

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155325	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/02/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  MEADOW VIEW HEALTH AND REHABILITATION CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 900 ANSON ST SALEM, IN 47167
---	--

(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 IN00107305.</p> <p>Complaint IN00107305 - Substantiated. Federal/State deficiencies related to the allegations are cited at F323.</p> <p>Survey dates: May 1 and 2, 2012</p> <p>Facility number:000218 Provider number: 155325 AIM number: 100274800</p> <p>Survey team: Anne Marie Crays RN</p> <p>Census bed type: SNF: 2 SNF/NF: 93 Total: 95</p> <p>Census payor type: Medicare: 9 Medicaid: 82 Other: 4 Total: 95</p> <p>Sample: 3</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC</p>	F0000	<p>Submission of the Plan of Correction does not Constitute an admission by this facility of any fact or conclusion set forth in the statement of deficiency. This Plan of Correction is being submitted, as required by law.We respectfully request this Plan of Correction servie as our Allegation of Compliance date being 5/11/2012.We would also like to request a desk review.</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:  155325	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/02/2012
---	--	--	--

NAME OF PROVIDER OR SUPPLIER  MEADOW VIEW HEALTH AND REHABILITATION CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 900 ANSON ST SALEM, IN 47167
---	--

(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
	16.2.  Quality review 5/04/12 by Suzanne Williams, RN			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155325		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/02/2012	
NAME OF PROVIDER OR SUPPLIER  MEADOW VIEW HEALTH AND REHABILITATION CENTE				STREET ADDRESS, CITY, STATE, ZIP CODE 900 ANSON ST SALEM, IN 47167			
(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.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident received adequate supervision and assistance when transported in a wheelchair, resulting in a fall with a laceration to the head requiring sutures, for 1 of 3 residents reviewed for falls, in a sample of 3. Resident A</p> <p>Findings include:</p> <p>1. On 5/1/12 at 1:45 P.M., during the initial tour, LPN # 1 indicated Resident A had fallen recently and received sutures to her head. LPN # 1 indicated Resident A was not interviewable.</p> <p>On 5/1/12 at 2:30 P.M., Resident A was observed propelling herself up and down the hallways. Resident A was observed to be sitting near the edge of her wheelchair seat. A sensor alarm was attached to her wheelchair.</p> <p>On 5/1/12 at 2:40 P.M., the clinical record of Resident A was reviewed. Diagnoses included, but were not limited to, senile</p>	F0323	<p>It is the intent of this facility to keep residents free of accidents/hazards as is possible and that each resident receives adequate supervision and assistance to prevent accidents. Resident (A) fell from her wheel chair on 4/27/12 when CNA #1 was trying to move resident out of the way of EMT's responding to a Coded Resident. CNA tried to pull W/C back to remove resident from the hall out of harms way and the CNA was attempting to act quickly due to the circumstances and event transpiring with another resident. Resident was sitting in W/C seat and when CNA pulled back on the W/C the resident slid out of W/C hitting the back of her head on the W/C. The resident is ambulatory around the unit in her W/C the resident has had no falls since since 10/20/11. Management to prevent further falls since that time</p>	05/11/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155325	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/02/2012
NAME OF PROVIDER OR SUPPLIER  MEADOW VIEW HEALTH AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 ANSON ST SALEM, IN 47167		
(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>dementia, history of falls, osteoporosis, and status post right hip pinning 10/11.</p> <p>A care plan, dated 1/18/12, indicated: "Fall/Injury Risk related to: Musculoskeletal, back pain, osteoporosis, Cognitive Impairment Factors, Dementia, Sensory Impairment Factors, visual...." The Interventions included: "Ambulation: 2A [two assist], Transfer: 2A...Chair alarm, Bed alarm...."</p> <p>A Minimum Data Set [MDS] assessment, dated 4/13/12, indicated Resident A had a short-term and long-term memory problem and was moderately impaired in cognitive skills for daily decision making. The MDS assessment indicated the resident required extensive assist of two+ staff for transfer, walking in room, and locomotion on the unit. A test for balance during transitions and walking indicated, "Not steady, only able to stabilize with staff assistance."</p> <p>An "Accident/Incident Report," dated 4/27/12 at 6:30 P.M., indicated, "...CNA [name of CNA # 1] was assisting res. [resident]. CNA pulled w/c [wheelchair] back to [illegible] and res noted to come out of chair. Res hit back of head on bottom part of w/c...Pain Yes, back of head...Confused...Laceration 3.5 x .4 x .1 cm [centimeters]...Res sent out for tx</p>		<p>have been successful, safety devices that were implemented have since been discontinued due to reduction plan being successful with no further fall. There was no deficient practice that took place; there was however an emergency situation that the CNA responded to move this resident out of the way of the emergency crew that was responding to a resident that was a full code. This was just a freak accident that happened during an emergency situation and the intent was for the safety of the resident and we can not care plan for emergency accidents. First Aide was administered for this resident A and 911 was called to transport resident to the emergency room for Treatment. Residents treatment and care plan was reviewed by Interdisciplinary Team and Therapy Screen was done 4/30/2012 and the resident was given a different W/C that is shorter and smaller than the W/C that resident had. No other residents have been found to have been affected by this incident/practice. CNA was in serviced on 4/30/2012</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155325	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/02/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  MEADOW VIEW HEALTH AND REHABILITATION CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 900 ANSON ST SALEM, IN 47167
---	--

