

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 02/12/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH WOODS VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2233 W JEFFERSON ST KOKOMO, IN 46901
---	--

(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 a Recertification and State Licensure Survey.</p> <p>Survey dates: February 4,6,7,10,11,12, 2014</p> <p>Facility Number: 000064 Provider Number: 155139 AIM Number: 100288770</p> <p>Survey team: Rita Mullen, RN TC Bobette Messman, RN Maria Pantaleo, RN</p> <p>Census bed type: SNF: 16 SNF/NF: 137 Total: 153</p> <p>Census Payor Type: Medicare: 31 Medicaid: 92 Other: 30 Total: 153</p> <p>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2</p> <p>Quality Review was completed by Tammy Alley RN on February 19, 2014.</p>	F000000	<p>February 28, 2014 Ms. Kim Rhoades Indiana State Department of Health 2 North Meridian St. Indianapolis, Indiana 46204 Dear Ms. Rhoades: Please accept this 2567 Plan of Correction for the Recertification and State Licensure Survey ending February 12, 2014, as our Letter of Credible Allegation and we respectfully request a Desk Review in lieu of a post survey revisit on or after March 10, 2014. We also respectfully request paper review IDR to reduce scope on F371. Thank you for your time in reviewing our plan of correction and please call with any questions. Sincerely, Cathy S. Greene Executive Director North Woods Village EnclosureThe 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 requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and respectfully requests Desk Review in lieu of a Post Survey Review on or after March 10, 2014. This facility respectfully request paper review IDR to reduce scope on F371.</p>	
---------	--	---------	--	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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 02/12/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH WOODS VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2233 W JEFFERSON ST KOKOMO, IN 46901
---	--

(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
--------------------	--	---------------	---	----------------------

F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to ensure the Hospice records were current and accurate for 1 of 2 residents receiving Hospice care. (Resident #89).</p> <p>Findings included:</p> <p>The clinical record of Resident #89 was reviewed on 2/10/14 at 1:30 p.m. Resident is on Hospice.</p> <p>Diagnoses included but were not limited to, anemia, cardiomyopathy, gout, hypothyroidism, depression, anxiety and congestive heart failure..</p> <p>A review of the Hospice Chart, on 2/10/14 at 2:00 p.m., indicated the last Hospice assessment was on</p>	F000309	<p>F309 Provide Care / Services for Highest Well Being It is the practice of this provider to ensure each resident receives and the facility provides the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice • Resident #89 has current hospice notes in the resident's medical record.</p> <p>• The Hospice group was notified and had current hospice notes in medical record with in the hour and notified to ensure notes were kept current on medical record. How will you identify other residents having the potential to be affected by the</p>	03/10/2014
-----------------	---	---------	---	------------

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 02/12/2014
NAME OF PROVIDER OR SUPPLIER NORTH WOODS VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2233 W JEFFERSON ST KOKOMO, IN 46901		
(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>11/6/13, the last care plan was on 11/12/13 and the last nursing notes were dated 11/6/13.</p> <p>During an interview with the Staff Development Coordinator, on 2/10/14 at 2:30 p.m., she indicated the Hospice agency had been contacted and the missing notes would be here within the hour and they should have been in the Hospice chart.</p> <p>3.1-37(a)</p>		<p>same deficient practice and what corrective action will be taken</p> <ul style="list-style-type: none"> Residents who are on hospice services have the potential to be affected . Current residents receiving Hospice Services have been reviewed and have current notes on medical record by DNS (Director of Nursing Services)/Designee . Hospice company aware that they must keep current notes on medical record . Noncompliance with facility policy and procedure may result in termination of Hospice agreement. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur • Medical Records personnel will review Hospice medical record for current notes weekly . Hospice company informed to comply with keeping current notes on medical records. Noncompliance with facility policy and procedure may result in termination of Hospice agreement . Licensed nurses and nurse managers have been educated on ensuring Hospice documentation is present on medical record, on 3-4-14 by the DNS/designee. 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 		

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 02/12/2014
NAME OF PROVIDER OR SUPPLIER NORTH WOODS VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2233 W JEFFERSON ST KOKOMO, IN 46901		
(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	
F000325 SS=D	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on record review and interview, the facility failed to initiate interventions to prevent weight loss in a timely manner for 1 of 3 residents reviewed for weight loss (Resident #99). Findings include: The clinical record of Resident #99 was reviewed on 2/10/14 at 9:00 a.m. Resident # 99 was admitted to the facility on 12/23/13, admission weight was 130 pounds.</p>	F000325	<p>A Charting CQI tool will be utilized weekly x 4, monthly x2 and then quarterly thereafter for at least 6 months to monitor compliance charting availability from Hospice. • The CQI committee will review the data. If the threshold for 90% compliance is not met, an action plan will be developed. Compliance date: 3/10/14</p> <p>F325 Maintain Nutrition Status Unless Unavoidable It the practice of this provider, based on a resident's comprehensive assessment to ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible. Receives a therapeutic diet when there is a nutritional problem. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice • Resident #99 was receiving</p>	03/10/2014	

