STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	155783		06/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENLEAF HEALTH CAMPUS	1201 E BEARDSLEY ELKHART, IN 46514

(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
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00202415. Complaint IN00202415 - Substantiated. Federal/State deficiencies related to the allegation are cited at F279 and F323. Survey dates: June 15 and 16, 2016 Facility number: 002661 Provider number: 155783 AIM number: 201056540 Census bed type: SNF: 40 SNF/NF: 9 Residential: 50 Total: 99 Census payor type: Medicare: 20 Medicaid: 9 Other: 20 Total: 49 Sample: 3 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency 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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	Quality Review completed by 14454 on June 23, 2016.			
F 0279 SS=D Bldg. 00	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).			
	Based on record reviews and interview, the facility failed to develop a Care Plan to address a cognitively impaired, dependent resident's desire to sit independently outside the facility unattended for 1 of 1 residents reviewed for Care Plans in a sample of 3. (Resident "D") Finding includes:	F 0279	**Date: July 5, 2016** **F-279** **Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice:** **Resident D careplan has been**	07/15/2016

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	The record of Resident "D" was reviewed on 06/15/16 at 9:30 a.m. Resident "D" was admitted to the facility on 02//29/12. The diagnoses included, but were not limited to: cardiovascular disease, hypertension, difficult ambulation, diabetes, advanced dementia, chronic kidney disease and chronic BLE (Bilateral Lower Extremity). The most recent Quarterly MDS (Minimum Data Set) assessment, dated 05/06/16, indicated Resident "D" was not cognitively intact, short term and long term memory were OK, required extensive assistance of 1 for transfers and toileting, and limited assistance of 1 for ambulation and locomotion for movement between locations in the facility. A "Progress Note" indicated: "06/06/16 11:00 a.m. Outside fall: resident requested to be placed outside to enjoy the weather; call was made to nurse who agreed that resident could go outside. Wheelchair placed outside, brakes locked, and was under supervision from front office staff. Resident was then found on ground apparently attempting to transfer self." The Progress Notes indicated the resident		**updated to reflect residents desire to be outside and appropriate interventions to reduce risk factors.** **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:** **All residents were reviewed for desire to by outside. Residents that voiced choice of being outside were reviewed for risk factors and safety. Careplans of individuals who desire to go outside were updated to reflect desire and appropiate supervision and interventions to promote safety.** **Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur:** **Licensed nursing staff, activities staff, and social services were re-educated to determine residents choice to go outside facility and to assess risk factors associated going outside on admission/readmission and with changes in condition, and updating careplans to reflect**	

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	was being treated with antibiotics for a UTI (Urinary Tract Infections). The ED (Executive Director) was interviewed on 06/15/16 at 2:30 p.m. The ED indicated the fall investigation noted Resident "D" was seated outside a maximum of 6 minutes prior to a Hospice employee entering the building to inform staff the resident was on the sidewalk towards the entry drive. A hospice employee reported seeing the resident change position but did not actually witness the fall. The ED indicated Resident "D" refuses to sit in the enclosed courtyard and requests sitting outside in the sun and prefers to be left alone. The ED indicated the fall was unwitnessed. The ED indicated the facility attempts to recognize the Resident's right to sit in an area of her choice within visual sight of staff and the resident had been doing so since admission to the facility in 2012. The ED indicated the resident was to be checked by staff every 10 minutes and if she needed assistance, she was to raise her hand. The DNS (Director Nursing Services) indicated, on 06/16/15 at 10:50 a.m., Care Plans viewed in the computer record were those in effect for Resident "D." There was no Care Plan in the record to		**choices and interventions.** **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** **DHS/designee will audit admission/re-admission charts to ensure residents are assessed for desire to go outside, risk factors, and interventions, and careplans are updated timely to reflect on admission/readmission. Monday thru Fri 5 residents weekly times 4 weeks then 3 residents weekly times 4 weeks then 1 resident weekly times 4 weeks. Audits will be reviewed in Quality Assurance meeting monthly for 3 months and if findings are 100% compliance then consider system working and if not then re-education of Licensed nurses as needed.**	

