

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155658	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/25/2016
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NAME OF PROVIDER OR SUPPLIER  WESLEY MANOR HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1555 N MAIN ST FRANKFORT, IN 46041
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(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
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F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaint IN00197788.</p> <p>Complaint IN00197788 - Substantiated. Federal/State deficiencies related to the allegations are cited at F323.</p> <p>Survey date: April 25, 2016</p> <p>Facility number: 001152 Provider number: 155658 AIM number: 200221050</p> <p>Census bed type: SNF/NF: 84 Residential: 136 Total: 220</p> <p>Census payor type: Medicare: 9 Medicaid: 47 Other: 28 Total: 84</p> <p>Sample: 3</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed by 14454 on</p>	F 0000	<p>Wesley Manor Retirement Community is committed to providing high quality services to its residents and considers itself to be a partner with State and Federal regulatory agencies in order to continually improve care. We accept any and all feedback as an opportunity to look inward and to engage in continuous quality improvement activities. Although we acknowledge the cited tag and submit the required plan of correction, the listed corrections shall not be construed as an admission that Wesley Manor provides anything other than high quality services to our residents. The survey process is one of many means to assure quality of care and services and compliance with State and Federal regulations. As required, the facility submits the following plan of correction.</p>	
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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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F 0323 SS=D Bldg. 00	<p>May 2, 2016.</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 implement a fall care plan intervention for 1 of 3 residents reviewed for falls (Resident B).</p> <p>Finding includes:</p> <p>The record of Resident B was reviewed on 4/25/16 at 10:00 a.m. Diagnoses included, but were not limited to, history of falls and hypertension.</p> <p>A care plan, dated 10/07/15, revised 1/13/16, indicated Resident B was at risk for falls due to weakness, history of falls and psychotropic medication use. Interventions included, but were not limited to, up with assist of one staff member, a gait belt and 2-wheeled walker.</p> <p>A progress note, dated 3/25/16, indicated Resident B was ambulated by staff to the bathroom. The resident was using a walker and staff for assistance. The</p>	F 0323	<p>This tag was cited due to a staff member not following acare planned intervention for a resident who was at risk for falls and did fallwhile being assisted by staff. The facility has a Nurse Aide plan of care for eachresident. The intervention to use a gait belt for Resident B was written intothe Nurse Aide plan of care. Thefacility provides education to Nurse Aides at the time of hire regarding thefacility's policy for use of gait belts <b>(AttachmentA)</b>, for which an acknowledgement is signed by each newly hired Nurse Aide <b>(Attachment B)</b>. During the post fall investigation for Resident B, thefacility learned that the Nurse Aide who was assisting Resident B did, in fact,signed an acknowledgement form to indicate that she had been provided educationregarding the facility's policy for use of gait belts. In order to prevent further occurrences for this resident orwith this staff member, the facility provided counseling to the Nurse Aide whoprovided</p>	05/25/2016			

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	<p>resident fell in the bathroom and landed on top of her walker.</p> <p>During an interview on 4/25/16 at 1:05 p.m., the Director of Nursing indicated the wheel of Resident B's walker hit the transition piece between the bathroom and bedroom. Resident B continued to walk forward after the wheel stopped, causing the walker and Resident B to fall forward. She indicated a gait belt was not in use at the time.</p> <p>During an interview on 4/25/16 at 3:45 p.m., CNA (Certified Nursing Assistant) #1 and CNA #2 indicated Resident B required staff assistance to ambulate, along with a walker and a gait belt at all times.</p> <p>A current facility policy, titled, "Fall Risk Identification/ Fall Investigation," dated 8/19/14, provided by the Executive Director on 4/25/16 at 9:40 a.m., indicated "...2. CAA (Care Area Assessment) analysis during the MDS [Minimum Data Set] process will identify residents who are potentially at risk for fall. These residents will have prevention plans implemented...."</p> <p>This Federal tag relates to complaint IN00197788.</p>		<p>assistance to Resident B. In order to avoid this occurrence with any other residents or staff members, all nursing staff received copies of the facility's policy regarding the use of gait belts and signed an acknowledgment to indicate they received it. In order to monitor compliance with the facility's policy and systems for preventing falls, nurse managers and facility administration completed quality assurance audits (<b>Attachment C</b>) to make certain that nursing staff (1) have their gait belts with them when providing direct care; (2) are using their gait belts when required; (3) are using their gait belts appropriately. The facility will continue to perform these audits weekly and on various shifts over the next month, and monthly for the following 90 days, and only discontinue routine auditing when compliance is 100% on all shifts. Additionally, Nurses have audited each Nurse Aide plan of care to confirm that interventions to prevent falls are up-to-date and accurate for each resident. All of these actions had been taken prior to the survey. However, ongoing education and quality assurance audits will continue as specified above. The facility's in-service coordinator will make certain that gait belt use is emphasized in future in-services regarding fall prevention. All corrections</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	3.1-45(a)(2)		for this tag will be completed by May 25,2016.		