

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155205	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/10/2012
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NAME OF PROVIDER OR SUPPLIER  GREENCROFT HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1225 GREENCROFT DR GOSHEN, IN 46527
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: 10/1, 10/2, 10/3, 10/4, 10/5, 10/9, 10/10/12</p> <p>Facility number: 000112 Provider number: 155205 AIM number: 100288710</p> <p>Survey Team: Carol Miller, RN, TC Shelly Vice, RN Debra Kammeyer, RN</p> <p>Census Bed Type: SNF/NF: 142 SNF: 65 Total: 207</p> <p>Census Payor Type: Medicare: 20 Medicaid: 110 Other: 77 Total: 207</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on October 18, 2012 by Bev Faulkner, RN</p>	F0000	<p><b>F 000 Initial Comments</b> This plan of correction constitutes Greencroft Healthcare's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission or that a deficiency exists, or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. We respectfully request a desk review of this 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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F0156 SS=A	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes:</p>						

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	<p>A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the</p>			

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	<p>individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>Based on record review and interview, the facility failed to ensure that 2 of 3 residents reviewed for discharge from Medicare services received notification in a timely manner. (Resident #255 and #238)</p> <p>Findings include:</p> <p>Interview on 10-9-12 at 2:15 p.m., with Social Services #6 indicated the Notice of Medicare Provider Non-coverage (NOMNC) forms are explained and completed with the resident and the social service staff. The Social Service #6 indicated there is no policy for completing the NOMNC form and she would present 3 resident's NOMNC forms for review.</p> <p>On 10-10-12 at 9:30 a.m., the Notice of Medicare Provider Non-Coverage</p>	F0156	<p>The goal of the facility is to follow F 483.10 (b) (5)-(10), 483.10 (b) (1) Notice of Rights, Rules, Services, and Charges. The facility practice on Medicare discharges has been to follow Medicare guidelines. The facility has written a policy regarding Notification for Discontinuation of Medicare Services (Attachment J). Social Services staff have been inserviced on the Notification for Discontinuation of Medicare Services (Attachment K). The Director of Social Services will review discharges for the last 30 days for proper notification. The ADON or Assessment Nurse will monitor all Medicare resident discharges weekly for compliance. A report will be submitted to the Administrator weekly for the first month and then quarterly. Results will be reported to the QI committee quarterly for review and</p>	10/30/2012

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	<p>forms were left in the conference room and reviewed.</p> <p>The OMB Approval No. 0938-0953 form entitled Notice of Medicare Provider Non-Coverage (NOMNC) for Resident #255 indicated, "The effective date coverage of your current skilled nursing services will end: 5-30-12." The form was signed on 5-29-12.</p> <p>The OMB Approval No. 0938-0953 form entitled NOMNC for Resident #238 indicated, "The effective date coverage of your current skilled nursing services will end: 4-23-12." The form was signed on 4-23-12.</p> <p>The Director of Nursing Services (DNS) indicated on 10-10-12 at 3:07 p.m., there was no policy regarding the completion of a NOMNC form.</p> <p>3.1-4(a)</p>		<p>recommendation. Alleged date of compliance 10/30/2012.</p>		

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F0225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p>	F0225	<b>F 225 Investigate/Report</b>	10/30/2012			

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	<p>Based on interview and record review, the facility failed to report an alleged allegation of physical abuse (Resident #90) for 1 of 3 incidents of abuse and neglect, reviewed for reporting, in a sample of 3.</p> <p>Findings include:</p> <p>On 10/10/12 at 9:00 a.m., the facility Internal Investigation Form , dated 3/12/12, indicated Resident #90 had complained LPN #100 had been rough with the resident during a transfer to the commode. A handwritten statement by LPN #100 indicated "...I did help transfer her to the commode. She was wanting meds (medication) and I felt it would be best to wait a bit longer. Because I'm so short I wanted to make sure she did not fall . No intention to hurt her ..." A statement by Resident #90 included "...I yelled (at) them because I was in pain. I apologized. But they should not have been in a hurry...."</p> <p>On 10/2/12 at 2:00 p.m., an interview with Resident #90 in regard to how staff had treated the resident indicated back in April 2012 during a transfer from the bed to the commode the third shift RN "grabbed my hip and jerked me around and it caused</p>		<p><b>Allegations/Individuals</b></p> <p>The facility goal is to report all unusual occurrences as required by I C 4.3.12.2. CFR 483.1 (C) (2) the definition of abuse reads as follows: "Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment." This event was not reported due to the professional interpretation of "willful infliction." The staff person and the resident denied willful infliction. There were no further complaints from resident #90. On 3/12/2012 resident had complained about "rough" treatment during transfer and was immediately investigated and found of no "willful intent" to cause harm by nurse #100 during transfer, rather it was a hurried transfer to prevent a fall. Resident #90 has been interviewed twice since the survey (10/15/2012 and 10/24/2012). In the interview on 10/15 she was asked, "Do you believe you have intentionally been mistreated, disrespected or treated in an abusive manner since moving here?" On 10/24 she was asked, "Do you feel you have ever been abused while living here?" Her response was "no" on both occasions. One hundred twenty-two investigations were reviewed for accuracy in reporting with follow-up. All staff were in-serviced and reeducated on Abuse Reporting</p>				

