

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155736	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/25/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MILL POND HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1014 MILL POND LN GREENCASTLE, IN 46135
---	---

(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 the investigation of complaint numbers IN00156017 and IN00156790.</p> <p>Complaint IN00156017- Substantiated. Federal/State deficiencies related to the allegations are cited at F-309.</p> <p>Complaint IN00156790-Substantiated. Federal/State deficiencies related to the allegations are cited at F-323.</p> <p>Survey Dates: September 24 and 25, 2014.</p> <p>Facility number: 004550 Provider number: 155736 AIM number: 200526450</p> <p>Survey Team: Mary Weyls RN TC</p> <p>Census Bed Type: SNF/NF: 40 SNF: 20 Residential: 37 Total: 97</p> <p>Census by payor type: Medicare: 20 Medicaid: 23 Other: 54</p>	F000000	<p>Preparation or execution of this plan correction does not constitute admission or agreement of provider of the truth of facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the complaint survey (IN00156017 and IN00156790) on September 25, 2014. Please accept this plan of correction as the provider's compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</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: 155736	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/25/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MILL POND HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1014 MILL POND LN GREENCASTLE, IN 46135
---	---

(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>Total: 97</p> <p>Sample: 8</p> <p>These deficiencies also reflect State findings in accordance with 410 IAC 16.2-3.1</p> <p>Quality review completed 9/30/14 by Brenda Marshall, RN.</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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 interview and record review, the facility failed to ensure a thorough assessment when a resident had a change in condition for 1 of 1 resident reviewed for change in condition requiring hospitalization. (Resident B)</p> <p>Findings include:</p> <p>During review of Resident B's clinical record on 9/25/14 at 10 a.m. Diagnosis</p>	F000309	Resident B was kept confidential as part of the complaint survey. All residents could be affected by this alleged deficient practice. DHS/designee will evaluate assessments daily during clinical meeting on those residents identified as having a change of condition. ' DHS/Designee will re-educate all licensed nursing staff on the Guidelines for Change of Condition and Notification of MD on October 23, 2014. Medical	10/24/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155736	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/25/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MILL POND HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1014 MILL POND LN GREENCASTLE, IN 46135
---	---

(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>included, but was not limited to, COPD [chronic obstructive pulmonary disease] and a history of lung cancer with a recent right lower lobectomy.</p> <p>A "Skilled Nursing Assessment and Data Collection," dated 6/14/14 at 2:40 a.m. indicated the resident's blood pressure as 96/64. The form had a check mark indicating edema was present in both lower extremities but did not indicate the amount of edema or an assessment of lung sounds.</p> <p>A nurses note, dated 6/14/14 at 9:45 a.m., indicated the resident was pale, SOB (short of breath) with exertion and B/P was 88/62. The record did not indicate a lung assessment was completed and did not identify the extent of the edema. Documentation indicated the B/P was re-checked at 10 a.m. and was 94/68. The clinical record indicated the next assessment was more than 3 hours later, at 12:52 p.m. Documentation indicated the resident was pale, diaphoretic and nurse was unable to obtain a B/P. A physician's order was received to send the resident to the emergency room.</p> <p>A hospital record, received on 9/25/13 at 9 a.m., indicated the resident was admitted to the emergency room on 6/13/14 at 1:16 p.m. and had severe</p>		<p>Records/designee will audit resident charts to ensure a thorough assessment of those residents identified as having a change of condition. Audits will be completed as follows: 2 residents weekly per hall x 4 weeks, then 2 residents per hall every 2 weeks x 1 month, then 2 residents per hall monthly x 4 months. All audit results will be reported monthly at QA meeting x 6 months. After 6 months Medical Records Coordinator will audit 3 charts monthly with routine chart audits to assure continued compliance and those results will be reported monthly to QA committee.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155736		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/25/2014	
NAME OF PROVIDER OR SUPPLIER MILL POND HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1014 MILL POND LN GREENCASTLE, IN 46135			
(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>dyspnea, was hypotensive (low blood pressure), had a firm distended abdomen and 4 plus pitting edema of the right lower extremity involving the foot, ankle and lower leg and 3 plus pitting edema of the left lower extremity involving the foot, ankle and lower leg.</p> <p>During interview of the DON (director of nursing) on 9/25/14 at 3 p.m., the DON indicated the "Skilled Nursing Assessment and Data Collection" was a checklist filled out every 24 hours for any resident receiving medicare coverage. The "Skilled Nursing Assessment and Data Collection," dated 6/14/14 at 2:40 a.m., indicated the resident's B/P was 96/64 (which was a much lower B/P than the previous readings) and indicated edema in lower extremities. The assessment did not identify the extent of edema and did not indicate the resident's lung sounds were assessed. .</p> <p>An undated facility policy and procedure titled "CLINICAL DOCUMENTATION SYSTEMS Skilled Nursing Assessment and Data Collection" was received on 9/25/14 at 10:30 a.m. from the DON. Documentation indicated but was not limited to, "5. The form shall be completed daily for each day the resident is receiving skilled services." and "8. Staff not assigned to complete the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155736	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/25/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MILL POND HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1014 MILL POND LN GREENCASTLE, IN 46135
---	---