(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>[treatment] eval [evaluation] to ER [emergency room]...."</p> <p>A Progress Note, dated 4/27/12 at 8:00 P.M., indicated, "Res back from ER, res received 4 stitches...stitches intact to back of head...."</p> <p>A Progress Note, dated 4/30/12 at 10:35 A.M., indicated, "IDT [interdisciplinary team] met to review fall on 4/27. CNA was assisting resident in w/c, pulled w/c back to move resident out of hallway, resident slid out of w/c. Resident hit back of head on w/c causing laceration to back of head...returned [with] 4 stitches to head. CNA inserviced on making sure resident is sitting completely back in w/c before assisting to move resident...."</p> <p>A Multi-Disciplinary Therapy Screening Tool, dated 4/30/12, indicated, "...Fall from w/c on 4/27/12...Pt [patient] cushion [and] w/c appropriate for safe positioning."</p> <p>On 5/2/12 at 10:00 A.M., during interview with the Director of Nursing [DON], she indicated she was not present during the resident's fall on 4/27/12, but from what she understood, the CNA was trying to pull the resident out of the hallway, and pulled the wheelchair back, then the resident fell and hit her head on</p>		<p>on transfers and the importance for making sure a resident is secure in W/C and that the resident knows what you are attempting to do before moving them even under emergency situations. In-service will be provided to all nursing staff concerning transfers in emergency situations when moving a resident out of harms way. DON/Designee will review fall risk residents weekly for 4 weeks and then on going through QA meetings monthly there after.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155325		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/02/2012	
NAME OF PROVIDER OR SUPPLIER  MEADOW VIEW HEALTH AND REHABILITATION CENTE				STREET ADDRESS, CITY, STATE, ZIP CODE 900 ANSON ST SALEM, IN 47167			
(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 wheelchair frame. The DON indicated that Resident A is "squirmy anyway," and she inserviced CNA # 1 that she should have told Resident A what she was doing prior to moving her.</p> <p>2. On 5/2/12 at 12:40 P.M., the DON provided the current facility policy on "Transferring, Turning, Positioning, and Seating Safety Process," dated March 2007. The policy included: "...Residents will be transferred, turned, positioned and seated according to their co-morbidities and individual abilities. [Name of corporation] strives to reduce the risk of injury to residents with the use of transferring, turning, positioning and seating techniques and wheelchair safety checks...Observe the following when assessing wheelchair positioning:...Upright posture without excessively leaning to the right or left, Shoulders level when placed on arm rests, Head in neutral upright position....Reposition resident as indicated to maintain proper wheelchair position...."</p> <p>This federal tag relates to Complaint IN00107305.</p> <p>3.1-45(a)(2)</p>						