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	<p>me pain."</p> <p>The Quarterly Minimum Data Set Assessment, dated 8/8/12, indicated the resident had no cognitive impairment.</p> <p>On 10/9/12 at 2:45 p.m., the Administrator was interviewed in regard to not reporting to the Indiana Department of Health Resident #90's alleged allegation of abuse. The Administrator indicated she immediately investigated the alleged allegation of abuse on 3/13/12 and did not feel she could substantiate the alleged allegation of abuse and felt LPN #100 could had been more gentle with the resident's transfer. The Administrator further indicated " I felt it was more of a safety issue...." and LPN #100 did not want the resident to fall during the transfer to the commode. The Administrator indicated the resident had apologized and the resident felt she had overreacted to the situation. The Administrator indicated the investigation of the alleged allegation of abuse was completed prior to LPN #100 returning to work.</p> <p>3.1-28(c)</p>		<p>Policy (Attachment A) to immediately notify their supervisor of any allegations or complaints from residents or families. The supervisor will immediately notify the Administrator or designee. The Administrator or designee will report allegations to the State and an investigation will be initiated immediately. This is ongoing. IC 4.3.12.2 was reviewed for clarity by the Administrator. Staff will continue to communicate any alleged abuse to their supervisor immediately and record on the 24 hour report sheet. The supervisor will notify the Administrator immediately and begin an internal investigation (Attachment B). Allegation reporting also occurs during AM report. The morning report form (Attachment C) tracks unusual occurrences reported at the morning meeting. The internal investigation form also identifies alleged violations that may occur (Attachment B). The Director of Nursing (DON) or designee will review the 24 hour report sheets daily for allegations from residents. The DON will confirm that all allegations have been reported to the Administrator or designee. The Administrator or designee will initiate appropriate investigations and report complaints to protect from harm within 24 hours of the event, unless earlier reporting is indicated under the Elder Justice</p>		

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			Act. The Administrator or designee will report the findings quarterly to the QI committee for review and recommendation. Alleged date of compliance October 30, 2012.	

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F0226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interview and record review, the facility failed to follow the facility policy in regard to reporting an alleged allegation of physical abuse (Resident #90) for 1 of 3 incidents of abuse and neglect, reviewed for reporting, in a sample of 3.</p> <p>Finding include:</p> <p>On 10/10/12 at 9:00 a.m., the facility Internal Investigation Form, dated 3/12/12, indicated Resident #90 had complained LPN #100 had been rough with the resident during a transfer to the commode. A handwritten statement by LPN #100 indicated "...I did help transfer her to the commode. She was wanting meds (medication) and I felt it would be best to wait a bit longer. Because I'm so short I wanted to make sure she did not fall . No intention to hurt her ..." A statement from Resident #90 indicated "...I yelled (at) them because I was in pain. I apologized.</p>	F0226	<p><b>F 226 Develop/Implement Abuse Neglect, Etc Policies</b></p> <p>The facility goal is to report all unusual occurrences as required by I C 4.3.12.2. CFR 483.1 (C) (2) the definition of abuse reads as follows: "Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment." This event was not reported due to the professional interpretation of "willful infliction." The staff person and the resident denied willful infliction. There were no further complaints from resident #90. On 3/12/2012 resident had complained about "rough" treatment during transfer and was immediately investigated and found of no "willful intent" to cause harm by nurse #100 during transfer, rather it was a hurried transfer to prevent a fall. Resident #90 has been interviewed twice since the survey (10/15/2012 and 10/24/2012). In the interview on 10/15 she was asked, "Do you believe you have intentionally been mistreated with disrespect or in an abusive manner since moving here?" On 10/24 she was asked, "Do you feel you have ever been abused</p>	10/30/2012			

