

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155019	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/13/2011
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NAME OF PROVIDER OR SUPPLIER GARDEN VILLA	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 S CURRY PK BLOOMINGTON, IN47403
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F0000	<p>This visit was for the Investigation of Complaints IN00100770 and IN00100638.</p> <p>Complaint IN00100770 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00100638 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Unrelated deficiencies cited.</p> <p>Survey dates: December 12 and 13, 2011</p> <p>Facility number: 000007 Provider number: 155019 AIM number: 100275040</p> <p>Survey team: Marla Potts, RN, TC Melinda Lewis, RN Sharon Whiteman, RN</p> <p>Census bed type: SNF: 17 SNF/NF: 187 Total: 204</p> <p>Census payor type: Medicare: 31</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.

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F0282 SS=D	<p>Medicaid: 134 Other: 39 Total: 204</p> <p>Sample: 4</p> <p>Theses deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 12/15/11 by Jennie Bartelt, RN.</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview and record review, the facility failed to ensure the resident's care plan was followed so that a resident needing assistance with transfers and mobility had a call light in reach, and who required direct supervision when up, was provided with the supervision to prevent falls for 1 of 4 residents reviewed for care plans, in the sample of 4. (Resident D)</p>	F0282	F 282 It is the policy of Garden Villa to provide services by qualified persons in accordance with each resident's written plan of care. Garden Villa submits the following action as evidence of its commitment to compliance with regulatory requirements. <i>What corrective action will be accomplished for the resident found to be affected by the deficient practice?</i> I. Resident D will have a call light within reach while in bed. Staff to ensure	01/09/2012	

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	<p>Findings include:</p> <p>On 12/12/11 at 10:15 A.M., Resident D was observed to be asleep in a low bed with mattress extenders in place. The call light was observed to be in a basket on the bedside table approximately 4-5 feet from Resident D.</p> <p>The clinical record for Resident D was reviewed on 12/12/11 at 11:00 A.M.</p> <p>A care plan, dated 5/7/08 and revised on 11/20/09, indicated a problem of "Risk for falls characterized by history of falls, alternating exotropia, hemiparesis, unsteady gait, (10/23/08) antidepressant therapy. 5/2/09 Fall from bed. 5/21/09 Fall from w/c." The interventions included but were not limited to "Assist resident with transfers with assist of 1 staff member. Call light within reach and answer promptly. Remind resident to call for assistance. Fall Intervention: 6/30/08 direct supervision at all times when up."</p> <p>The Nurses Notes, dated 7/15/11 at 4:00 A.M., indicated, "Res [resident] was found on floor next to mats. Res stated I didn't fall; just slid off the mats. No apparent injuries noted. Will cont [continue] to monitor."</p> <p>The fall care plan was updated on 7/15/11</p>		<p>placement. <i>How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?</i> II. All residents have the potential to be affected. All residents will have call lights within reach while in bed unless deemed inappropriate by assesmmnt. <i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</i> III. Memos have been posted to remind staff to ensure call lights are within reach. Audits have been made to ensure commpliance. <i>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place and by what date the systemic changes will be completed?</i> IV. Audits will be completed by Nursing Administration on 50% of all residents weekly for 3 months and reports given to Quality Assurance committee monthly for review. <i>Completion date:</i> V. January 9, 2012 Enclosures: Memo and Audit</p>		

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	<p>to include the intervention of "Proper placement of soft touch call light."</p> <p>The Nurses Notes, dated 8/24/11 at 7:00 P.M., indicated, "Res fell today in shower room, I was sitting at nurses desk charting, CNA (name) rushed over to tell me (Resident D) had fallen in shower room. Upon arriving to (Resident D) she was lying on her back on the floor Res stated she forgot to lock her w/c brakes. Res denied bumping her head and denies pain or injury...Res was assisted back into w.c by staff and taken back to her room...Res will be monitored throughout the night tonight."</p> <p>The fall care plan was updated on 8/24/11 to include the intervention of "Back up breaks (sic) to w/c. Med [medication] change for elevated blood sugar."</p> <p>The Nurses Notes, dated 11/16/11 at 7:20 A.M., indicated, "CNA alerted this nurse res on floor in Station 3 DR [dining room]. On initial assessment while res on floor res stated I did this myself I was trying to stand to walk. Res denies hitting head and denies pain/discomfort...no visible injuries...."</p> <p>The fall care plan was updated on 11/16/11 to include the intervention of "labs requested UA [urinalysis]."</p>				

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F0323 SS=D	<p>The Nurses Notes, dated 11/22/11 at 7:40 P.M., indicated, "Res fell in living room area while attempting to ambulate out of w/c onto couch. Landed on L [left] hip...stated L hip a little sore...reddish bruise to L hip measuring 7" x [by] 3". Area visibly swollen raised 2"..."</p> <p>The fall care plan was updated on 11/22/11 to include the intervention of "Send to (name) ED [emergency department], labs/Xrays."</p> <p>The fall care plan was updated on 11/25/11 to include the intervention of "Up for PM meal no earlier than 5:45 P."</p> <p>In an interview with the Director of Nursing, on 12/13/11 at 9:40 A.M., she indicated Resident D was in the room and sight of the Activity Assistant when she stood and fell on 11/22/11 but the Activity Assistant could not reach her before she fell.</p> <p>3.1-35(g)(2)</p> <p>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>			