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 02/12/2014	
NAME OF PROVIDER OR SUPPLIER NORTH WOODS VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 2233 W JEFFERSON ST KOKOMO, IN 46901			
(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>Care Plan for nutrition, dated 12/23/13, interventions were not limited to, supplements as ordered, honor food preferences, monitor intake and weight, notify MD of 5 pound weight changes and Registered Dietitian of significant changes, serve diet as ordered.</p> <p>The weights recorded were as follows:</p> <p>1/2/14: 126 pounds, a 4 pound weight loss.</p> <p>1/7/13: 124 pounds, a 6 pound weight loss.</p> <p>1/13/13: 124 pounds, no weight change.</p> <p>1/22/14: 120 pounds, a 10 pound weight loss.</p> <p>1/28/14: 124 pounds, a 4 pound weight gain.</p> <p>A Dietary Clinician note, dated 12/30/13, indicated Resident #99 had an admission weight of 130 pounds, consumed 100% of meals and was on a regular diet.</p> <p>An Interdisciplinary Team (IDT) meeting note, dated 1/2/14,</p>		<p>Ensure Plus and discharged home on 2-16-14. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</p> <ul style="list-style-type: none"> Residents with weight loss and interventions for weight loss have the potential to be affected by the alleged deficient practice. Residents with weight loss and interventions for weight loss have been reviewed to ensure all interventions are in place by DNS/Designee. Licensed nurses and nurse managers have been re-educated on starting interventions upon receipt of order for intervention on 3-4-14 by the DNS/designee. Failure to follow interventions by licensed nurses will result in disciplinary action up to and including termination. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur Residents with weight loss and interventions for weight loss are reviewed weekly at NAR (Nutritional At Risk) Meeting or more frequently if ordered by Physician. Physician orders for interventions for weight loss are reviewed every morning by Medical Records Personnel and IDT (Interdisciplinary Team), Monday thru Friday and Weekend Nurse Manager will review on Saturday and Sunday to ensure compliance. 				

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 02/12/2014
NAME OF PROVIDER OR SUPPLIER NORTH WOODS VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2233 W JEFFERSON ST KOKOMO, IN 46901		
(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>indicated Resident #99 was down 4 pounds, was on a regular diet, had no skin problems and was on a multivitamin daily.</p> <p>A Dietary Clinician note, dated 1/8/14, indicated Resident #99's weight on 1/2/14 was 126 pounds and this was a 4 pound decline since admission. He was on a regular diet with fortified cereal added on 1/3/14. Resident #99 had a 6 pound weight loss on 1/7/14.</p> <p>An IDT note, dated 1/9/14, indicated Resident #99's current weight was 122 pounds, down 4 pounds this week. "Will try/request 120 ml [milliliters] 2-cal [a dietary supplement] BID X 30 DAYS [twice a day for 30 days]."</p> <p>The Physician Summary for the month of January 2014, indicated a new order, dated 1/10/14, new dietary order for 2-cal 120 ml bid.</p> <p>A Dietary Clinician note, dated 1/15/14, indicated the fortified cereal was discontinued because the Resident did not eat cereal hot or cold.</p> <p>A Dietary Clinician note, dated 1/20/14, indicated an overall weight</p>		<ul style="list-style-type: none"> Licensed nurses and nurse managers have been re-educated on starting interventions upon receipt of order for intervention on 3-4-14 by the DNS/designee. Failure to follow interventions by licensed nurses will result in disciplinary action up to and including termination. 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 • The CQI Tool "Nutrition Assessment" will be utilized weekly x 4, monthly x2 and then quarterly thereafter for at least 6 months to monitor compliance. The CQI committee will review the data. If the threshold for 90% compliance is not met, an action plan will be developed. Compliance date: 3/10/14 		

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 02/12/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH WOODS VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2233 W JEFFERSON ST KOKOMO, IN 46901
---	--

