

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
--	--

(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	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey dates: July 18, 19, 20, 21, 22, 23, 25 and 26, 2016</p> <p>Facility number: 000501 Provider number: 155635 AIM number: 100266260</p> <p>Census bed type: SNF/NF: 68 SNF: 10 Residential: 51 Total: 129</p> <p>Census payor type: Medicare: 10 Medicaid: 44 Other: 24 Total: 78</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed by 14454 on August 2, 2016.</p>	F 0000	<p>Submission and implementation of this plan of correction shall not constitute an admission by Grace Village Health Care to any allegations of deficiency as contained in the "Summary Statement of Deficiencies" or agreement with claims made therein, rather, this plan is submitted in accordance with State and Federal requirements. Grace Village Administration requests paper compliance for this Plan of Correction.</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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
--	--

(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 0241 SS=D Bldg. 00	<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 record review, the facility failed to ensure dependent residents were assisted in to eat in a dignified manner in 1 of 3 dining rooms for 2 of 3 meals observed.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. During the breakfast meal observation in the main healthcare dining room, conducted on 07/19/16 from 6:43 A.M. - 8:56 A.M. an unidentified nursing staff member was noted to stand to feed Resident #86 who was not feeding himself his meal. After several minutes, the staff member did sit down to assist the resident. 2. During an observation of the 	F 0241	<p>F241 – Dignity and respect of individuality I. <u>Corrective action taken for affected residents:</u> Nursing staff were reminded of the policy that requires them to remain seated while assisting residents with feeding. II. <u>How other residents potentially affected will be identified:</u> All residents dependent upon staff for assistance with feeding could have been affected. Re-education on facility policy included the requirement that all residents who need assistance with feeding are assisted by a staff member in a seated position. III. <u>Measures implemented to ensure deficiency does not recur:</u> Policy has been updated and will be communicated with staff by mandatory in-service to state that the hostess and the nurse supervisor during meals will</p>	08/25/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/26/2016	
NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY				STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590			
(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			
	<p>breakfast meal in the main healthcare dining room, conducted on 07/22/16 from 7:47 A.M. - 8:50 A.M., the following was noted: CNA (Certified Nursing Assistant) #6 was noted to kick a stool out of the way and stand to feed an unidentified resident seated in a Broda chair at a table near the windows in the assisted side of the dining room. After 8 minutes, at 7:56 A.M., CNA #6 pulled the stool back to her and sat to feed the resident. LPN #5 was noted to stand and give several different residents bites of food and sips of drinks and then walk away. LPN (Licensed Practical Nurse) #5, at 8:17 A.M., after having cued Resident #95 several times to eat her breakfast, stood and assisted her to eat when the resident was unable to follow repeated cues to feed herself.</p> <p>A current, undated policy, titled "Feeding the Residents," provided by the Assistant Director of Nursing (ADON), on 07/23/16 in the afternoon, indicated the following, in bold type: "CNA (certified nursing assistants) are to remain seated at all times when assisting residents to eat!!"</p> <p>3.1-3(t)</p>		<p>interact, communicate, cue, help set up as they walk through and supervise the dining room, but they will not feed a resident unless they sit down.</p> <p>(Attachment A) The nurse supervising the dining room is responsible to ensure staff is seated while residents are being fed to maintain their dignity.</p> <p>IV. <u>How corrective measures will be monitored:</u> Director of Nursing (DON), Assistant Director of Nursing (ADON) and unit managers will conduct observations during mealtimes a minimum of 10 meals per week for a minimum of 6 months to ensure policy for dignified feeding is followed by all staff. A monitoring tool will be used to track the rate of compliance with policy. (Attachment B) The data will be presented in quarterly QA meetings. A 95% rate of compliance must be achieved and maintained in order for the monitoring frequency to be reduced.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
--	--

(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 0279 SS=D Bldg. 00	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>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.</p> <p>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).</p> <p>Based on observations, record review and interviews the facility failed to ensure one of one residents receiving dialysis had a care plan with interventions for</p>	F 0279	F279 – Develop comprehensive care plans I. <u>Corrective action taken for affected residents</u> : The care plan for resident #61 has been updated to include all	08/25/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
--	--

(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
	<p>dialysis care. (Resident #61)</p> <p>Finding includes:</p> <p>On 7/21/16 at 11:30 A.M., a review of the clinical record was conducted for Resident #61. The record indicated the resident was admitted on 2/19/16 with a re-admit on 3/31/16 after a hospital stay. The resident's diagnoses included, but were not limited to: altered mental status, end stage renal disease, hypertension, and generalized weakness.</p> <p>A Quarterly MDS (Minimum Data Set) Assessment, dated 6/30/16, indicated the resident's BIMS (Brief Interview Mental Status) was 9, moderate dementia. Resident #61 had a feeding tube and received dialysis.</p> <p>On 6/21/16 at 9:55 A.M., the resident was observed being assessed by RN (Registered Nurse) #22. RN #22 completed vital signs, listen to the resident's lungs, and assessed his fistula (bruit & thrill) located on his right forearm.</p> <p>A care plan titled "Potential for Complications Renal Failure" related to dialysis was dated 2/17/16. The care plan goal was for the resident to maintain fluid balance. The interventions included but</p>		<p>current interventions provided for a resident receiving dialysis care.</p> <p>II. <u>How other residents potentially affected will be identified</u>: No other residents are currently receiving dialysis care.</p> <p>III. <u>Measures implemented to ensure deficiency does not recur</u>: Analysis of the deficiency points to insufficient training and a system failure. To correct the problem, the system has been revised so that floor nurses are now responsible for the writing and updating of care plans rather than the MDS coordinator and unit managers will oversee the process to ensure they are updated timely and appropriately and individualized to the resident. All nurses (including unit managers) will be trained on the correct way to write and update care plans. Care plans will be reviewed on admission, readmission, significant changes and quarterly by the interdisciplinary team (IDT). (Attachment A) IV. <u>How corrective measures will be monitored</u>: ADON and nurse managers will audit at least 3 charts on each hall weekly for a minimum of 6 months to ensure care plan writing and updating is carried out according to policy. A monitoring tool will be used to document the results of the audits which will be reported to the QA Committee quarterly. (Attachment C) A compliance rate of 95% must be achieved</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 07/26/2016	
NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY				STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590			
(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			
	<p>were not limited to: medication per physician, monitor edema, RD (Registered Dietician) consult and activities to encourage fluid intake.</p> <p>On 7/21/16 at 2:15 P.M., the Assistant Director of Nursing (ADON) provided a policy titled "Dialysis, Arteriovenous Shunt/Access, Care of," dated 7/18/16, and indicated the policy was the one currently use by the facility. The policy indicated the nurse should assess for the bruit and thrill and check dressing for bleeding. The policy indicated "...Do not attempt to obtain blood pressure from arm where a shunt is present...Do not perform venipuncture where a shunt is present...Monitor shunt site for signs and symptoms of infection...." The policy indicated "...It is essential to call and check in with the dialysis center routinely to follow up on any issues...."</p> <p>On 7/23/16 at 12:40 P.M., the ADON provided a policy titled "Care Plans Resident Care Planning," revised on 8/17/14, and indicated the policy was the one currently used by the facility. The policy indicated "... 1. Purpose To promote individualized resident care plan with specific plans from nursing and other disciplines. To provide continuity of care. To provide a tool for evaluating quality of care and goal accomplishment.</p>		and maintained or the monitoring will be extended and additional corrective actions will be enacted by the QA Committee.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
--	--