(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
F000323 SS=D	<p>assessment shall note on the back of the form any changes to the assessment and/or any pertinent information that occurs during their shift."</p> <p>This federal tag relates to complaint IN00156017.</p> <p>3.1-37(a)</p> <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 interview and record review the facility failed to ensure interventions to safely transfer a resident were implemented 1 of 3 residents reviewed for transfers assisted by staff and/or assistive devices (Resident A). Findings include:</p> <p>Resident A's clinical record was reviewed on 9/24/14 at 2 p.m. The record indicated the resident was admitted to the facility following surgery for a right femoral periosteal fracture (a broken bone</p>	F000323	<p>Resident A was kept confidential as part of the complaint survey. All residents with restrictions to weight bearing could be affected by this alleged deficient practice. Director of Health Service/designee will consult daily during clinical meeting with Physical Therapy Director to identify those residents who have weight bearing restrictions. Those residents will be assessed by DHS/designee and therapy to assure proper transfer techniques being utilized. Director of Health Services /designee will</p>	10/24/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155736	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/25/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MILL POND HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1014 MILL POND LN GREENCASTLE, IN 46135
---	---

(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>that occurs around the components or implants of a total hip replacement).</p> <p>A Physical Therapy Plan of Care, dated 8/31/14 was provided by the Physical Therapist on 9/24/14 at 3:20 p.m. Documentation indicated the resident suffered a R [right] femoral periprosthetic fracture on 8/24/14 due to a fall. The record indicated the fracture was surgically repaired prior to admission to the facility (s/p [status post] ORIF [open reduction internal fixation]). The plan of care indicated, " ...The patient complains of pain, difficulty in performing functional mobility and decreased functional ability in ADLs [activities of daily living]. Physical Therapy is needed for patient to increase level of independence..." The plan of care identified the resident as non weight bearing on the right lower extremity and required maximum assist with two people with transfers.</p> <p>A form titled "Therapy Communication to Nursing," dated 9/2/14, was received from the PT on 9/24/13 at 3:55 p.m. Documentation on the form indicated Resident A was "To stand pivot transfer with use of a pivot transfer disk getting into w/c [wheelchair] on left side of bed. Getting into bed from wheelchair on right side of bed. Use stand pivot transfer</p>		<p>re-educate all nursing staff on resident transfer techniques with return demonstration on October 24, 2014. Director of Health Care Services/designee will audit nursing staff to ensure proper transfer technique being utilized. Audits will be completed as follows: Observe 2 transfers per hall x 4 weeks, then 2 transfers per hall every 2 weeks x one month and then 2 transfers per hallway monthly x 4 months. All audit results will be reported monthly at QA meeting x 6 months. After 6 months Medical Records Coordinator will audit 3 charts monthly with routine chart audits to assure continued compliance and those results will be reported monthly to QA committee.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155736		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/25/2014	
NAME OF PROVIDER OR SUPPLIER MILL POND HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1014 MILL POND LN GREENCASTLE, IN 46135			
(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>disk coming on/off commode." Documentation under the title of "Precautions/Other "Will need [unable to determine word] to stand tall and use left arm to help pivot self."</p> <p>A Physical Therapy Plan of Care, dated 9/9/14, indicated "Continue with POC [plan of care] until weight bearing status changes."</p> <p>An undated "Nursing Assistant Assignment Sheet," received from the DON on 9/24/14 at 2:05 p.m., indicated Resident A required assistance of two staff for "mobility." The assignment sheet indicated, " ...Res [resident] to use pivot turn to w/c [wheelchair] NWB [non-weight bearing] to right leg-prefers to use BSC [bed side commode]"</p> <p>During interview of CNA #4, on 9/24/14 at 1 p.m., the CNA indicated she assisted the resident, on 9/7/14, prior to lunch, from the bed to her wheelchair. The CNA indicated the resident refused to use the transfer disk. The CNA indicated she transferred the resident by herself from the bed to the wheelchair by having the resident "put her arms around me." The CNA indicated the resident screamed and stated "It hurts when you move me." When queried why another staff was not summoned to assist with the transfer, the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155736	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/25/2014
NAME OF PROVIDER OR SUPPLIER MILL POND HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1014 MILL POND LN GREENCASTLE, IN 46135		
(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 stated, "I don't know."</p> <p>During interview of the DON (Director of Nursing) on 9/24/14 at 3 p.m., the DON indicated Resident A was transferred via the facility bus to her routine orthopedist visit on 9/10/14. The bus driver returned to the facility and informed the facility staff, the resident was being admitted to the hospital due to a fracture of her right leg.</p> <p>During interview of the Physical Therapist (PT) on 9/24/14 at 3:45 p.m., the therapist indicated he provided a communication sheet to nursing staff indicating the resident could use a pivot transfer disk to assist with transfers and staff were provided with training. The therapist indicated the resident continued with the status of non-weight bearing and, if the "disk" was not used, needed assistance of at least two staff for transfers.</p> <p>This Federal tag relates to complaint IN00156790.</p> <p>3.1-45(a)(2)</p>				