

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/22/2015
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NAME OF PROVIDER OR SUPPLIER VILLAGES AT OAK RIDGE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1694 TROY ROAD WASHINGTON, IN 47501
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F 0000 Bldg. 00	<p>This visit was for an Initial Certification and State Licensure Survey.</p> <p>Survey dates: June 18, 22, 2015</p> <p>Facility number: 013332 Provider number: pending AIM number: pending</p> <p>Census bed type: SNF: 2 SNF/NF: 0 Residential: 3 Total: 5</p> <p>Census payor type: Other: 2 Total: 2</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1</p>	F 0000	<p>Preparation or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged, or conclusions set forth on the statement of deficiencies.</p> <p>This plan of correction is prepared and executed solely because it is required by Federal and State law.</p> <p>This plan of correction is submitted in order to respond to the allegations of noncompliance cited during initial certification survey review concluding on</p> <p>6-22-2015</p> <p>Please accept this plan of correction as the provider's credible aggregation of compliance effective on or before 7-3-2015</p> <p>We respectfully request paper compliance for this survey review.</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>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 interventions were implemented, in that, a dependent resident identified as requiring the assistance of two staff for transfers was not provided the assistance of two staff for transfers for 1 of 2 residents, who met the criteria for review of accidents. (Resident #5)</p> <p>Findings include:</p> <p>On 6/18/15 at 11:39 A.M., Resident #5 was observed during a total mechanical lift transfer from a bed located next to the window to a wheelchair by CNA #1 and RN #5. The recliner was observed, at that time, to be located across the room next to the exit door.</p> <p>The clinical record of Resident #5 was reviewed on 6/18/15 at 10:11 A.M. The record indicated Resident #5 was admitted on 5/18/15 at 11:00 A.M. The diagnoses of Resident #5 included, but were not limited to, cerebrovascular</p>	F 0323	F 323 Resident #5 suffered no ill effects from the alleged deficiency. Resident #5 is transferred by a total mechanical lift since 5-19-2015 Completion Date 7-3-2015 All other residents are at risk to be affected by the alleged deficiency and through alterations in processes and in servicing the campus will 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. All residents safety plans of care have been reviewed to assure interventions in place to prevent accidents. Completion Date 7-3-2015 Nursing staff have been in serviced concerning following the care plan that include fall interventions and transfer needs. Systemic change is that Nursing Administration will review the initial nursing assesment the following day in our clinical care meeting to assure interventions are appropriate. Interdisciplinary approach has been taken to help assess and identify residents to prevent accidents and fall risks,	07/03/2015

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	<p>accident, muscle weakness, difficulty walking, dementia, depression, and obesity.</p> <p>The Admission Physician's Orders dated 5/18/15, included, but were not limited to, an order for, "Transfer with a sit-to-stand mechanical lift"</p> <p>An "Admission Assessment and Data Collection" form dated 5/18/15 indicated Resident #5 required the extensive assistance of two staff and/or a lift device for transfers. The assessment further indicated Resident #5 was not able to bear weight.</p> <p>A Lift Evaluation assessment dated 5/18/15 indicated Resident #5 required the extensive assist of two staff and a total mechanical lift for transfers.</p> <p>An Event Report dated 5/19/15 at 10:53 P.M., read as follows: "...staff was transferring resident from recliner to bed in the sit to stand lift...resident's arms started to give out and she said she could not hold on anymore so staff lowered her to floor...INTERVENTION - Immediate measures taken...transferring resident from recliner to wc [wheel chair] then from wc to bed so resident can get closer to bed..." The report lacked any documentation related to the number of</p>		<p>such as, pharmacological interventions. Initiate Physical and/or Occupational therapy services with changes of ADL's, and adjustments of care plans as individual needs change.</p> <p>Completion Date 7-3-2015 DHS /designee will monitor 2 random resident at risk for falls to assure safety interventions in place and interventions effective 3x a week for a month then, 1x a week for a month with results forwarded to QA committee monthly x6 months and quarterly thereafter for further suggestions/comments</p> <p>Completion Date 7-3-2015</p>				