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	<p>But they should not have been in a hurry...."</p> <p>On 10/2/12 at 2:00 p.m., an interview with Resident #90 in regard to how staff had treated the resident indicated back in April 2012 during a transfer from the bed to the commode the third shift RN "grabbed my hip and jerked me around and it caused me pain."</p> <p>The Quarterly Minimum Data Set Assessment, dated 8/8/12, indicated the resident had no cognitive impairment.</p> <p>The Abuse Prohibition Policy revised 5/07 was found on the conference room table on 10/1/12 at 4:00 p.m., and was reviewed and indicated "...The Administrator ...shall report any allegation of abuse...to the appropriate...agencies as follows:... Indiana State Department of Health shall be notified by fax within 24 hours of allegation.:</p> <p>On 10/9/12 at 2:45 p.m., the Administrator was interviewed in regard to not reporting to the Indiana Department of Health Resident #90's alleged allegation of abuse. The Administrator indicated she immediately investigated the alleged</p>		<p>while living here?" Her response was "no" on both occasions. One hundred twenty-two investigations were reviewed for accuracy in reporting with follow-up. All staff were in-serviced and reeducated on Abuse Reporting Policy (Attachment A) to immediately notify their supervisor of any allegations from residents or families. The supervisor will immediately notify the Administrator or designee. The Administrator or designee will report all allegations to the State and an investigation will be initiated immediately. This is ongoing. IC 4.3.12.2 was reviewed for clarity by the Administrator. Staff will commit to communicate any alleged abuse to their supervisor immediately and record on the 24 hour report sheet. The supervisor will notify the Administrator immediately and begin an internal investigation (Attachment B). Allegation reporting also occurs during AM report. The morning report form (Attachment C) tracks unusual occurrences reported at the morning meeting. The internal investigation form also identifies alleged violations that may occur (Attachment B). The Director of Nursing (DON) or designee will review the 24 hour report sheets daily for allegations from residents. The DON will confirm that all allegations have</p>		

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	<p>allegation of abuse on 3/13/12 and did not feel she could substantiate the alleged allegation of abuse and felt LPN #100 could had been more gentle with the resident's transfer. The Administrator further indicated " I felt it was more of a safety issue...." and LPN #100 did not want the resident to fall during the transfer to the commode. The Administrator indicated the resident had apologized and the resident felt she had overreacted to the situation. The Administrator indicated the investigation of the alleged allegation of abuse was completed prior to LPN #100 returning to work.</p> <p>3.1-28(a)</p>		<p>been reported to the Administrator or designee. The Administrator or designee will initiate appropriate investigations and report allegations to protect from harm within 24 hours of the event, unless earlier reporting is indicated under the Elder Justice Act. The Administrator or designee will report the findings quarterly to the QI committee for review and recommendation. Alleged date of compliance October 30, 2012.</p>		

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F0241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation and interview, the facility failed to ensure the urinary catheter bag (a device that holds urine) was covered with a dignity bag in 1 of 3 residents observed. (Resident #162)</p> <p>Finding include:</p> <p>On 10-1-12 at 11:40 a.m., during the initial tour, the urinary catheter bag for Resident #162 could be viewed from the hallway. Urine was observed in the bag. The bag did not have a dignity bag covering the urinary catheter bag.</p> <p>On 10-4-12 at 3:00 p.m., the urinary catheter bag was observed in Resident #162's room and it was not covered with a dignity bag.</p> <p>On 10-5-12 at 9:05 a.m., the urinary catheter bag for Resident #162 was observed from the hallway without a dignity bag covering its contents.</p> <p>On 10-5-12 at 1:35 p.m., the interview</p>	F0241	<p><b>F 241 Dignity and Respect of Individuality</b></p> <p>Resident #162's catheter bag was covered with a dignity bag. Resident #162 did not suffer any psychosocial distress. Unit rounds were conducted to make sure that all catheter bags were covered with dignity bags. Nursing staff were in-serviced and reeducated on dignity, reminding staff that a dignity bag must be used to cover catheter bags (Attachment I) NTL or designee will monitor for dignity issues daily during unit rounds and correct issues as needed. Abnormal findings will be reported on the Healthcare Community Report Sheets (Attachment E). This will be ongoing and reported to the DON or designee daily. The DON or designee will report the findings quarterly to the QI committee quarterly for review and recommendations. Alleged date of compliance October 30, 2012.</p>	10/30/2012			