(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>loss of 6 pounds and weight had increased from 122 pounds to 124 pounds.</p> <p>A Registered Dietitian note, dated 1/21/14, indicated Resident #99 had an urinary tract infection on 1/18/14, his weight had increased increased 122 pounds to 124 pounds and "no recommendations at this time."</p> <p>An IDT note, dated 1/24/14, indicated Resident #99's current weight was 120 pounds, down 4 pounds that week, was on an antibiotic for an UTI, and would request a change to Ensure Plus from 2-cal 120 ml bid.</p> <p>A dietary order, dated 1/27/14, indicated the 2-cal was to be discontinued and 1 can of Ensure Plus bid times 30 days was to be started.</p> <p>A Physicians's Summary, dated for the month of January 2014, indicated the 2-cal 120 ml bid was discontinued on 1/24/14 and the Ensure Plus 1 can bid was not started until 1/27/14.</p> <p>During an interview with the Director of Nursing, on 2/10/14 at 11:00 a.m., she indicated the 2-cal was stopped</p>			

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 02/12/2014
NAME OF PROVIDER OR SUPPLIER NORTH WOODS VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2233 W JEFFERSON ST KOKOMO, IN 46901		
(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>on 1/24/14, a Friday, and the Ensure Plus was not started until Monday 1/27/14.</p> <p>During an interview with the Dietary Clinician, on 2/11/14 at 10:25 a.m., she indicated, "If I had know there was a 6 pound weight loss, on 1/7/14, I would have recommended a change to add 2-cal on 1/8/14.... I did not know the resident didn't like cereal and wasn't eating it, until 1/15/14."</p> <p>3.1-46(a)(2)</p>				

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 02/12/2014	
NAME OF PROVIDER OR SUPPLIER NORTH WOODS VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 2233 W JEFFERSON ST KOKOMO, IN 46901			
(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			
F000371 SS=E	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the facility failed to ensure that foods stored in the refrigerator were properly covered and dated. This had the potential to affect 44 of 153 residents served food from the kitchen.</p> <p>Findings include:</p> <p>A tour of the kitchen was conducted on 2/10/14 at 1:30 p.m.</p> <p>The refrigerator was observed with a tray of single serving jello and puddings, there was no covering or dates on the tray of servings. Two food containers had coverings not secured on the containers. The lids did not fit securely onto the container rather resting on top of it. Neither were dated.</p> <p>During an interview on 2/10/14 at 2:00 p.m., with the Dietary Manager and Executive Director, they indicated they were aware of the</p>	F000371	F371 Food Procure, Store, Prepare/Serve-Sanitary It is the practice of this facility to Procure food from sources approved or considered satisfactory by Federal, State or local authorities and store, prepare, distribute and serve food under sanitary conditions. This facility respectfully request paper review IDR to reduce scope on F371. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice • No residents were affected by this practice. • The one tray with jello and puddings were just placed in the refrigerator after lunch and was covered and immediately. • The two food containers were covered with the lid, one corner of the lid was not snapped on tightly, and was corrected and dated immediately. 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 who reside in the facility have the potential to be affected by the alleged deficient	03/10/2014			

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 02/12/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH WOODS VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2233 W JEFFERSON ST KOKOMO, IN 46901
---	--

(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>regulation regarding dating and covering food products and the new employee had not covered or dated the food.</p> <p>3.1-21(i)(3)</p>		<p>practice. • All items in the refrigerator were reviewed by Dietary Manager and Executive Director to ensure all items were covered and dated properly.</p> <ul style="list-style-type: none"> • Dietary Staff has been re-educated on proper covering and dating of stored food in the refrigerator on 3-4-14 by SDC/Dietary Manager/Designee.. • Failure to follow interventions by dietary staff will result in disciplinary action up to and including termination. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur • Dietary Staff has been re-educated on proper covering and dating of stored food in the refrigerator on 3-4-14 by SDC/Dietary Manager/Designee • The Dietary Manager/Kitchen Manager will monitor to ensure food in the refrigerator is covered and dated properly every shift daily. • Failure to follow interventions by dietary staff will result in disciplinary action up to and including termination. 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 • An "Infection Control" CQI tool will be utilized weekly x 4, monthly x2 and then quarterly thereafter for at least 6 months to monitor compliance with covering and 	

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 02/12/2014
NAME OF PROVIDER OR SUPPLIER NORTH WOODS VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2233 W JEFFERSON ST KOKOMO, IN 46901		
(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	
			dating stored food. • The CQI committee will review the data. If compliance of threshold of 90% is not met, an action plan will be developed. Compliance date: 3/10/14		

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 02/12/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH WOODS VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2233 W JEFFERSON ST KOKOMO, IN 46901
---	--

(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
F000431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, and interview the facility failed to provide a separately locked , permanently affixed compartment for storage of</p>	F000431	F431 Drug Records, Label/Store Drugs & Biologicals It is the practice of this provider to ensure that drugs and biologicals used in the facility must provide	03/10/2014