(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
	<p>To provide guidelines for nursing assignments. To orient new nursing personnel. To provide guidance in documentation in nursing process To serve as the oral report tool...Procedure 2. The Comprehensive Assessment shall be preformed to identify needs, problems, goals based on assessed needs and approaches to accomplish the goals..."</p> <p>On 7/23/16 at 10:38 A.M., the MDS Assistant indicated the care plan regarding the resident's hemodialysis was on the care plan titled, "Potential for Complications Renal Failure", dated 2/17/16 and reviewed date of 7/6/16. The MDS Assistant indicated it would be her responsibility to make sure the care plan reflected the residents specific plan, interventions and the facility's treatment protocol. The MDS Assistant indicated the care plan did not reflect the pre/post dialysis assessments (including assessment of fistula), pre dialysis treatment (topic lidocaine at access site) days resident attended dialysis, who would transport the resident and how/when nurses communicated with the dialysis facility.</p> <p>3.1-35(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
--	--

(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 0280 SS=D Bldg. 00	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on observation, record review and interviews, the facility failed to ensure care plans regarding fall prevention were revised for 2 of 4 residents reviewed for accidents/falls. (Resident #31 and #85) In addition, the facility failed to ensure a nutritional care plan was updated for 1 of 1 residents reviewed for nutrition.</p>	F 0280	<p>F280 – Right to participate in care planning – C.P. revision</p> <p>I. <u>Corrective action taken for affected residents:</u> The care plans for residents #31 and #85 were reviewed and interventions for fall prevention were updated. The nutritional care plan for resident #61 was reviewed and updated. II. <u>How other residents</u></p>	08/25/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/26/2016
NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590		
(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	
	<p>(Resident #61)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #31 was reviewed on 07/20/2016 at 3:30 P.M. Resident #31 was admitted to the facility, on 01/06/16 and readmitted on 04/15/16 with diagnoses, including but not limited to: chronic pain syndrome, traumatic hemorrhage of the cerebrum, insomnia, functional urinary incontinence, multiple fractures of the ribs, edema, osteoporosis, and weakness.</p> <p>The most recent Minimum Data Set (MDS) assessment, completed on 04/21/16, indicated Resident #31 required extensive staff assistance for transfers and wheelchair locomotion.</p> <p>The care plan related to falls, initiated on 04/26/16, indicated the resident was at high risk for falls. The interventions included administer medications per physician's order, monitor and report any side effects and effectiveness, monitor fluid intake, safety checks as needed, monitor bowel record, fall assessment quarterly, increased nutrition and hydration - monitor, call light in reach, glasses on AM, clean and in good working order, off at HS (bedtime), non-skid socks, slippers or shoes, safety</p>		<p><u>potentially affected will be identified:</u> All resident care plans for falls and nutrition are currently being reviewed and updated as needed and according to policy.</p> <p>III. <u>Measures implemented to ensure deficiency does not recur:</u> Analysis of the deficiency points to insufficient training and a system failure. To correct the problem, the system has been revised so that floor nurses are now responsible for the writing and updating of care plans rather than the MDS coordinator and unit managers will oversee the process to ensure they are updated timely and appropriately and individualized to the resident. All nurses (including unit managers) will be trained on the correct way to write and update care plans. Care plans will be reviewed on admission, readmission, significant changes and quarterly by the interdisciplinary team (IDT). More specifically, to address interventions for falls, every fall will be analyzed to identify root cause and new interventions added to the care plan, if appropriate, to try to prevent further falls. (Attachment A) Dietician has been provided additional training on updating care plans on facility EMR system. IV. <u>How corrective measures will be monitored:</u> ADON and nurse managers will audit at least 3 charts on each hall weekly for a minimum of 6</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/26/2016	
NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY				STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590			
(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			
	<p>checks as needed, praise efforts with ADL (Activities of Daily Living), extensive assist for transfers and mobility.</p> <p>Another fall care plan, initiated on 05/02/16 indicated the resident had a history of falls, and an unsteady gait interventions included call light in reach, remind to ask for assistance each time, non-skid socks, slippers or socks, 2 side rails up when in bed, safety checks as needed, personal alarm, bed alarm, low bed in low/floor position, report if resident is anxious or agitated to nurse, report if resident had any discomfort.</p> <p>There were no fall interventions initiated after 05/02/16, when the fall care plan was rewritten. The CNA (Certified Nursing Assistant) assignment sheets for Resident #31 indicated she was to receive supervision for mobility to and from the bathroom and safety checks.</p> <p>During an interview, on 07/19/2016 at 9:49 A.M., the Assistant Director of Nursing (ADON) she indicated Resident #31 had fallen one time in the past month. She indicated the resident had fallen, on 07/18/16 at 3:00 A.M., in her room and suffered abrasions to her right forehead area.</p>		<p>months to ensure fall interventions and nutritional interventions have been added to care plans according to policy. A monitoring tool will be used to document the results of the audits which will be reported to the QA Committee quarterly. (Attachment C) A compliance rate of 95% must be achieved and maintained or the monitoring will be extended and additional corrective actions will be enacted by the QA Committee.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
--	--