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	address the dependent resident's desire to sit outside the building. This Federal tag relates to Complaint IN00202415. 3.1-35(a) 3.1-35(b)(1)			
F 0323 SS=G Bldg. 00	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 record review, observation and interview, the facility failed to ensure adequate supervision for a cognitively	F 0323	**Resident D has had no recorded falls in over 6 months. Resident D will have her choice and self**	07/15/2016

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	impaired, dependent resident which resulted in a fall. The resident sustained a laceration to the (L) (Left) middle finger which required sutures and an abrasion to the forehead. This deficiency affected 1 of 1 dependent residents in a sample of 3 residents who were reviewed for falls. (Resident "D") Finding includes: The record of Resident "D" was reviewed on 06/15/16 at 9:30 a.m. Resident "D" was admitted to the facility on 02//29/12. The diagnoses including, but were not limited to: cardiovascular disease, hypertension, difficult ambulation, diabetes, advanced dementia, chronic kidney disease, and chronic BLE (Bilateral Lower Extremity). The most recent Quarterly MDS (Minimum Data Set) assessment, dated 05/06/16, indicated Resident "D" was not cognitively intact, short term and long term memory were OK, required extensive assistance of 1 for transfers and toileting, and limited assistance of 1 for ambulation and locomotion for movement between locations in the facility. A "Progress Note" indicated: "06/06/16 11:00 a.m. Outside fall:		**determination protected as referenced in the CMS SUMMARY OF REVISED GUIDELINES FOR F323-ACCIDENTS AND SUPERVISION, "… not all accidents are avoidable; and it is reasonable to accept some risks as a trade off for the potential benefits, including resident diginity, self-determination, and control over one's daily life". In this situation the resident voiced her desire to go outdoors and has utilized this right without injury or harm since her admission in 2012. Resident D scored a 9/15 on BIMS assessment that was completed 6.15.2016, which indicates that she is "not cognitively intact but her long and short term memory are OK" per MDS dated 5/6/2016. On the day in question, Resident D approached AP/HR regarding her desire to go outdoors. AP/HR then called Resident D's attending nurse and asked if she could go outside. Nurse assessed resident and established that she was able to go outdoors as per her usual. The resident was then brought outside and stragetically placed in sitting area at facilities entry way per her request and with in direct visibility of facility staff. Office**	

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	resident requested to be placed outside to enjoy the weather; call was made to nurse who agreed that resident could go outside. Wheelchair placed outside, brakes locked, and was under supervision from front office staff. Resident was then found on ground apparently attempting to transfer self." The Progress Notes indicated the resident was being treated with antibiotics for a UTI (Urinary Tract Infections). The "ER [Emergency Room] PHYSICIAN REPORT," dated 06/06/16 11:18 a.m., indicated: "...the patient was reportedly was in a wheelchair outside of the nursing home and was unattended [sic] the patient apparently attempted to stand up and fell forward. The patient has abrasions to the face and nose as well as a laceration to her left middle finger....Extensive workup here in the emergency department reveals evidence of a urinary tract infection. CT [Computerized Tomography] of the head neck and face bones show no evidence of acute abnormalities....left hand x-ray shows no fracture...a 1 cm [centimeter]...of the 3rd middle finger. The patient has excellent flexion and extension. I do not appreciated [sic] any acute tendon injuries." The laceration was closed: "...#3 sutures, with 5-0 nylon,		**staff visualized Resident D several times prior to the fall. Resident D's incident occurred at a maximum of 6 minutes after last check. Within the facility resident propels self independently as desired. Resident is checked on within the facility at least every 2 hours per nursing standards. This indicates that the resident was checked on at a much greater frequency outdoors than when inside. Resident had no alarms or devices in place that would require her to have direct supervision outside. Resident was not taking any medications that would impair her cognition or affect her dexterity. In conclusion, findings indicate that the resident was at no greater risk of harm outside than she would have been inside the facility. The resident was receiving greater supervision outside the facitility at the time of the incident than she would have been inside as previously stated. A fall inside of the community may/could yield the same or greater injury with/without greater response time. This qualifies no change in supervision inside or outside the facility.Corrective Actions accomplished for those residents found to have**	

