

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/19/2012
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NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526
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F0000	<p>This visit was for the investigation of Complaints #IN00109565 and IN00109855.</p> <p>Complaint #IN00109855 - Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00109565-Substantiated: Federal/State deficiencies related to the allegation are cited at F323.</p> <p>Survey Dates: 6/18-19/12</p> <p>Facility number: 011150 Provider number: 155760 Aim number: 200831020</p> <p>Survey Team: Ellen Ruppel, RN</p> <p>Census bed type: SNF: 16 SNF/NF: 39 Total: 55</p> <p>Census payor type: Medicare: 16 Medicaid: 19 Other: 20 Total: 55</p> <p>Sample: 4</p>	F0000	<p>This is the requested Plan of Correcction for Complaint IN00109565. This constitutes the written allegation of compliance for the deficiencies cited.</p> <p>However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by state and federal law.The Maples at Waterford Crossing Health Campus desires this Plan of Correction to be considered as the facility's allegation of compliance. Compliance was effective June 19, 2012.The Maples at Waterford Crossing Health Campus respectfully requests this Plan of Correction be submitted as desk review for compliance for the deficiencies cited.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiencystatement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	<p>This deficiency also reflect state finding cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 6/19/12 Cathy Emswiller RN</p>				

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F0323 SS=D	<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, interviews and record review, the facility failed to ensure one of two residents in a sample of four, who was transferred by use of a wheelchair in the facility van, was secured properly to prevent accidents. Resident B</p> <p>Finding include:</p> <p>The clinical record for Resident B was reviewed on 6/18/12 at 5:00 a.m., and indicated the resident had been admitted to the facility in May of 2011. His diagnoses included, but were not limited to: cerebral palsy, left sided hemiparesis and pulmonary congestion.</p> <p>Hospital notes, of 2/27/12, indicated Resident B had been treated for a superficial skin tear to</p>	F0323	<p>F323 1. Resident B received medical treatment on 2/27/2012 for a superficial skin tear. No other residents were involved in this incident.2. Any resident that would have been transferred in the bus. No other deficiencies were noted related to this incident.3. Transporter (Bus Driver) was inserviced 6/18/2012 on appropriate securing of the wheelchair in the bus. Only transporters (Bus Driver) who have been trained will be able to secure a resident in the bus. The Executive Director or designess will monitor 5 residents per month to ensure safety straps are applied appropriately. The ED or designee will report findings monthky and as needed to QA and A.4. QA and A will monitor monthly for 3 months of 100% compliance acheived. QA and A will monitor for any trends and make reccomendations to the Plan of Correction as needed.5. Compliance completed 6/19/2012</p>	06/19/2012	

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	<p>the scalp following his wheelchair tipping over in the facility's wheelchair van.</p> <p>On 6/18/12 at 9:10 a.m., the van driver was queried about the way Resident B had been secured in the van on 2/27/12. She demonstrated how it had been secured using Resident B's wheelchair, with the Director of Nursing (DON) sitting in the chair. She secured the wheels with the ratchet tie downs and locked the wheels. Then she pulled the single strap, which was anchored to the van, across the lap of the DON and clipped it across his lap. When queried about a shoulder strap, she indicated the previous employee, who had oriented her, had not demonstrated the use of a shoulder strap. A sign attached to the back wall in the van indicated the single strap was to be used as a combination shoulder and lap belt.</p> <p>The Administrator, DON and Van Driver then investigated and</p>						

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	<p>determined the strap had not been used, on 2/27/12, as indicated in the information on the van wall.</p> <p>On 6/19/12 at 9:30 a.m., the DON provided information indicating all staff members who participated in van transfers, using wheelchairs for transport, had been inserviced regarding the proper securing of residents in wheelchairs.</p> <p>This federal tag relates to Complaint IN00109565.</p> <p>3.1-45(a)(2)</p>				