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	<p>staff involved in the event.</p> <p>The Admission MDS (Minimum Data Set) assessment dated 5/25/15 indicated Resident #5 experienced moderate cognitive impairment, balance impairment, functional range of motion impairment to one side of the lower extremities and/or required the extensive assist of two staff for transfers.</p> <p>During an interview on 6/22/15 at 3:40 P.M., the Director of Nursing (DON) indicated Resident #5 was transferred with a sit to stand lift and one staff member because they had an order for that type of transfer. The DON then indicated, the admitting nurse must not have understood how to complete the form accurately, because a manufacturer's representative had indicated it was safe to transfer with a sit to stand lift using one staff. The Manufacturer's Instructions were requested of the DON on 6/22/15 at 3:30 P.M. and not provided.</p> <p>A letter from the manufacturer's representative for the sit-to-stand lift dated 11/25/14 was provided by the DON on 6/22/15 at 10:19 A.M., it read as follows, "...[Name of Healthcare company] does not make a formal recommendation on the number of caregivers required to use a mechanical</p>			

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	<p>lift and to transfer a patient....[Name of Healthcare company] recognizes that based on staff skill levels and individual patient factors each lift situation has different requirements for safe patient transfer(s). With that said we recommend that each facility establish an internal policy for assessing all residents and for providing the proper equipment..."</p> <p>The Guidelines for "SWAT" (Safe Work Action Team) Program were provided by a corporate representative on 6/22/15 at 4:31 P.M., and they read as follows: "...2. A "Resident Lift Assessment Profile" algorithm is available to assist with determining the type of lift most appropriate for the individual...6. Staff should seek the assistance of a second person for those residents'...as needed for safe handling...7. The Dependent Mechanical Lift shall be used for individuals who cannot bear weight, have poor trunk stability and require extensive assistance or total dependence with transfers..."</p> <p>3.1-45(a)(2)</p>			

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R 0000 Bldg. 00	<p>This visit was for an Initial State Residential Licensure Survey. This visit included an Initial Recertification and State Licensure Survey.</p> <p>Residential Census: 3 Sample: 3</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-5.</p>	R 0000	<p>Preparation or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged, or conclusions set forth on the statement of deficiencies.</p> <p>This plan of correction is prepared and executed solely because it is required by Federal and State law.</p> <p>This plan of correction is submitted in order to respond to the allegations of noncompliance cited during initial certification survey review concluding on</p> <p>6-22-2015</p> <p>Please accept this plan of correction as the provider's credible aggregation of compliance effective on or before 7-3-2015</p> <p>We respectfully request paper compliance for this survey review.</p>	
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R 0409 Bldg. 00	<p>410 IAC 16.2-5-12(d) Infection Control - Noncompliance (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter.</p> <p>Based on interview and record review, the facility failed to ensure a resident Health Statement had been obtained on admission to the facility, in that, a Health Statement was lacking in 1 of 3 clinical records reviewed. R #1.</p> <p>Findings include:</p> <p>The clinical record of R #1 was reviewed on 6/22/15 at 2:15 P.M. The admission orders of 5/20/15, and her current orders of June 2015, included but were not limited to, the statement of "... I CERTIFY THIS RESIDENT TO BE FREE OF COMMUNICABLE /INFECTIOUS DISEASE AND ACTIVE TUBERCULOSIS..." A line in front of the statement had been left blank indicating documentation was lacking that the resident was free of communicable disease.</p> <p>During an interview on 6/22/15 at 3:06 P.M., the Director of Health Services</p>	R 0409	<p>Residents #1 did not suffered ill effects from alleged deficient practice. The health statement was received from the physicaian.</p> <p>Completion Date 7-3-2015</p> <p>All residents have the potential to be affected by the alleged deficient practice and through alterations in processes, and in-servicing the nursing staff will ensure that residents are assessed to be free from communicable diseases and have the order upon admission.</p> <p>Completion Date 7-3-2015</p> <p>In service all nurses/CRMA's on importance that completing the admission statement/and/or receiving a MD order that all residents are free from any/all communicable disease upon admission to our campus.</p>	07/03/2015			

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	<p>(DHS) was made aware R #1's clinical record lacked documentation of a Health Statement indicating the resident was free of communicable disease. The DHS indicated the facility had a call out to the resident's physician in regard to the resident's Health Statement.</p> <p>On 6/22/15 at 4:03 P.M., the DHS indicated she would look for a facility policy in regard to resident Health Statements. On 6/22/15 at 5:15 P.M., no policy regarding resident Health Statements had been provided.</p>		<p>Completion Date 7-3-2015</p> <p>Systemic change: Nursing Administration will review the initial nursing orders the following day in our clinical care meeting to assure order received that all residents are free from cumminicable diseases.</p> <p>Completion Date 7-3-2015</p> <p>DHS /designee will monitor 2 random resident at risk for falls to assure order written upon admission 3x a week for a month then, 1x a week for a month with results forwarded to QA committee monthly x6 months and quarterly thereafter for further suggestions/comments Completion Date 7-3-2015</p>	