(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
	<p>A review of the nursing notes and fall incident reports from May through July 2016, indicated the resident had incurred multiple falls.</p> <p>On 05/01/16 at 5:21 A.M., the resident had slid out of bed and she did not incur any injuries.</p> <p>On 05/01/15 at 11:45 P.M., the resident had been found on the floor by her bed. The resident had stated she had to go to the bathroom. She suffered an abrasion to her right knee. On 05/02/16, a fall care plan was rewritten and interventions to add a personal and bed alarm, and complete safety checks and remind the resident to ask for assistance was added.</p> <p>On 05/24/16 at 8:43 A.M., Resident #31 was found lying beside her bed. She indicated she had slid out trying to get to the edge of her bed. She suffered an abrasion to her right eye and a small lesion above her right eye The fall care plans were reviewed but there were no additional interventions implemented.</p> <p>On 06/11/16 at 6:48 P.M., the resident was found on the floor in her bathroom. The resident stated she was on the toilet and fell from the toilet.</p> <p>During an interview, on 07/22/16 at 2:00</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
--	--

(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
	<p>P.M., the ADON indicated there were no interventions newly implemented due to the fall on 5/21/16. The ADON indicated Resident #31 was left in the bathroom alone and then fell on 6/11/16. The ADON indicated the resident incurred a hematoma to her head and was sent to the emergency room to be evaluated for her head injury. There were no interventions added to the resident's care plan. The ADON indicated a "butterfly" program was initiated for Resident #31 and other resident's at fall risk to alert staff not to leave these residents in the bathroom alone.</p> <p>On 7/1816 at 3:15 A.M., Resident #31 slipped out of her bed, hit her forehead on the floor, and was noted to be incontinent. She suffered an abrasion to her right forehead. There were no interventions implemented to address the resident's most recent fall.</p> <p>During an interview, on 07/22/16 at 2:00 P.M., the ADON indicated there were no interventions newly implemented due to the fall on 5/21/16. The ADON indicated Resident #31 was left in the bathroom alone and then fell on 6/11/16. The ADON indicated the resident incurred a hematoma to her head and was sent to the emergency room to be evaluated for her head injury. There were no interventions</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
--	--

(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
	<p>added to the resident's care plan. The ADON indicated a "butterfly" program was initiated for Resident #31 and other resident's at fall risk to alert staff not to leave these residents in the bathroom alone.</p> <p>2. On 7/21/16 at 10:35 A.M., Resident #85 was observed in the activity room. She was seated in a wheelchair (wheels were unlocked) and was listening to music. Several times, the resident sang along with the music and indicated she liked the music. The resident was observed to have a hard cast or splint on her left forearm. The cast or splint was covered with an ace bandage.</p> <p>On 7/21/16 at 2:14 P.M., resident was observed alone, in her room, in her bed. The bed was in the low position and the call light was within reach.</p> <p>On 7/21/16 at 3:30 P.M., the resident was observed in her room, lying in bed, a staff member was sitting beside the bed. The staff member was talking with her and engaged the resident in a conversation. CNA #21 came into the room to check on the resident. CNA #21 indicated the resident was on 15 minute checks and she was just checking on her. CNA#21 did not ask the resident if she needed to use the restroom or if she needed anything.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
--	--

(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
	<p>On 7/22/16 at 8:56 A.M.,the resident was seated near the nurse cart in a wheelchair, the wheels of the wheelchair were unlocked. She had her shoes on and her feet were resting on the foot pedals.</p> <p>On 7/22/16 at 10:11 A.M., a review of the clinical record for Resident # 85 was conducted. The record indicated the resident was admitted on 3/10/16. The resident's diagnoses included, but were not limited to: Alzheimer's disease, depressive disorder, restless, agitation, peripheral vascular disease, hypothyroidism and recent hip replacement due to fracture.</p> <p>An Admission MDS (Minimum Data Set) Assessment, dated 3/18/16, indicated the resident's BIMS (Brief Interview Mental Status) score was 5, severe dementia. The assessment indicated the resident needed extensive assist of one person to dress and use the toilet. The resident was a limited assist of one person with transfers and walking.</p> <p>The Fall Risk Assessments for Resident #85 indicated the following: on admission (3/10/16) the resident scored a 21, on 5/6/16 the risk score was a 20, on 5/12/16 the resident scored a 12, on 7/7/16 she scored a 15 and on 7/14/16</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
--	--

(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
	<p>she scored a 14. The assessment indicated a score of 15 or higher meant the resident was at high risk for falls.</p> <p>A care plan, dated 3/11/16, titled "High Risk of Falls" due to poor safety awareness from Alzheimer and antidepressant use. The care plan indicated the following intervention to prevent falls "...Nurses-- if falls occur, Nurse notify family and physician, chart details of fall and update care plan. Fall assessment to be completed quarterly and after each fall...monitor for unsafe situations that may cause a fall...."</p> <p>A Fall Report, dated 5/6/16 at 2:15 A.M., indicated the resident fell in the hallway, near the nurses cart. The report indicated the resident was observed trying to get a tissue off the nurses cart. The report indicated the resident fell onto the trash container, located on the cart, and hit her head. The resident complained of pain in her nose and started to have a nose bleed and headache. First aid treatment was given, to treat nose bleed, the physician was called and the resident was sent to local Emergency Room (ER). The report indicated the "resident's explanation for the fall: wanted a Kleenex." The fall report did not include old or new preventive interventions to prevent another fall.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
--	--

(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
	<p>An ER report, dated 5/6/16, indicated CT (Computerize Tomography) of head, CT of cervical spine and CT of facial bones was completed and were negative. The resident was sent back to facility.</p> <p>Another fall report, dated 5/12/16 at 10:50 P.M., indicated the resident fell in the hallway, had non skid slippers on and was lying on her left side. The report indicated the resident said she was going to her room, she felt sleepy. The fall report indicated the resident had no injury related to the fall. The report indicated the care plan was reviewed and ongoing, no new interventions were documented.</p> <p>The care plan for Risk of Falls, dated 3/11/16, had no updated interventions and remained the same after the falls on 5/6/26 and 5/12/16.</p> <p>Another fall report indicated the resident fell on 7/7/16 at 8:55 AM. The report indicated the resident was found sitting on the floor in her room. The report indicated the resident was unable to recall what happened but complained of left hip pain. The resident's physician was notified and the facility received new orders to send the resident to the ER for evaluation.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
--	--

