

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 12/18/2012
--	---	--	---

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
F0000	<p>This visit was for the investigation of Complaint IN00120951.</p> <p>Complaint IN00120951 Substantiated. Federal/state deficiencies related to the allegations are cited at: F279 and F323.</p> <p>Survey dates: December 17-18, 2012</p> <p>Facility number: 002662 Provider number: 155684 AIM number: 200315930</p> <p>Survey team: Honey Kuhn, RN</p> <p>Census bed type: SNF: 33 SNF/NF: 20 Total: 53</p> <p>Census payor type: Medicare: 18 Medicaid: 13 Other: 22 Total: 53</p> <p>Sample: 3</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2 in regard to the Investigation</p>	F0000	<p>This Plan of Correction constitutes the written allegation of compliance for the deficiencies 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.</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: 155684	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/18/2012
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	
	of Complaint IN00120951. Quality Review completed on December 28, 2012, by Brenda Meredith, R.N.				

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 12/18/2012
--	---	--	---

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
F0279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review, observation and interview, the facility failed to develop a care plan to address the usage of a specialty mattress for 1 of 3 residents reviewed for care plans in a sample of 3. (Resident "B")</p> <p>Finding includes:</p> <p>During the initial tour, on 12/17/12 between 9:30 a.m. and 10:15 a.m., while accompanied by the ADNS (Assistant Director Nursing Services), Resident "B" was identified as sustaining a fall from a specialty bed</p>	F0279	The Plan of Care for "Resident B" has been revised to include appropriate interventions related to bowel movements and the use of the specialty bed. An audit has been conducted for all others residents' Plans of Care, that could be affected by this practice, this includes specific needs related to bowel movements and all specialty beds. All other affected residents' Plans of Care have also been revised. To prevent reoccurrence, The Skin and Weight Committee, a subcommittee of the Quality Assurance, which meets weekly, will audit all future residents who	01/17/2013

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 12/18/2012	
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>which resulted in fracture of the (L) (left) tibia and (L) fibula. The ADNS indicated due to the primary diagnosis of multiple sclerosis, the resident could no longer safely sit on a commode or use a bedpan and the fall from her bed occurred while in the bed, on her side, toileting. The resident was identified as unable to stand independently, dependent for mobility needs and interviewable.</p> <p>The record of Resident "B" was reviewed on 12/17/12 at 2:00 p.m. Resident "B" was admitted to the facility on 03/15/01, with diagnoses including, but limited to, multiple sclerosis, arthritis, constipation, neurogenic bladder with chronic Foley catheter, diabetes, spasticity, and depression.</p> <p>Review of the MDS (Minimum Data Set: a tool used to assess for care needs of residents) dated 08/31/12, indicated the resident was cognitive, required extensive assistance of 2 + (two plus) persons for: Bed mobility (how resident moves to and from lying position, turns side to side, and positions body while in bed ...) as well as transfers and toileting. The MDS indicated the resident's "Functional Limitation in Range of Motion -...limitation that interfered with daily</p>		<p>are placed on a specialty beds, to assure they are included on the Plan of Care. The MDS Coordinators will audit all Bowel and Bladder Assessments, in conjunction with each Plan of Care's scheduled review, to assure that all elimination issues are addressed. If absence, the Plan of Care will be updated and the omission reported to the Quality Assurance Committee quarterly. Both of these activities will be done indefinitely. The results of The Skin and Weight Committee's weekly audits will be reported to the Quality Assurance Committee quarterly. The Director of Nursing is responsible to carry out the Plan of Correction. Failure to do so will result in disciplinary action up to and including termination.</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 12/18/2012
--	---	--	---