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	<p>with CNA #1 on the west hallway of Gables indicated if a resident has a Foley catheter bag it's to be covered in a dignity bag at all times.</p> <p>Interview with hospice nurse #2 on 10-5-12 at 2:28 p.m., indicated hospice staff is aware the Foley catheter bag is to be in a dignity bag.</p> <p>3.1-3(t)</p>			

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F0315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on interview, and record review, the facility failed to obtain an order from the physician in regard to the resident's placement of an indwelling urinary catheter. This deficiency affected 1 of 2 residents with an indwelling urinary catheter (Resident #12).</p> <p>Finding include:</p> <p>The record of Resident #12 was reviewed on 10/5/12 at 10:00 a.m., and indicated Resident #12's diagnoses included, but were not limited to, debility, depression, and mild cognitive impairment.</p> <p>The hospital Hospice Progress Notes, dated 8/30/12, indicated the resident was readmitted to the facility from the hospital on hospice with an indwelling urinary catheter.</p>	F0315	<p><b>F 315 No Catheter, Prevent UTI, Restore Bladder</b></p> <p>Resident #12 was readmitted from IU Health Goshen Hospital (IUHGH) to Greencroft on 8/30/2012 with an indwelling catheter and hospice care. The catheter was discontinued on 10/3/2012. Resident #12 did not suffer and adverse effects from the use of an indwelling catheter. Charts of all residents with indwelling catheters were reviewed to make sure a physician's order was on the chart and an appropriate diagnosis was in place for the use of a catheter. All licensed nurses were in-serviced and reeducated on obtaining a physician order for the use of an indwelling catheter (Attachment D). Nurse Team Leader or designee will monitor that a physician's order is on the chart prior to placement of an indwelling catheter and upon admission or</p>	10/30/2012	

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	<p>The hospital Patient Transfer Form included Physician's Orders, dated 8/30/12, did not indicate the resident had an indwelling urinary catheter.</p> <p>The facility's Nurse's Notes, dated 8/30/12 at 10:00 p.m., indicated the resident's indwelling urinary catheter was draining light yellow urine.</p> <p>On 10/5/12 at 11:00 a.m., an interview with RN #26 in regard to the indwelling urinary catheter indicated she had reviewed the resident's chart and was unable to find a current Physician's Order for the indwelling urinary catheter. RN #26 further indicated Resident #12's physician should had been notified and a Physician's Order received for the indwelling urinary catheter.</p> <p>The Nursing Physician Services Policy found on the conference table on 10/5/12 at 3:00 p.m., and reviewed indicated "...Physicians will be notified ...when the resident's medical or physical conditions warrants physician notification...."</p> <p>3.1-41(a)(1)</p>		<p>readmission to the facility. This will be reported via the Healthcare Community Report Sheets (Attachment E) daily. This will be ongoing and reported to the DON or designee.</p> <p>The DON or designee will report the findings to the QI committee quarterly for review and recommendations.</p> <p>Alleged date of compliance October 30, 2012.</p>				

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F0329 SS=D	<p><b>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</b></p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review, the facility failed to obtain an order to attempt a gradual reduction for antipsychotic medications for 1 of 10 residents reviewed for unnecessary medications (Resident #188)</p> <p>Finding include:</p> <p>The clinical record of Resident #188 was reviewed on 10-5-12 at 2:50 p.m. The resident's diagnoses included but</p>	F0329	<p><b>F329 Unnecessary Medications</b></p> <p>A fax request was sent to the physician on 10/22/2012 to attempt to reduce or obtain a clinical rationale for not attempting a dose reduction of Resident #188 antipsychotic medications per federal guidelines. The physician wrote a progress note on 10/25/12 providing clinical rationale to continue current dose of the antipsychotic medication. Charts of residents receiving antipsychotic medications were reviewed to make sure</p>	10/30/2012	