(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
	<p>The clinical record indicated the resident returned to the facility, on 7/10/16 at 1:20 P.M., after receiving a left hip arthroplasty (surgical procedure to treat a hip fracture).</p> <p>A care plan, related to a fall in past 30 days, dated 7/13/16, indicated falls were manifested by: fall (or near fall) in past 180 days, anti-hypertensive use, antipsychotic use, and hip fracture. The care plan inventions included but were not limited to "...Nurses---If falls occur, Nurse notify family and physician, chart details of fall, and update care plan. Fall assessments to be completed quarterly and after each fall...Monitor food intake. Monitor fluid intake...CNA--Call light within reach, Show Resident the call light and tell how to use each time in room; Remind Resident to use for assistance, Remind to ask for assistance each time with Resident, Toilet q [every] hr [hour], assist as needed, upon rising, before and after meals and before bedtime. Do not leave unattended when toileting...."</p> <p>Another fall report, dated 7/14/16, indicated the resident fell at 8:15 P.M. The report indicated the resident was found in her room, lying on her back on the floor. The resident's wheel chair was located approximately 1-3 feet from the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
--	--

(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
	<p>resident with the brakes off. The report indicated it appeared the resident had gotten clothes out of her drawers and was folding them on the bed. The report indicated the resident had no explanation for the fall. The resident did not complain of pain, therefore the report indicated no apparent injury. The report indicated the resident was instructed on the use of her call light. The resident's physician was notified of the fall via a fax. There was no new interventions added to the 7/13/16 care plan.</p> <p>A Nursing Notes, dated 7/15/16, indicated the physician fax was received on 7/15/16 at 12:13 P.M., with no new orders. At 3:48 P.M., the physician was in the building and examined the resident due to swelling of her left wrist. The physician ordered an x-ray of the left wrist and hand.</p> <p>A Nursing Note, dated, 7/16/16 at 9:44 A.M., indicated a call was made to the on call physician regarding the x-ray findings and the physician directed staff to send to ER for an evaluation of fracture and application of a cast/splint.</p> <p>A form titled "Emergency Department Chart," dated 7/16/16, indicated the resident had a Colles fracture (a type of broken wrist) of the left wrist . The</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
--	--

(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
	<p>report indicated the resident presented to ER for care of the fracture and resident could not give any history because of her chronic mental status. The report indicated the fracture was stabilized in the department with a Sugar tong orthoglass splint and ace wraps (stabilizes the forearm and writst).</p> <p>An undated CNA (Certified Nursing Assistant) Assignment Sheet was received from the Assistant Director of Nursing (ADON), on 7/22/16 at 10:07 A.M. The CNA sheet indicated the resident used a wheel chair, a walker and needed 1 person assist for transfers. The Needs section of the assignment sheet indicated extensive assist with toileting, bed mobility and no ambulation at this time.</p> <p>On 7/23/16 at 12:40 P.M., the ADON provided a policy titled "Fall Management," undated, and indicated the policy was the one currently used by the facility. The policy indicated "Purpose: To assess all residents for risk factors that may contribute to falling. To provide planned interventions identified by the team, as appropriate, for resident use in maintaining or returning to the highest level of physical, social and psychosocial functioning as possible...MONITORING OF RESIDENTS WITH RECURRENT</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
--	--

(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
	<p>FALLS...a resident with recurrent falls will be monitored and reviewed to determine if further intervention is applicable."</p> <p>During an interview, on 7/23/16 at 2:30 P.M., the ADON indicated the reason for the resident's falls were due to her dementia. The ADON indicated the nurse assessment did not provide new interventions to prevent a fall as those questions were not part of the facility's incident report. The ADON indicated she had not noted any patterns to the resident's falls.</p> <p>3. On 7/21/16 at 11:30 A.M., a review of the clinical record was conducted for Resident #61. The record indicated the resident was admitted on 2/19/16 with a re-admit on 3/31/16 after a hospital stay. The resident's diagnoses included, but were not limited to: altered mental status, end stage renal disease, hypertension, and generalized weakness.</p> <p>A Quarterly MDS Assessment, dated 6/30/16, indicated the resident's BIMS (Brief Interview Mental Status) was 9, moderate dementia. The assessment indicated the resident had a feeding tube and received dialysis. The resident received 51% or more of his total calories</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
--	--

(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
	<p>a day through the tube feedings.</p> <p>A physician order, dated 7/7/16, indicated to discontinue the Jevity (a liquid nutrition) 1.0 tube feedings and start Nepro (a liquid nutrition for people on dialysis) 85 ml/hr (milliliter per hour) for 12 hours (8 PM to 8 AM), Continue feedings adding H2O (water) flushes of 200 milliliters (ml) every shift daily for total of 600 ml per the Dietician.</p> <p>The Dietician Notes were as follows: - On 4/1/16 resident returned from the hospital on Nepro running continuously at 50 ml/hr This provided 2160 kcal (kilocalorie), 97 protein, 872 ml of fluid. Resident also received 60 ml with each med pass and 230 ml flushes QID (4 times a day) for a total of 1972 ml of water daily. -On 4/7/16 - Diet NPO (nothing by mouth) with Nepro feeds at 50 ml/hr Total fluid needs:1895 ml,Protein needs: 84-105 grams, Total calories: 1895-2370. 2000 fluid restriction. -On 4/21/16 - Diet change-recommend 5 cans of Nepro to provide 2125 calories, 95.5 grams of protein and 860 of fluid, 60 ml flushes before and after each bolus and medication pass. Additional 60 ml flush once a day. provides 2000 fluid a day. -On 7/7/16 G-tube replaced due to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
--	--

