high/low bed and a fall mat. The full QAPI Committee, which includes the Medical Director, meets quarterly and is informed of the Fall Subcommittee's work. The Medical Director, in her role as the primary care physician, is notified at the time of each incident, for those residents that she treats. Furthermore, the Medical Director reviews the Incident and Accident Log weekly for all residents.</p> <p>This weekly inspection will continue as long as the resident utilizes the specialty air mattress. The Director of Nursing is responsible to carry out the Plan of Correction. Failure to execute the Plan of Correction may result</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155684		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/24/2014	
NAME OF PROVIDER OR SUPPLIER  SOUTHFIELD VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 6450 MIAMI CIR SOUTH BEND, IN 46614			
(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>9/21/2014, indicated Resident A was re-admitted to the facility on 8/25/2014 from hospital.</p> <p>Consultation Final Report [name of health system], dated 8/20/2014, indicated "...There is an acute displaced comminuted fracture of the proximal right femur...."</p> <p>During an interview on 9/23/2014 at 2:30 p.m., The DON (Director of Nursing) indicated the air mattress control box had an audio instructor. The audio instructor gives operating instruction which informs the listener that the air mattress will deflate after 15 minutes at maximum firmness.</p> <p>During an interview on 9/24/2014 at 9:07 a.m., LPN #1 indicated before the fall of Resident A on 8/20/2014 she did not know about the air mattress deflating after 15 minutes of maximum firmness. She indicated she trained herself on the function of the air mattress.</p> <p>During an interview on 9/24/2014 at 9:19 a.m., CNA #1 indicated she was the only one in the room with Resident A. After positioning Resident A on the left edge of the bed, CNA #1 provided personal care and positioned the Hoyer lift sling. CNA #1 indicated she was not aware if</p>		in disciplinary action, up to and including, termination.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155684	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SOUTHFIELD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 6450 MIAMI CIR SOUTH BEND, IN 46614
--	---

(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 A was not in the center of the bed when air mattress inflated Resident A would fall.</p> <p>During an observation of a demonstration and interview with CNA#1 on 9/24/2014 at 9:55 a.m., CNA #1 demonstrated what happened on 8/20/2014 when Resident A fell out of bed onto the floor which resulted in a fractured right femur and a six day hospital stay. The air mattress control box was attached to the foot board of Resident A's bed. There were 2 buttons to control the firmness of the mattress. Button number one was for elevation support which includes eating, watching TV and visiting. Button number 2 was for maximum firmness needed during personal care, repositioning, transferring and wound care. The maximum firmness setting deflates automatically to the normal air mattress firmness after 15 minutes. On 8/20/14, CNA #1 pressed the number 2 button on the air mattress controls panel for the maximum firmness. Resident A was positioned toward the left edge of the bed with her back toward the CNA #1. CNA #1 provided private area care to Resident A. Then, CNA #1 started to position the Hoyer lift sling under the Resident A and the air mattress automatically started to deflate. CNA #1 reached to the end of the bed and pressed</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155684	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SOUTHFIELD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 6450 MIAMI CIR SOUTH BEND, IN 46614
--	---

(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>button number two button to reinflate the mattress to maximum firmness. As the mattress started to inflate, Resident A's feet and legs went over the side of the bed causing the resident's body to follow resulting in a fracture to the right femur.</p> <p>This Federal tag relates to Complaint IN00155530.</p> <p>3.1-45(a)(2)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155684	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SOUTHFIELD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 6450 MIAMI CIR SOUTH BEND, IN 46614
--	---

(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