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	<p>not limited to: vascular dementia, anxiety, depression, osteoporosis, dementia with behavioral disturbances, and osteoarthritis.</p> <p>On 10-5-12 at 3:00 p.m., the pharmacy review form for Resident #188 titled "Signature Log for Medication Review" indicated on 4-30-12 a note to the physician and facility to attempt a gradual dose reduction on Zyprexa and on 8-30-12, the pharmacist made a recommendation to reduce Zyprexa due to a triglyceride test being high at 419 with the normal range being within 0-150.</p> <p>A "Note to Attending Physician/Prescriber," dated 4-30-12, indicated the resident "is due for review of her psychoactive regimen and potential trial dose reduction. In addition to her cognitive enhancing therapy she receives Zyprexa 2.5 mg hs(at night) and Lorazepam 0.5 mg bid (twice a day). Review by behavior management team finds paranoia has improved. Her suspiciousness appears to have improved as well. In effort to ensure lowest effective regimen is being utilized, may we reduce Zyprexa 2.5 mg to every other day and continue Lorazepam unchanged?" The physician's</p>		<p>recommendations for gradual dose reductions were accepted or a clinical rationale was provided for declined recommendations. A letter was mailed to physicians who follow patients at Greencroft Goshen (Attachment H). The Consultant Pharmacist reviews charts monthly and makes recommendations to physicians. NTL will monitor pharmacy recommendations to make sure that physicians have responded and accepted or provided a clinical rationale for their decision. A physician who does not provide the necessary documentation to the facility to maintain compliance with the federal regulation will be discussed with the Medical Director for further recommendation and direction. This will be ongoing and reported to the DON via the Healthcare Community Report Sheet (Attachment E). The DON or designee will report findings quarterly to QI committee quarterly for review and recommendations. Alleged date of compliance October 30, 2012.</p>				

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	<p>response was check marked "disagree continue same patient stable but still has yelling out spells."</p> <p>The pharmacy form titled "Note To Attending Physician/Prescriber," dated 8-30-12, indicated that Resident #188's "triglyceride level has been increased from 267 on 7-12-11 to 419 on 7-10-12. Of concern is her use of Zyprexa 2.5 mg hs (at night). The antipsychotic agents have a risk of increased Triglycerides which increases risks of TIA (transient ischemic attack), stroke, and cardiovascular events. To reduce significant risks associated with current medication, please consider tapering her off of Zyprexa and follow for change of behaviors."</p> <p>The physician's response was checked "disagree" with the rationale listed as "see chart," dated 9-5-12. No other notes from the physician were noted in the record (chart) on 9-5-12.</p> <p>On 10-5-12 at 3:30 p.m., review of care plan indicated the problem: psychotropic drug use and potential for adverse effects related daily use of psychotropic meds Lorazepam and Zyprexa The intervention indicated,</p>			

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	<p>to evaluate effectiveness and side effects of medications for possible decrease/elimination of psychotropic drugs.</p> <p>On 10-10-12 at 4:10 p.m., interview with the Director of Nursing Services (DNS) indicated Physician #7 has been approached in the past regarding the pharmacist's recommendations and his unwillingness to proceed with the recommendations. The DNS indicated that Medical Director for the facility may have talked to Physician #17 but was unclear about what was discussed.</p> <p>On 10-10-12 at 4:20 p.m., a policy titled Medical Director was reviewed and indicated the medical director is responsible for: "acting as a liaison between administration and attending physicians, and assuring that physicians services are in compliance with current rules, regulations, and guidelines concerning long-term care."</p> <p>3.1-48(b)(2)</p>			

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F0425 SS=D	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on interviews and record review, the facility failed to ensure medications were signed or initialed as administered to the resident in accordance with facility policy. (Resident #10)</p> <p>Findings include:</p> <p>On 10-10-12 at 10:30 a.m., review of the Medication Administration Record (MAR) for Resident # 10 indicated that on 10-5-12, two 8:30 a.m. medications (Celexa and Colchicine) were not initialed as given. On 10-6-12 and 10-9-12, the 2:30 p.m.</p>	F0425	<p><b>F 425 Pharmaceutical Svc-Accurate Procedure</b></p> <p>Staff members involved confirmed that resident #10 received medications, however they were not initialed on the MAR. Staff members involved were counseled.</p> <p>An audit of MAR's was conducted to make sure that all medications and treatments were administered and that the MAR was initialed to reflect this. All licensed nurses and qualified medication aides (QMA) were in-serviced and reeducated on medication administration (Attachment F). It is the responsibility of each licensed</p>	10/30/2012			