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 02/12/2014
NAME OF PROVIDER OR SUPPLIER NORTH WOODS VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2233 W JEFFERSON ST KOKOMO, IN 46901		
(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>controlled drugs in 1 of 3 medication storage areas.</p> <p>Findings include :</p> <p>Medication storage areas were observed on 2/10/2014 and the following observation was made:</p> <p>On 2/10/2014 at 1:48 p.m., on the second floor, 4 containers of Lorazepam, (anti-anxiety), oral concentrate were in the unlocked refrigerator. The refrigerator was located in the locked medication storage area for halls Magnolia and Willow Lanes.</p> <p>During an interview with LPN # 8, on 2/10/2014 at 1:52 p.m., she indicated that the refrigerator on the second floor for halls Magnolia and Willow should have been locked.</p> <p>During an interview with the DoN, on 2/12/2014 at 2:00 p.m., she indicated Lorazepam oral concentrate should be double locked on all units, at all times.</p> <p>3.1-25(n)</p>		<p>separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> No resident was affected. Second floor refrigerator with Lorazepam in it was locked immediately and was in a locked medication room. Nurses were re-educated to make sure all scheduled II drugs are double locked at all times immediately and on 3-4-14 by DNS/SDC. 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 residing at the facility have the potential to be affected by the alleged deficient practice • All refrigerators with scheduled drugs in them were inspected by DNS/Designee to ensure double locks were in place. • Nurses were re-educated to make sure all scheduled II drugs are double locked at all times immediately and on 3-4-14 by DNS/SDC. 		

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 02/12/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH WOODS VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2233 W JEFFERSON ST KOKOMO, IN 46901
---	--

(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
F000456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. Based on observation and interview the facility failed to maintain patient care equipment in safe operating condition for 2 of 2 residents. This deficient practice impacted 2 of	F000456	What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? <ul style="list-style-type: none"> The scheduled II drugs will be monitored daily by unit managers/weekend manager to ensure double lock is in place. Nurses were re-educated to make sure all scheduled II drugs are double locked at all times immediately and on 3-4-14 by DNS/SDC. 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? <ul style="list-style-type: none"> The CQI tool "Medication Storage Review" will be tool will be utilized weekly x 4, monthly x2 and then quarterly thereafter for at least 6 months to monitor compliance with schedule II medications being double locked. The CQI committee will review the data. If compliance of threshold of 90% is not met, an action plan will be developed. Compliance date: 3/10/14 	03/10/2014

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 02/12/2014
NAME OF PROVIDER OR SUPPLIER NORTH WOODS VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2233 W JEFFERSON ST KOKOMO, IN 46901		
(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 residents. (Residents # 258 and 259)</p> <p>Findings include:</p> <p>During a 2/6/2014, and 2/7/2014 resident room observation the following was observed:</p> <p>1.) Room 135 on 2/6/2014 at 1:09 p.m., Resident # 259, wheelchair seat cover was ripped and torn on the edges.</p> <p>2.) Room 133 on 2/7/2014 at 1:58 p.m., Resident # 258, bathroom shower chair was ripped and torn.</p> <p>On 2/11/2014 at 10:05 a.m. during the environmental tour with the Administrator, Maintenance Supervisor and Laundry/Housekeeping Supervisor, they indicated they were unaware of the resident equipment needing repairs.</p> <p>3.1-19(bb)</p>		<p>condition. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. • Resident #258 and #259 were not affected.</p> <p>• Room 135 and resident #259 wheelchair seat cover was removed and replaced immediately and torn one discarded. • Room 133 had bathroom shower chair removed immediately and was discarded. 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 residing at this facility have the potential to be affected by the alleged deficient practice.</p> <p>• Resident care equipment was observed by DNS/Designee to ensure equipment was free from tears. • Staff has been inserviced on monitor daily for ripped or torn in resident equipment, to replace and/or complete a maintenance repair slip immediately if found, on 3-4-14 by SDC/Housekeeping manager/Designee What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur • Monitor for ripped or torn resident equipment daily by nursing staff. If found replace immediately and/or complete a maintenance repair slip. • Staff has been inserviced on monitoring daily for</p>		

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 02/12/2014	
NAME OF PROVIDER OR SUPPLIER NORTH WOODS VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 2233 W JEFFERSON ST KOKOMO, IN 46901			
(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			
F000465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, and interview, the facility failed to ensure a clean, sanitary, and home like environment related to 4 of 4 facility hallway floors, 1 of 2 water fountains, 5 of 14 resident bathrooms (Room's #, 102, 109, 115, 123, and 133) and 2 of 2 elevator floor grids. This deficient practice had the	F000465	F465 Safe/Functional/Sanitary/Comfortable Environment It is the practice of this provider to ensure residents are provided with a safe, functional, sanitary and comfortable environment, for residents, staff and the public. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice • Both elevator tracks were cleaned	03/10/2014			