(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
	<p>multiple clogging, returning with Nepro continuously at night. Recommend Nepro at 85 ml/hr from 8 PM to 8 AM. This would provide 1836 kcal, 83 grams of protein and 742 of water. Received 60 ml of fluid before and after each feeding and med pass and an additional 200 ml on each shift providing 1700 ml of water a day. Continue to monitor the fluctuations of weight and intolerance to tube feeding.</p> <p>There was a care plan, dated 12/21/14 with an update on 2/3/16, for potential weigh fluctuation related to end stage renal disease with dialysis; dementia and depression. The interventions included but were not limited to: monitor food intake, be positive in offering food, regular diet, provide healthy snacks and offer replacement food. Another care plan for potential weight fluctuation related to end stage renal disease, on hemodialysis was dated 4/5/16. The interventions included but were not limited to: provide tube feedings as ordered, flushes as ordered, monitor weights, monitor tube feed tolerance, and tube feeding-Nepro 170 ml x 6 bolus feedings.</p> <p>During an interview, on 7/22/16 at 8:50 A.M., the Dietician indicated the current nutritional care plan was not up to date to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
--	--

(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 0282 SS=D Bldg. 00	<p>reflect fluid restrictions and current tube feedings. She was not aware there was two care plans regarding weight fluctuation and one was dated 12/31/14, and was still part of the resident's care plan.</p> <p>On 7/23/16 at 12:40 P.M., the ADON provided a policy titled "Nutrition Care Supervision," undated, and indicated the policy was the one currently used by the facility. The policy indicated "...3. The dietitian supervises the development of a nutritional care plan and supervises its implementation...."</p> <p>3.1-35(d)(2)(B)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review and interviews, the facility failed to ensure incontinence care plans were followed for 2 of 2 residents reviewed for</p>	F 0282	F282 – Services by qualified persons per care plan I. <u>Corrective action taken for affected residents:</u> Toileting plans have been reviewed and	08/25/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 07/26/2016
NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590		
(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	
	<p>incontinence. (Residents #98 and #107)</p> <p>Findings include:</p> <p>1. Resident #107 was observed, on 07/20/16, from breakfast time through lunch time and she was not observed to have been assisted to the toilet or checked for incontinence.</p> <p>The clinical record for Resident #107 was reviewed on 07/20/2016 at 3:13 P.M. Resident #107 was admitted to the facility, on 01/29/16, with diagnoses, including but not limited to: dementia, major depressive disorder, diabetes, hypertension, pathological fracture of the femur, osteoporosis and falls.</p> <p>The most recent MDS (Minimum Data Set) assessment, completed on 05/13/16, indicated Resident #107 scored 4 of 15 on a BIMS (Brief Interview of Mental Status) and was severely cognitively impaired. Resident #107 required extensive staff assistance for transfers, toileting and personal hygiene needs, and was frequently incontinent of her bladder.</p> <p>The care plans for Resident #107 included a plan with a goal for the resident to be continent while awake. Interventions to the plan included to assist the resident to the toilet every 2</p>		<p>updated for residents #98 and #107 to reflect how toileting is provided to them based on the schedule that works best for them –their normal voiding pattern.</p> <p>II. <u>How other residents potentially affected will be identified</u>: Toileting care plans for all other residents are being reviewed with the team responsible for direct care on each hall and will be updated to reflect the residents' voiding patterns instead of a standardized every 2 hour plan. The nursing team on each hall (nurse manager, floor nurse, QMA's and CNA's) will work together to identify residents incontinence patterns for residents unable to verbally communicate their toileting needs, using a calendar of voiding patterns when appropriate. (Attachment D)</p> <p>III. <u>Measures implemented to ensure deficiency does not recur</u>: Analysis of the deficiency points to a system failure. To correct the problem, the system has been revised so that floor nurses are now responsible for the writing and updating of toileting plans rather than the MDS coordinator and unit managers will oversee the process to ensure toileting plans are updated timely and appropriately and individualized to the resident. All nurses (including unit managers) will be trained on the correct way to write and update toileting plans. Care plans will be reviewed on admission, readmission,</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
--	--

(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
	<p>hours and as needed, upon rising, before and after meals and before bedtime. The resident also had an intervention to wear briefs.</p> <p>The current CNA (Certified Nursing Assistant) assignment sheet for Resident #107, printed on 07/20/16 and provided by the Assistant Director of Nursing (ADON) on 07/20/16 at 3:25 P.M., indicated the resident required extensive assistance for toileting and hygiene needs but did not provide any specific instructions for toileting plans.</p> <p>On 07/22/16 at 7:40 A.M., Resident #107 was observed in her wheelchair in the dining room. She remained in eh dining room unit 8:35 A.M., when she was pushed to the hallway just across from the Healthcare nurse's station. At 9:30 A.M., she was taken into the shower room on Hall 3 and given a shower and her clothes and brief were changed. At 10:03 A.M., she was taken from the shower room to the activity room. She remained in the activity room from 10:03 - 11:39 A.M. when she was pushed to the dining room by CNA #8. At 1:38 P.M., she was pushed to her room and left in her wheelchair, sleeping beside her bed. At 2:01 P.M., she was toileted by CNA #8 and #9. Her brief was noted to be wet but she also voided in the toilet.</p>		<p>significant changes and quarterly by the interdisciplinary team (IDT). All CNA's will have access to the care plans and will be trained on the value and importance of following the toileting plan and participating in the development of an appropriate and individualized plan. Charge nurses and unit managers will ensure that aides are carrying out the plans as written. (Attachment A) IV. <u>How corrective measures will be monitored</u>: ADON and nurse managers will audit at least 3 charts on each hall weekly for a minimum of 6 months to ensure toileting care plan writing and updating is carried out according to policy. A monitoring tool will be used to document the results of the audits which will be reported to the QA Committee quarterly. (Attachment C) A compliance rate of 95% must be achieved and maintained or the monitoring will be extended and additional corrective actions will be enacted by the QA Committee.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
--	--

(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
--------------------	--	---------------	---	----------------------

	<p>2. On 07/20/16 from breakfast through lunch time, Resident #98 was not observed to be offered or assisted to the toilet.</p> <p>The clinical record for Resident #98 was reviewed on 07/20/2016 at 2:53 P.M. Resident #98 was admitted to the facility on 09/04/15 with diagnoses, including but not limited to: weakness, dementia, and arteriosclerotic heart disease.</p> <p>The most recent quarterly MDS (Minimum Data Set) assessment, completed on 05/09/16, indicated the resident scored 3 of 15 on a BIMS assessment, severely cognitively impaired. Resident #98 required extensive staff assistance for transfers, toileting and personal hygiene needs, and was frequently incontinent of his bladder.</p> <p>The care plans, last reviewed on 05/09/16, included a self care deficit care plan with interventions to provide extensive assistance of one staff for toileting needs. In addition, a care plan to address incontinence included interventions to remind and assist the resident to toilet every 2 hours and as needed and to assist upon rising, before and after meals and before bedtime.</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
--	--

