

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155026	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/10/2012
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NAME OF PROVIDER OR SUPPLIER  GREENWOOD VILLAGE SOUTH	STREET ADDRESS, CITY, STATE, ZIP CODE 295 VILLAGE LANE GREENWOOD, IN 46143
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F0000	<p>This visit was for the Investigation of Complaint IN00114475.</p> <p>Complaint IN00114475 - Substantiated. Federal/state deficiencies related to the allegations are cited at F323.</p> <p>Survey dates: September 7 &amp; 10, 2012</p> <p>Facility number: 000010 Provider number: 155026 AIM number: 100453660</p> <p>Survey team: Joyce Hofmann, RN</p> <p>Census bed type: SNF: 54 SNF/NF: 83 Residential: 154 Total: 291</p> <p>Census payor type: Medicare: 18 Medicaid: 27 Other: 246 Total: 291</p> <p>Sample: 3</p> <p>This deficiency also reflects state findings cited in accordance with 410 IAC 16.2.</p>	F0000	<p>Preparation and execution of this plan of correction in no way constitutes an admission or agreement by Greenwood Village South of the truth of the facts alleged in this statement of deficiency and plan of correction. In fact, this plan of correction is submitted exclusively to comply with state and federal law. Greenwood Village South reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts, and conclusions that form the basis of the deficiency. This plan of correction serves as the allegation of compliance by 09/14/12.</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.

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	Quality review 9/17/12 by Suzanne Williams, RN			

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F0323 SS=D	<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 observation, interview, and record review, the facility failed to implement supervision and an assistive device to prevent a resident from being in a location that was unsupervised for 1 of 3 residents reviewed for accidents/supervision in a sample of 3. [Resident #C]</p> <p>Findings include:</p> <p>The secured special care unit [dementia unit] was observed on 09/07/12 at 11:30 a.m. with the Clinical Leader, RN #1. Resident #C was observed in bed asleep. During interview at this time, RN #1 indicated the resident was ambulatory and needed cues and assistance with eating.</p> <p>Resident #C's clinical record was reviewed on 09/05/12 at 12:25 p.m. and indicated the resident had diagnoses which included, but were not limited to, Lewy body dementia, dementia with behaviors, difficulty walking, muscle weakness, history of falls, dysphagia, osteoporosis, restless leg syndrome, sleep</p>	F0323	<p>Corrective Actions:Resident "C" was assessed for injuries with none noted and no signs or symptoms of pain. The family was present and the physician was notified. She was placed on 15 minute checks. A care conference was held with the family. Weekly meetings were established and have been on-going with no concerns.Other Residents:Residents who require supervision due to the potential of wandering could have been affected by the alleged deficient practice. A systemic change has been made.Systemic Change:Code locks have been placed on all shower room doors throughout the community. The locking mechanism requires the entry of four digits to gain access into the room and locks automatically when the door is shut.Monitoring:The Plant Operations Director or his designee will check all of the locking mechanisms daily to ensure functionality with documentation of such. All documentationwill be forwarded to the Quality Assurance Committee monthly for the next six months for review and</p>	09/14/2012			

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	<p>apnea, Parkinson's disease, delusions, insomnia, and depression.</p> <p>Resident #C's most recent significant change Minimum Data Set [MDS] assessment dated 06/13/12, indicated the resident was moderately cognitively impaired with daily decision making skills, had inattention, disorganized thinking, and psychomotor retardation. The MDS assessment indicated the resident needed extensive assist of one person for bed mobility and transfers and supervision with ambulation.</p> <p>Resident #C's care plans included, but were not limited to, a care plan for problem of "I have been found to wander throughout the unit and attempt to leave the unit to go home." This care plan had an original date of 09/08/11. The goal indicated, "Current level of mobility will be maintained within a secure environment over the next 90 days." Interventions indicated, "Assess potential physical causes for wandering (need for toilet, water, food, pain relief). Check location/whereabouts on each shift. Check q [every] 15 min [minutes] c [with] location noted. Place in Special Care Unit. Ensure all door alarms/locks are armed to reduce the risk of me leaving secure area. Provide diversional activities</p>		<p>recommendations as necessary. Completion Date:9-14-12.</p>	