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	running technique." During a facility walk through on 06/15/16 at 10:00 a.m., Resident "D" was seated in a wheelchair in the 200 Unit common area in front of the TV. The resident's head was bent forward and a healing abrasion, approximately 1.5 inches in width and length was noted on the forehead and no other facial lacerations, bruising or discolorations were visible. During an interview on 06/15/16 at 1:45 p.m., the Business Office Employee (BOE: Front Office) #1 indicated, with permission from the Unit RN (Registered Nurse), Resident "D" was wheeled outside the facility to the sidewalk to the East of the front lobby window and the brakes were applied to the locked position. BOE #1 indicated Resident "D" could be observed through the glassed window of the Business Office, across the front lobby through the lobby window to the outside if the BOE raised slightly from her desk chair. The desk of BOE #1 faced West under the Business Office window and the employee had to turn to her left and look South to visualize through the area. BOE #1 indicated she had visualized Resident "D" several times.		**been affected by the alleged deficient practice: Resident D assessed for risk factors associated with her desire to be outdoors. It has been established that she will have supervision while outdoors until assessment reflects that risk factors are no longer present. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents were reviewed for desire to by outside. Residents that were determined to want to go outside were reviewed for risk factors and safety. Those that presented with risk factors have and appropriate interventions put into place. Care plans of individuals who desire to go outside have updated to reflect desire and appropriate supervision and interventions to promote safety. Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur: Licensed nursing staff, CRCAs, activities staff, and social services were re-educated to follow the care plans of residents who choose to go outside facility are in place. How the corrective measures will be monitored to ensure the alleged deficient**	

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	During an interview on 06/15/16 at 2:30 p.m., the ED (Executive Director), indicated the fall investigation noted Resident "D" was seated outside a maximum of 6 minutes prior to a hospice employee entering the building to inform staff the resident was on the sidewalk towards the entry drive. The hospice employee was reported to see the resident change position but did not actually witness the fall. The ED indicated Resident "D" refuses to sit in the enclosed courtyard and requests sitting outside in the sun and prefers to be left alone. The ED indicated the resident was to be checked by staff every 10 minutes and if she needed assistance, she was to raise her hand. The ED indicated the fall was unwitnessed. During an interview on 06/15/16 at 3:10 p.m., the SSD (Social Service Designee) indicated Resident "D", although able to verbalize, prefers to point or shake her head when communicating. The SSD indicated she had tried hard to build rapport with the resident and encouraged Resident "D" to use words for answering questions during assessment. During interview on 06/15/16 at 3:20 p.m., the MDS Coordinator-RN indicated Resident "D" fluctuates, "most of the time," between being forgetful and lucid.		**practice does not recur:** **DHS/designee will audit care plans to ensure they have been updated to reflect resident's desire to go outside, risk factors, and interventions.** **Monday thru Fri 5 residents weekly times 4 weeks then 3 residents weekly times 4 weeks then 1 resident weekly times 4 weeks. Audits will be reviewed in Quality Assurance meeting monthly for 3 months and if findings are 100% compliance then consider system working and if not then re-education of Licensed nurses as needed.**	

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	The MDS-RN indicated Resident "D" could verbalize but needed encouragement to do so. The MDS-RN indicated the resident had the cognitive portion of the MDS completed the morning of 06/15/16 and scored a "10" (moderately impaired). This Federal tag related to Complaint IN00202415. 3.1-45(a)(2)			