(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
	<p>On 07/22/16 at 7:40 A.M., Resident #98 was observed in the dining room at a table. He remained in the dining room unit 8:36 A.M., when he was pushed back to his room by CNA #8. He was transferred into his recliner by CNA #8. He was not offered or assisted to toilet prior to being placed in his wheelchair. He stayed in his recliner until 11:34 A.M. when he was assisted back into his wheelchair by CNA #8 and #9. He was left in his room in his wheelchair until 12:15 P.M. when he was given a medication by RN (Registered Nurse) #6 and pushed to the dining room by CNA #8. He was not offered or assisted to the toilet from 7:40 A.M. - 12:15 P.M. At 1:38 P.M., Resident #98 was observed lying in his bed asleep.</p> <p>During an interview, on 07/22/2016 at 2:02 P.M., CNA #8, indicated she had toileted Resident #98 before his shower, before breakfast, after breakfast and after lunch. She indicated he did stand at the toilet to void and was sometimes continent of his urine. She indicated Resident #98 was to be toileted before and after meals.</p> <p>3.1-35(g)(2)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
--	--

(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 0315 SS=D Bldg. 00	<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 observation, record review and interviews, the facility failed to ensure 2 of 2 residents reviewed for incontinence needs were thoroughly assessed for incontinence and had an individualized care plans to address needs implemented. In addition, the facility failed to ensure the current care plans were implemented. (Resident #98 and #107)</p> <p>Findings include:</p> <p>1. Resident #107 was observed on 07/20/16 from breakfast time through lunch time and she was not observed to have been assisted to the toilet or checked for incontinence.</p> <p>The clinical record for Resident #107 was</p>	F 0315	<p>F315 – No catheter, prevent UTI, restore bladder I. <u>Corrective action taken for affected residents</u>: Toileting plans have been reviewed and updated for residents #98 and #107 to reflect how toileting is provided to them based on the schedule that works best for them –their normal voiding pattern. II. <u>How other residents potentially affected will be identified</u>: Toileting care plans for all other residents are being reviewed with the team responsible for direct care on each hall and will be updated to reflect the residents' voiding patterns instead of a standardized every 2 hour plan. The nursing team on each hall (nurse manager, floor nurse, QMA's and CNA's) will work together to identify residents incontinence patterns for residents unable to</p>	08/25/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/26/2016	
NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY				STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590			
(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			
	<p>reviewed on 07/20/2016 3:13 P.M. Resident #107 was admitted to the facility on 01/29/16 with diagnoses, including but not limited to: dementia, major depressive disorder, diabetes, hypertension, pathological fracture of the femur, osteoporosis and falls.</p> <p>The most recent MDS (Minimum Data Set) assessment, completed on 05/13/16, indicated Resident #107 scored 4 of 15 on a BIMS (Brief Interview of Mental Status) and was severely cognitively impaired. Resident #107 required extensive staff assistance for transfers, toileting and personal hygiene needs, and was frequently incontinent of her bladder.</p> <p>The most recent bladder incontinence assessment, completed on 07/18/16, indicated the resident did not have a history of frequent urinary tract infections. Resident #107 had Alzheimer's dementia, was rarely aware of toileting needs and unaware of incontinence, voided in small amounts and displayed stress or overflow incontinence. Resident #107 had a diagnosis of depression but was well adjusted to the facility. The assessment indicated she voided correctly without incontinence less than once a day. There was no assessment of the resident's voiding pattern.</p>		<p>verbally communicate their toileting needs, using a calendar of voiding patterns when appropriate. (Attachment D) III. <u>Measures implemented to ensure deficiency does not recur:</u> Analysis of the deficiency points to a system failure. To correct the problem, the system has been revised so that floor nurses are now responsible for the writing and updating of toileting plans rather than the MDS coordinator and unit managers will oversee the process to ensure toileting plans are updated timely and appropriately and individualized to the resident. All nurses (including unit managers) will be trained on the correct way to write and update toileting plans. Care plans will be reviewed on admission, readmission, significant changes and quarterly by the interdisciplinary team (IDT). All CNA's will have access to the care plans and will be trained on the value and importance of following the toileting plan and participating in the development of an appropriate and individualized plan. Charge nurses and unit managers will ensure that aides are carrying out the plans as written. (Attachment A) IV. <u>How corrective measures will be monitored:</u> ADONand nurse managers will audit at least 3 charts on each hall weekly for a minimum of 6 months to ensure toileting care plan writing and</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
--	--

(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
	<p>The care plans for Resident #107 included a plan with a goal for the resident to be continent while awake. Interventions to the plan included to assist the resident to the toilet every 2 hours and as needed, upon rising, before and after meals and before bedtime. The resident also had an intervention to wear briefs.</p> <p>The current Certified Nursing Assistant (CNA) assignment sheet for Resident #107, printed on 07/20/16 and provided by the Assistant Director of Nursing (ADON) on 07/20/16 at 3:25 P.M., indicated the resident required extensive assistance for toileting and hygiene needs but did not provide any specific instructions for toileting plans.</p> <p>On 07/22/16 at 7:40 A.M., Resident #107 was observed in her wheelchair in the dining room. She remained in eh dining room until 8:35 A.M., when she was pushed to the hallway just across from the Healthcare nurse's station. At 9:30 A.M., she was taken into the shower room on Hall 3 and given a shower and her clothes and brief were changed. At 10:03 A.M., she was taken from the shower room to the activity room. She remained in the activity room from 10:03 A.M. - 11:39 A.M. when she was pushed</p>		<p>updating is carried out according to policy. A monitoring tool will be used to document the results of the audits which will be reported to the QA Committee quarterly. (Attachment C) A compliance rate of 95% must be achieved and maintained or the monitoring will be extended and additional corrective actions will be enacted by the QA Committee.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
--	--