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>functions or placed resident at risk of injury" was impairment of upper extremity (shoulder, elbow, wrist, hand) on one side and impairment of lower extremity (hip, knee, ankle, foot) on both sides.</p> <p>Review of nurses notes indicated Resident "B" had incurred a fall from bed on 11/11/12 at 11:00 a.m., which resulted in a fracture of the left tibia and fibula.</p> <p>Review of the current CNA assignment sheets, dated 12/16/12, indicated the resident was a Hoyer (an apparatus to mechanically transfer residents) transfer x 2 (2 assist). The "Cont/Incont (continent/incontinent)" area indicated, "cath (catheter)- CNA empty every 4 hours."</p> <p>Review of a care plan, titled, "Constipation-07/07/11," indicated an undated addition: "11. Res (resident) requests to lay on side p (after) supp (suppository) to facilitate results. Ensure res. is positioned in ctr (center of bed)." There was no care plan which addressed bowel movements.</p> <p>Review of care plans indicated there was no specific care plan in regards to the speciality mattress for Resident</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 12/18/2012
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>"B."</p> <p>CNA #5 was interviewed on 12/18/12 at 10:15 a.m. CNA #5 indicated she was the CNA normally assigned to Resident "B" and was providing care the day of the fall. CNA #5 indicated the bed's mattress was very slick. CNA #5 indicated she positioned Resident "B" as usual, turning her to her (R) (right) side. CNA #5 believed the resident was in the center of the bed and Resident "B" indicated she was also. The bed did not have siderails or bolsters. CNA #5 indicated she asked the resident if she was ok to leave alone, as usual, and the resident indicated she was. CNA #5 indicated she checked the resident twice without incident. CNA #5 indicated she entered the room and Resident "B" yelled and indicated the had fallen out of bed. When queried, CNA #5 indicated staff do not stay with Resident "B" while toileting. CNA #5 had not been inserviced on the mattress and staff do not do anything special with it.</p> <p>Resident "B" was interviewed on 12/18/12 at 10:30 a.m. Resident "B" was observed sitting in her motorized wheelchair. The resident's bed was observed to be in the lowest position and the surface of the mattress of a</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 12/18/2012
--	---	--	---

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>smooth/slick blue material. Resident "B" indicated she thinks she slid off the bed because she was not in the middle of the bed prior to being turned to her side for toileting needs. Resident "B" indicated she was aware of being too close to the edge of the bed when she began to fall. Resident "B" indicated the mattress surface was very slick but did not think the mattress was the cause of the fall but her placement on the bed. Resident "B" indicated one person would "normally" stay with her but "not consistently." Resident "B" indicated staff always ask if it's ok to leave her unattended before doing so.</p> <p>The DNS (Director Nursing Services) was interviewed on 12/18/12 at 2:00 p.m. The DNS indicated Resident "B" is the only resident in the facility utilizing this specific brand of speciality mattress. The DNS indicated the mattress, which preceded the DNS's employment with the facility, does not have any specific instructions in regards to usage. The DNS indicated staff were told to not adjust or change the bed settings from the current settings. The DNS indicated the facility did not have a policy and procedure on its usage and Resident "B" is not care planned for the mattress. The DNS indicated</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 12/18/2012
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>the surface was slick.</p> <p>During an interview on 12/18/12 at 1:30 p.m., the Administrator provided the speciality mattress manufacturer's manual. The Administrator indicated the facility obtained the mattress prior to his employ at the facility. The manual briefly addressed the following features: Comfort Control soft/firm; Cycle Timer, Alternating Therapy, and Auto Firm. Included in the preface of the manual: "NOTE: The back cover is a comprehensive list of Technical Support contact information for manufacturer's name)..." The information was vague and non-specific. The Administrator was queried if staff had ever been inserviced on the mattress and indicated they had not, to his knowledge.</p> <p>This Federal tag relates to Complaint IN00120951.</p> <p>3.1-35(a) 3.1-35(b)(1)</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 12/18/2012
--	---	--	---

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

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 12/18/2012
--	---	--	---

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
F0323 SS=G	<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 interviews, the facility failed to ensure a dependent resident was safely positioned in a speciality bed which resulted in a fall with fractures for 1 of 3 residents reviewed with a history of falls in a sample of 3. (Resident "B")</p> <p>Findings include:</p> <p>During the initial tour, on 12/17/12 between 9:30 a.m. and 10:15 a.m., while accompanied by the ADNS (Assistant Director Nursing Services), Resident "B" was identified as sustaining a fall from a speciality bed which resulted in fracture of the (L) (left) tibia and (L) fibula. The resident was identified as unable to stand independently, dependent for mobility needs and interviewable.</p> <p>The record of Resident "B" was reviewed on 12/17/12 at 2:00 p.m. Resident "B" was admitted to the facility on 03/15/01, with diagnoses including, but limited to, multiple</p>	F0323	<p>"Resident B" has not had any further falls, inclusive of her specialty bed. To assure this practice does not affect other residents, a policy and procedure has been developed regarding the use of specialty beds. Nursing staff have been inserviced regarding the policy and functionality of the beds. Introduction to specialty beds will be included in the new hire orientation and for other staff with the introduction of an new product. To prevent reoccurrence, licensed nurses will monitor and document specialty beds for proper functioning and resident positioning each shift. The Skin and Weight Committee, a subcommittee of the Quality Assurance Committee will monitor the license nurses' documentation monthly. The results of the Skin and Weight Committee's findings will be reported to the Quality Assurance Committee quarterly. This activity will continue indefinitely. The Director of Nursing is responsible to carry out the plan of correction. Failure to do so will result in disciplinary action, up to and including termination.</p>	01/17/2013