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	<p>doses of Sinemet were not initialed as given.</p> <p>On 10-10-12 at 10:35 a.m., interview with RN #5 indicated that she couldn't verify if the medication had been given to Resident #10 on the dates in question due to no initials in designated signature box (initials of nurse indicates medication had been given). The RN stated, "I wasn't working that day."</p> <p>On 10-10-12 at 11:50 a.m., the Policy and Procedure titled "Administration of Drugs" was review and indicated "The nurse administering the medication must initial resident's MAR on the appropriate line and date before administering the next resident's medication."</p> <p>On 10-10-12 at 2:15 p.m., the DNS indicated that he couldn't verify the medications were given since there was no initials indicating the medications had been given on the days and times questioned. He tried to call the nurses that worked those days and was unable to get hold of them. He indicated that no initials in box provided for the dates and times in questioned means the medication wasn't given. He indicated the nurses are to initial the MAR after the</p>		<p>nurse or QMA administering medications to residents to have their initial on the MAR and to audit the MAR at the end of each shift worked.</p> <p>NTL will monitor MAR once weekly to make sure that all medications were administer correctly. Licensed nurses and QMA who failed to initial all medications and/or treatments that were administered will be counseled. The findings will be monitored using the Healthcare Community Report sheet (Attachment E). Findings will be reported to the DON or designee. The DON or designee will report the findings to the QI committee quarterly for review.</p> <p>Alleged date of compliance October 30, 2012.</p>				

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	<p>medication has been given. The DNS indicated that the medications were probably given and the nurses just forgot to initial the box; however there was no way to know.</p> <p>3.1-25(b)(3)</p>			

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F0441 SS=D	<p><b>483.65</b> <b>INFECTION CONTROL, PREVENT SPREAD, LINENS</b> The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. <b>Based on interview, observation, and record review, the facility failed to</b></p>	F0441	<b>F 441 Infection Control Prevent Spread Linens</b>	10/30/2012			

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	<p>obtain an order to place a resident in contact isolation. (Resident #245)</p> <p>Findings include:</p> <p>The clinical record of Resident #245 was reviewed on 10-3-12 at 12:15 p.m. The resident's diagnoses included but not limited to: right femoral below the knee popliteal bypass with arterial graft, right leg osteomyelitis, hyperglycemia, right heel chronic ischemia ulcers-vascular, vancomycin resistant enterococcus (VRE) and severe peripheral vascular disease.</p> <p>On 10-3-12 at 12:14 p.m., during initial tour, an observation of signage outside of Resident #245's room indicated the resident was in isolation (unable to come out of room) with contact precautions (those entering room must wear Personal protective equipment (PPE) and remove before exiting room).</p> <p>On 10-3-12 at 12:20 p.m., interview with Resident # 245 indicated he had been in isolation due to his right leg problem since admission and didn't like being confined to his room.</p> <p>On 10-3-12 at 12:16 p.m., review of</p>		<p>Resident #245 was readmitted to Greencroft Goshen from IUHGH on 9/29/2012 with diagnosis including vancomycin-resistant enterococci (VRE) in the wound and stool. Physician progress note dated 10/1/2012 states resident is in isolation due to VRE.</p> <p>Chart audits of all residents in isolation were audited to make sure there was a physician order for contact isolation.</p> <p>Licensed nurses were in-serviced and reeducated on Isolation Precaution Policy and Procedures (Attachment G). A physician order will be obtained for all residents requiring isolation.</p> <p>NTL will audit all residents charts requiring isolation to make sure a physician order is obtained. This will be ongoing. Results will be reported to the DON or designee via the Healthcare Community Report Sheets (Attachment E). The DON or designee will report the finding to the QI committee quarterly for review and recommendations.</p> <p>Alleged date of compliance October 30, 2012.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155205	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/10/2012
NAME OF PROVIDER OR SUPPLIER  GREENCROFT HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1225 GREENCROFT DR GOSHEN, IN 46527		
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	<p>the clinical record indicated the resident was in contact isolation. No order for contact isolation was written or obtained from the physician.</p> <p>10-9-12 at 1:30 p.m., the Policy and Procedure titled Isolation Precautions revised 11/07 was received from the Director of Nursing Services (DNS), indicated an order will be obtained from the physician for the type of isolation.</p> <p>On 10-10-12 at 2:15 p.m., interview with DNS indicated there was no order for the contact isolation for Resident # 245. The DNS stated the policy indicated the facility should have an order for placing a resident in contact isolation and confined to the room</p> <p>3.1-18(b)(2) 3.1-18(j)</p>				