(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
	<p>to the dining room by CNA #8. At 1:38 P.M., she was pushed to her room and left in her wheelchair, sleeping beside her bed. At 2:01 P.M., she was toileted by CNA #8 and #9. Her brief was noted to be wet but she also voided in the toilet.</p> <p>2. On 07/20/16 from breakfast through lunch time, Resident #98 was not observed to be offered or assisted to the toilet.</p> <p>The clinical record for Resident #98 was reviewed on 07/20/2016 2:53:10 PM. Resident #98 was admitted to the facility on 09/04/15 with diagnoses, including but not limited to: weakness, dementia, and arteriosclerotic heart disease.</p> <p>The most recent quarterly MDS (Minimum Data Set) assessment, completed on 05/09/16, indicated the resident scored 3 of 15 on a BIMS assessment, severely cognitively impaired. Resident #98 required extensive staff assistance for transfers, toileting and personal hygiene needs and was frequently incontinent of his bladder.</p> <p>The most recent bladder incontinence assessment, completed on 05/19/16, indicated the resident had a history of urinary tract infections. Resident #98 had Alzheimer's disease and was rarely aware</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
--	--

(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
	<p>of his toileting needs or of incontinence, voided in large amounts and was never continent. Resident #9 did not have bladder distention or genital irritation. There was no indication if the resident had been toileted during the assessment period and no patterning noted on the assessment.</p> <p>The care plans, last reviewed on 05/09/16, included a self care deficit care plan with interventions to provide extensive assistance of one staff for toileting needs. In addition, a care plan to address incontinence included interventions to remind and assist the resident to toilet every 2 hours and as needed and to assist upon rising, before and after meals and before bedtime.</p> <p>On 07/22/16 at 7:40 A.M., Resident #98 was observed in the dining room at a table. He remained in the dining room until 8:36 A.M., when he was pushed back to his room by CNA #8. He was transferred into his recliner by CNA #8. He was not offered or assisted to toilet prior to being placed in his wheelchair. He stayed in his recliner until 11:34 A.M. when he was assisted back into his wheelchair by CNA #8 and #9. He was left in his room in his wheelchair until 12:15 P.M. when he was given a medication by RN #6 and pushed to the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
--	--

(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
	<p>dining room by CNA #8. He was not offered or assisted to the toilet from 7:40 A.M. - 12:15 P.M. At 1:38 P.M., Resident #98 was observed lying in his bed asleep.</p> <p>During an interview, on 07/22/2016 at 2:02 P.M., CNA #8 indicated she had toileted Resident #98 before his shower before breakfast, after breakfast and after lunch. She indicated he did stand at the toilet to void and was sometimes continent of his urine. She indicated Resident #98 was to be toileted before and after meals.</p> <p>3. During an interview, on 07/23/16 at 10:00 A.M., the ADON indicated the facility did not assess voiding patterns for incontinent residents.</p> <p>A note, provided by the ADON on 07/23/16 at 3:00 P.M., indicated the facility had no formal policy and procedure regarding incontinent assessments. The note indicated all healthcare residents were assessed for incontinent and/or catheter use upon admission and quarterly.</p> <p>3.1-41(a)(2)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/26/2016	
NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY				STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590			
(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 0323 SS=G 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. Based on observation, record reviews and interviews, the facility failed to complete a root cause analysis for 1 of 5 residents (Resident #85) and to ensure adequate interventions were developed and implemented to prevent falls for 2 of 5 residents reviewed for falls. (Resident #85 and Resident #31) This resulted in multiple falls with fractures for Resident #85.</p> <p>Findings include:</p> <p>1. On 7/21/16 at 10:35 A.M., Resident #85 was observed in the activity room. She was seated in a wheelchair (wheels were unlocked) and was listening to music. Several times, the resident sang along with the music and indicated she liked the music. The resident was observed to have a hard cast/splint on her left forearm. The cast/splint was covered with an ace bandage.</p>			F 0323	<p>F323 – Free of accidents, hazards provide supervision, devices I. <u>Corrective action taken for affected residents:</u> The care plans for residents #31 and #85 were reviewed and interventions for fall prevention were updated. II. <u>How other residents potentially affected will be identified:</u> All resident care plans for falls are currently being reviewed and updated as needed and according to policy. III. <u>Measures implemented to ensure deficiency does not recur:</u> Analysis of the deficiency points to insufficient training and a flawed system. To correct the problem, the system has been revised so that floor nurses are now responsible for the writing and updating of care plans rather than the MDS coordinator and unit managers will oversee the process to ensure they are updated timely and appropriately and individualized to the resident. All nurses (including unit managers)</p>		08/25/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
--	--

(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
	<p>On 7/21/16 at 2:14 P.M., Resident #85 was observed alone, in her room, in her bed with her eyes opened. The bed was in the low position and the call light was within reach. A staff member entered the room and took a meal tray from the room.</p> <p>On 7/21/16 at 3:30 P.M., resident was observed in her room, lying in bed, a staff member was seated beside the bed. The staff member was talking with her and engaged the resident in a conversation. CNA (Certified Nursing Assistant) #21 came into the room to check on the resident. CNA #21 indicated the resident was on 15 minute checks and she was just checking on her. CNA#21 did not ask the resident if she needed to use the restroom or if she needed anything</p> <p>During an interview, on 7/21/16 at 3:35 P.M., CNA #21 indicated she thought the 15 minute checks were due to her recent fall. CNA #21 indicated the 15 minute checks were not on her CNA assignment sheet.</p> <p>On 7/22/16 at 8:56 A.M., the resident was sitting near the nurse cart. She had her shoes on and her feet were resting on the foot pedals. There was no nurse at the cart.</p>		<p>will be trained on the correct way to write and update care plans. Care plans will be reviewed on admission, readmission, significant changes and quarterly by the interdisciplinary team (IDT). More specifically, to address interventions for falls, every fall will be analyzed to identify root cause and new interventions added to the care plan, if appropriate, to try to prevent further falls. (Attachment A) IV. <u>How corrective measures will be monitored</u>: ADON and nurse managers will audit at least 3 charts on each hall weekly for a minimum of 6 months to ensure fall interventions have been added to care plans according to policy. A monitoring tool will be used to document the results of the audits which will be reported to the QA Committee quarterly. (Attachment C) A compliance rate of 95% must be achieved and maintained or the monitoring will be extended and additional corrective actions will be enacted by the QA Committee.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
--	--