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 12/18/2012	
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>sclerosis, arthritis, constipation, neurogenic bladder with chronic Foley catheter, diabetes, spasticity, and depression.</p> <p>Review of the MDS (Minimum Data Set: a tool used to assess for care needs of residents) dated 08/31/12, indicated the resident was cognitive, required extensive assistance of 2 + (two plus) persons for: Bed mobility (how resident moves to and from lying position, turns side to side, and positions body while in bed ...) as well as transfers and toileting. The MDS indicated the resident's "Functional Limitation in Range of Motion -...limitation that interfered with daily functions or placed resident at risk of injury" was impairment of upper extremity (shoulder, elbow, wrist, hand) on one side and impairment of lower extremity (hip, knee, ankle, foot) on both sides.</p> <p>Review of nurses notes indicated: "11-11/12 11 a.m. Resident request to be placed on (L) side to move bowels. Stated "foot fell of (sic) bed causing chain reaction & (and) fell out of bed." Heard yell from room when staff arrived resident was lying on floor on back. C/O (complained/of) (arrow down: lower) body pain. ROM (range of motion) WNL (within normal</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 12/18/2012
--	---	--	---

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>limits) - (Physician's name) & mother (name) notified. New order x-ray (arrow down) body pain...."</p> <p>"11-11-12 6 p.m. Received copy of x-ray from (company name). called to (physician's name) N.O. (new order) received to send pt to (hospital name) for eval (evaluation)...."</p> <p>Review of the x-ray report indicated: "Radiology Interpretation...IMPRESSION: Interval fracture of the tibia, nondisplaced, with joint space effusion proximal tibia. It is difficult to evaluate...Left Tibia-Fibula: The fracture of the proximal tibia described as previously stated...Theses images do demonstrated a nondisplaced fracture of the proximal tibia and proximal fibula as well....IMPRESSION: 1. Fractures of the proximal tibia and fibula. 2. The shafts of the left tibia and fibula are intact."</p> <p>Review of a care plan, titled "Constipation-07/07/11," indicated an undated addition: "11. Res (resident) requests to lay on side p (after) supp (suppository) to facilitate results. Ensure res. is positioned in ctr (center of bed)."</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 12/18/2012
--	---	--	---

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>CNA #5 was interviewed on 12/18/12 at 10:15 a.m. CNA #5 indicated she was the CNA normally assigned to Resident "B" and was providing care the day of the fall. CNA #5 indicated the bed's mattress was very slick. CNA #5 indicated she positioned Resident "B" as usual, turning her to her (R) (right) side. CNA #5 believed the resident was in the center of the bed and Resident "B" indicated she was also. The bed did not have siderails or bolsters. CNA #5 indicated she asked the resident if she was ok to leave alone, as usual, and the resident indicated she was. CNA #5 indicated she checked the resident twice without incident. CNA #5 indicated she entered the room and Resident "B" yelled and indicated the had fallen out of bed. When queried, CNA #5 indicated staff do not stay with Resident "B" while toileting. CNA #5 had not been inserviced on the bed and staff do not do anything special with it.</p> <p>Resident "B" was interviewed on 12/18/12 at 10:30 a.m. Resident "B" was observed sitting in her motorized wheelchair. The resident's bed was observed to be in the lowest position and the surface of the mattress of a smooth/slick blue material. Resident "B" indicated she thinks she slid off</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 12/18/2012
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>the bed because she was not in the middle of the bed prior to being turned to her side for toileting needs. Resident "B" indicated being aware of being too close to the edge of the bed when she began to fall. Resident "B" indicated the mattress surface is very slick but did not think mattress was the cause of the fall but her placement on the bed. Resident "B" indicated one person will "normally" stay with her but "not consistently." Resident "B" indicated staff always ask if it's ok to leave unattended before doing so.</p> <p>The DNS (Director Nursing Services) was interviewed on 12/18/12 at 2:00 p.m. The DNS indicated Resident "B" is the only resident in the facility utilizing this brand of speciality mattress. The DNS indicated the mattress, which preceded the DNS's employment with the facility, does not have any specific instructions in regards to usage. The DNS indicated the facility did not have a policy and procedure on its usage and Resident "B" was not care planned for the mattress. The DNS indicated the surface was slick.</p> <p>This Federal tag relates to Complaint IN00120951.</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 12/18/2012
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	
	3.1-45(a)(2)				