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	<p>Based on observation, interview and record review, the facility failed to implement the care plan to ensure a resident needing assistance with transfers and mobility had a call light in reach, and who required direct supervision when up, was provided with the supervision to prevent falls for 1 of 3 residents reviewed for falls in the sample of 4. (Resident D)</p> <p>Findings include:</p> <p>On 12/12/11 at 10:15 A.M., Resident D was observed to be asleep in a low bed with mattress extenders in place. The call light was observed to be in a basket on the bedside table approximately 4-5 feet from Resident D.</p> <p>The clinical record for Resident D was reviewed on 12/12/11 at 11:00 A.M. The record indicated Resident D had diagnoses that included but were not limited to CVA [cerebrovascular accident (stroke)] with hemiparesis and depression. The MDS [minimum data set] assessment, dated 11/2/11, indicated Resident D had moderately impaired cognition. Resident D required extensive assistance of two with bed mobility, transfers and ambulation. Resident D had fallen twice without injury since the prior assessment.</p>	F0323	<p>F 323 It is the policy of Garden Villa to ensure that the resident environment remains as free from accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Garden Villa submits the following action as evidence of its commitment to compliance with regulatory requirements. What corrective action will be accomplished for the resident found to be affected by the deficient practice? I. Resident D will have a call light within reach while in bed, as well as all other interventions that have been implemented for fall prevention. Staff to ensure all interventions are in place. <i>How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?</i> II. All residents have the potential to be affected. All residents will have call lights within reach while in bed unless deemed inappropriate by assesmmnt. <i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</i> III. Memos have been posted to remind staff to ensure call lights are within reach. Audits have been made to ensure commpliance with the placement of call lights in addition to other fall interventions. <i>How the corrective action will be monitored to ensure the deficient</i></p>	01/09/2012	

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	<p>A care plan, dated 5/7/08 and revised on 11/20/09, indicated a problem of "Risk for falls characterized by history of falls, alternating exotropia, hemiparesis, unsteady gait, (10/23/08) antidepressant therapy. 5/2/09 Fall from bed. 5/21/09 Fall from w/c." The interventions included but were not limited to "Assist resident with transfers with assist of 1 staff member. Call light within reach and answer promptly. Remind resident to call for assistance. Fall Intervention: 6/30/08 direct supervision at all times when up."</p> <p>A Fall Risk Assessment, dated 5/14/11, indicated a score of 22. The form indicated, "Total Score above 10 represents HIGH RISK."</p> <p>The Nurses Notes, dated 6/25/11 at 7:05 A.M., indicated, "Other Day Nurse informed this writer that resident had layed (sic) head down on table and w/c had slid out and she landed on her bottom. Denies hitting head...no apparent injury."</p> <p>The fall care plan was updated on 6/25/11 to include the intervention of "lock w/c when at DR table."</p> <p>The fall care plan was updated on 6/29/11 to include the intervention of "Dycem in w/c."</p>		<p><i>practice will not recur, i.e., what quality assurance program will be put into place and by what date the systemic changes will be completed?</i> IV. Audits will be completed by Nursing Administration on 50% of all residents weekly for 3 months and reports given to Quality Assurance committee monthly for review. Completion date: V. January 9, 2012 Enclosures:</p>	

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	<p>The Nurses Notes, dated 7/15/11 at 4:00 A.M., indicated, "Res [resident] was found on floor next to mats. Res stated I didn't fall; just slid off the mats. No apparent injuries noted. Will cont [continue] to monitor."</p> <p>The fall care plan was updated on 7/15/11 to include the intervention of "Proper placement of soft touch call light."</p> <p>The fall care plan was updated on 7/21/11 to include the intervention of "Toilet upon rising, before/after meals, 2P et [and] at HS [bedtime] et at 5A."</p> <p>The Nurses Notes, dated 8/8/11 at 1:40 A.M., indicated, "This nurse summoned to res room res noted sitting on floor next to ext [extension] matt [mattress] Res initially stated that she hit her head then later changed it and said that maybe she didn't neuro checks were initiated at this x [time] D/T [due to] prev [previous] statement...no apparent injury noted from slip off of matt."</p> <p>In an interview with the Director of Nursing, on 12/13/11 at 9:40 A.M., she indicated the incident on 8/8/11 had been deemed not a fall as Resident D had stated she was going to scoot herself all the way to the bathroom.</p>				

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	<p>area while attempting to ambulate out of w/c onto couch. Landed on L [left] hip...stated L hip a little sore...reddish bruise to L hip measuring 7" x [by] 3". Area visibly swollen raised 2"..."</p> <p>The fall care plan was updated on 11/22/11 to include the intervention of "Send to (name) ED [emergency department], labs/Xrays."</p> <p>The fall care plan was updated on 11/25/11 to include the intervention of "Up for PM meal no earlier than 5:45 P."</p> <p>In an interview with the Director of Nursing, on 12/13/11 at 9:40 A.M., she indicated Resident D was in the room and sight of the Activity Assistant when she stood and fell on 11/22/11 but the Activity Assistant could not reach her before she fell.</p> <p>In an interview with the Director of Nursing, on 12/13/11 at 10:10 A.M., she indicated Resident D's physician was wanting to increase her activity in an attempt to decrease her blood sugars. She indicated this was being attempted between the 16th and the 22nd of November when the two falls had occurred so they had stopped the attempt to increase activity.</p>				

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