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 02/12/2014
NAME OF PROVIDER OR SUPPLIER NORTH WOODS VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2233 W JEFFERSON ST KOKOMO, IN 46901		
(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>potential to impact 153 residents out of 153 residents utilizing hallways and elevators. This deficient practice had the potential to impact 153 out of 153 residents utilizing the second floor water fountain. This deficient practice impacted 5 of 5 residents utilizing the bathrooms.</p> <p>Findings include;</p> <p>1. During the initial tour on 2/4/2014 at 9:50 a.m., the following was observed:</p> <p>a.) 2 of 2 elevator floor grids were observed to be full of dust, dirt, and debris.</p> <p>b.) The hallway floors for Magnolia, Willow, Walnut, Birch, Maple and Oak were observed to contain dirt, dust, lint, candy, medication syringe top, buttons, debris, and medication cups</p> <p>c.) The water fountain found on the second floor was observed to have empty water cups on the floor beside the container, a dirty grid beneath the water dispenser fountain, and dirt marks along the sides of the container.</p> <p>2. During resident room</p>		<p>immediately and are on a daily cleaning schedule by housekeeping staff. • The Hallway floors on Magnolia, Willow, Walnut, Birch, Maple and Oak were dust mopped immediately and floor machine ran on all hallway floors and are on a daily cleaning schedule by housekeeping staff. • The water fountain found on second floor was cleaned that day and is on the daily cleaning schedule by housekeeping staff. • Rooms #102, #109, #115, #123, and #133 had the bathroom tile behind the sink that was identified was removed and the area has been painted maintenance supervisor. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</p> <p>• Residents who reside in the facility have the potential to be affected by the alleged deficient practice. • Housekeeping Staff including Maintenance and Housekeeping Supervisors were made aware immediately and have been educated on 3-4-14 by SDC on observing for painting needs, cracked tile, dust, dirt, debris in hallways and resident rooms on daily rounds. • All rooms and hallways were checked and proper cleaning and repairs were completed by 2-13-14 by Housekeeping and Maintenance Supervisor. What measures will be put into place or</p>		

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 02/12/2014
NAME OF PROVIDER OR SUPPLIER NORTH WOODS VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2233 W JEFFERSON ST KOKOMO, IN 46901		
(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>observations on 2/6/2014, and 2/7/2014, the following was observed:</p> <p>a.) Room 102 2/7/2014, at 11:07 a.m., the bathroom tile was chipped and stained.</p> <p>b.) Room 109 2/7/2014, at 11:42 a.m., the bathroom tile was cracked</p> <p>c.) Room 115 2/7/2014 at 11:49 a.m., the bathroom tile was chipped and cracked.</p> <p>d.) Room 123 2/6/2014 at 11:16 a.m., the bathroom tile was chipped and cracked</p> <p>e.) Room 133 2/7/2013 at 2:09 p.m., the bathroom tile was chipped</p> <p>On 2/11/2014 at 10:05 a.m., during the environmental tour with the Administrator, Maintenance Supervisor and Laundry/Housekeeping Supervisor, they indicated they were unaware of the tiles needing repair in residents rooms.</p> <p>3.1-19(f)</p>		<p>what systemic changes you will make to ensure that the deficient practice does not recur • Preventive Maintenance schedule will be followed by maintenance supervisor to identify areas of repair and/or replacement by Maintenance. • Housekeeping Departments will complete daily rounds to observe daily cleaning is done per schedule. Monitored daily by Housekeeping supervisor/designee. • Housekeeping Staff including Maintenance and Housekeeping Supervisors were made aware immediately and have been educated on 3-4-14 by SDC on observing for painting needs, cracked tile, dust, dirt, debris in hallways and resident rooms on daily rounds. • Customer Care Representative will monitor on daily rounds and report accordingly to ensure resident rooms are clean and in proper repair. 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 audit tool will be completed weekly x 4. Monthly x 2, and then quarterly thereafter for at least 6 months by Housekeeping Supervisor/Maintenance Supervisor. • The CQI committee reviews the audits and action plans are developed to</p>		

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 02/12/2014
NAME OF PROVIDER OR SUPPLIER NORTH WOODS VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2233 W JEFFERSON ST KOKOMO, IN 46901		
(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	
			ensure safe/clean environment if threshold of 90% not met. Compliance date: 3/10/14		