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	<p>(folding, rummaging box, packing/unpacking). Record behaviors on Behavior Tracking Form. Up ad lib c assist. Redirect my behavior/activity when wandering is observed. Use veri chip/location monitor daily. I wear a bracelet with my name, facility name, unit I live on and phone # of my health care facility."</p> <p>Another care plan with original date of 09/07/11, for problem of "I am at risk for mood and behavior issues due to my dx [diagnosis] dementia i.e.. trying to assist others, hx [history] physically resisting care, exit seeking and wandering." The goal was "I will exhibit no increase in mood or behavior concerns through the next assessment period. Interventions indicated the following: "Attempt to build rapport with me. Monitor my behavior for changes and report any changes to the behavior management team. Encourage me to attend activities to decrease boredom and increase socialization. Administer my meds as ordered and monitor for side effects i.e.: sedation, drowsiness, dry mouth, constipation, blurred vision, hypotension, weight gain, appetite changes. If possible, keep me away from exit doors and [sic] on the unit as much as possible as my exit seeking increases when I leave the unit. I will reside on a secured unit</p>			

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	<p>and will have a wanderguard for safety. Monitor my interaction with other residents and redirect if I start attempting to provide care. Refer me for a psych consult if needed. Do not engage in argument with me, use therapeutic fibbing. Redirect me through activity, snack, or offer a nap."</p> <p>Review of Physician/Nurse Practitioner notes, dated 08/10/12, indicated last month several medications were discontinued and husband did not want aggressive treatment for syncopal episodes. "Res [Resident] sat on shower room floor 7/25 (she was defecating on floor) has been ambulatory c [with] walker."</p> <p>Nurse's Notes dated 07/25/12 at 7 p.m. indicated, "Resident was found squatting on the shower room defecating on the floor - she then sat down on her buttocks to 'finish cleaning up' - Lg. [Large] formed BM [bowel movement] was noted - denied falling, hitting head or feeling dizzy - no signs of injury noted @ this time - ROM [Range of motion] is WNL [within normal limits]. Res. [Resident] was assisted to a standing position w/o [without] diff. [difficulty] by two staff members - Able to assist - no c/o [complaint of] pain noted - VS [Vital signs] 121/79 T [Temperature] 98.1 R</p>			

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	<p>[Respirations] 18 P [Pulse] 74 02 [oxygen sats] 94%. Daughter was present in facility @ the time - POA [Power of Attorney] called &amp; msg [message] left to call facility - MD faxed re: noninjury witnessed event."</p> <p>Interview with RN #1 on 09/07/12 at 11:30 a.m. indicated Resident #C was moving to a different facility. RN #1 explained the resident's daughter came in one evening and could not find the resident. The resident was found in the shower room defecating on the floor. The door to the shower room had been left unlocked after showers that evening and the resident had wandered into the shower room. RN #1 explained two nurses and three aides were working the unit, and no one admitted to leaving the shower room unlocked. During this time one nurse and one aide had left for their breaks, and the other two aides were assisting a gentleman in his room, thus leaving 1 nurse on the floor. RN #1 indicated the facility had a care plan conference with Resident #C's family, had implemented 15 minute checks with the location of the resident noted, was calling the spouse weekly and asking if he had any concerns, and the facility has placed a different lock on the shower room door which takes a code to get in and locks itself after each use.</p>				

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	<p>The shower room was observed on 09/10/12 at 11:10 a.m. and a code lock was observed on the outside of the door. A dead bolt lock was used before this incident and was observed on the door.</p> <p>Interview with the Director of Nursing [DON] on 09/10/12 at 11:55 a.m. indicated the practice on the unit was to keep the door locked to prevent residents being in an area they can't be supervised. The DON indicated the facility had nothing in writing in regard to this and there had been no inservices since she had came to the facility. The DON indicated the aides do not carry keys.</p> <p>Interview with the DON on 09/10/12 at 12:03 p.m. indicated the keys to the shower room are accessible to the aides at the utility room doors on a hook. The DON indicated the door had to be physically locked and unlocked due to the dead bolt.</p> <p>This federal tag relates to Complaint IN00114475.</p> <p>3.1-45(a)(2)</p>				