(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
	<p>On 7/22/16 at 10:11 A.M., a review of the clinical record for Resident #85 was conducted. The record indicated the resident was admitted on 3/10/16. The resident's diagnoses included, but were not limited to: Alzheimer's disease, depressive disorder, restless, agitation, peripheral vascular disease, hypothyroidism and recent hip replacement.</p> <p>An Admission MDS (Minimum Data Set) Assessment, dated 3/18/16, indicated the resident's BIMS (Brief Interview Mental Status) score was 5 (severe dementia). The assessment indicated the resident needed the extensive assist of one person to dress and use the toilet. The resident required the limited assist of one person with transfers and walking.</p> <p>A Psychiatric Consult, dated 5/2/16, indicated the resident recently moved from the independent living, was exit seeking at times and paranoid about her medications.</p> <p>The Fall Risk Assessments for Resident #85 indicated the following: on admission (3/10/16) the resident scored a 21, on 5/6/16 the risk score was a 20, on 5/12/16 the resident scored a 12, on 7/7/16 she scored a 15 and on 7/14/16 she scored a 14. The assessment</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
--	--

(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
	<p>indicated a score of 15 or higher, meant the resident was at high risk for falls.</p> <p>A care plan, dated 3/11/16, titled "High Risk of Falls" due to poor safety awareness from Alzheimer and antidepressant use. The care plan indicated the following intervention to prevent a fall "...Nurses-- if falls occur, Nurse notify family and physician, chart details of fall and update care plan. Fall assessment to be completed quarterly and after each fall...monitor for unsafe situations that may cause a fall...."</p> <p>A Fall Report, dated 5/6/16 at 2:15 A.M., indicated the resident fell in the hallway, near the nurses cart. The report indicated the resident was observed trying to get a tissue off the nurses cart. The resident fell onto the trash container, located on the cart, and hit her head. The resident complained of pain in her nose and started to have a nose bleed and headache. First aid treatment was given to treat nose bleed, the physician was called and the resident was sent to local Emergency Room (ER). The report indicated the "resident's explanation for the fall: wanted a Kleenex." The fall report did not include old or new preventive interventions to prevent another fall.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
--	--

(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
	<p>Another fall report, dated 5/12/16 at 10:50 P.M., indicated the resident fell in the hallway, had non skid slippers on and was lying on her left side. The resident said she was going to her room and she felt sleepy. The fall report indicated the resident had no injury related to the fall. The care plan was reviewed and ongoing and no new interventions were documented.</p> <p>The care plan for Risk of Falls, dated 3/11/16, had no updated interventions and remained the same after the falls on 5/6/26 and 5/12/16.</p> <p>Another fall report indicated the resident fell on 7/7/16 at 8:55 AM. The report indicated the resident was found sitting on the floor in her room. The resident was unable to recall what happened but reported her left hip area hurt. The resident's physician was notified with new orders to send to ER for evaluation.</p> <p>The clinical record indicated the resident returned to the facility, on 7/10/16 at 1:20 P.M., after receiving a left hip arthroplasty (surgical procedure to treat a hip fracture).</p> <p>A Falls care plan, related to a fall in past 30 days, dated 7/13/16, indicated falls were manifested by: fall (or near fall) in</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
--	--

(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
--------------------	--	---------------	---	----------------------

	<p>past 180 days, anti-hypertensive use, antipsychotic use, and hip fracture. The care plan inventions included but were not limited to "...Nurses---If falls occur, Nurse notify family and physician, chart details of fall, and update care plan. Fall assessments to be completed quarterly and after each fall...Monitor food intake. Monitor fluid intake...CNA--Call light within reach, Show Resident the call light and tell how to use each time in room; Remind Resident to use for assistance, Remind to ask for assistance each time with Resident, Toilet q [every] hr [hour], assist as needed, upon rising, before and after meals and before bedtime. Do not leave unattended when toileting...."</p> <p>Another Fall Report, dated 7/14/16, indicated the resident fell at 8:15 P.M. The report indicated the resident was found in her room, lying on her back on the floor. The resident's wheel chair was located approximately 1-3 feet from the resident with the brakes off. The report indicated it appeared the resident had gotten clothes out of her drawers and was folding them on the bed and the resident had no explanation for the fall. The resident did not complain of pain, therefore the report indicated no apparent injury. The report indicated the resident was instructed on the use of her call light.</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
--	--

(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
	<p>The resident's physician was notified of the fall via a fax. No new interventions added to the 7/13/16 care plan.</p> <p>A Nursing Notes, dated 7/15/16, indicated the physician fax was received on 7/15/16 at 12:13 P.M., with no new orders. At 3:48 P.M. the physician was in the building and examined the resident due to swelling of her left wrist. The physician ordered an x-ray of the left wrist and hand. Another Nursing Note dated, 7/16/16 at 9:44 A.M., indicated a call was made to the on call physician regarding the x-ray findings and the physician directed staff to send the resident to the ER for an evaluation of fracture and application of cast/splint.</p> <p>A Radiology Report, dated 7/15/16, indicated the resident had an acute impacted, intra-articular distal radius fracture and mildly displaced ulnar styloid process fracture.</p> <p>A form titled "Emergency Department Chart," dated 7/16/16, indicated the resident had a Colles fracture (a type of broken wrist) of the left wrist . The resident presented to ER for care of the fracture and the resident could not give any history because of her chronic mental status. The fracture was stabilized in the department with a Sugar tong orthoglass</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
--	--

(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
	<p>splint and ace wraps (used to stabilize the forearm and wrist).</p> <p>An undated CNA (Certified Nursing Assistant) Assignment Sheet was received from the Assistant Director of Nursing (ADON), on 7/22/16 at 10:07 A.M. The CNA sheet indicated the resident used a wheel chair, a walker and need 1 person assist for transfers. The Needs section of the assignment sheet indicated extensive assist with toileting, bed mobility and no ambulation at this time.</p> <p>On 7/23/16 at 12:40 P.M., the ADON provided a policy titled "Fall Management," undated, and indicated the policy was the one currently used by the facility. The policy indicated "Purpose: To assess all residents for risk factors that may contribute to falling. To provide planned interventions identified by the team, as appropriate, for resident use in maintaining or returning to the highest level of physical, social and psychosocial functioning as possible...MONITORING OF RESIDENTS WITH RECURRENT FALLS...a resident with recurrent falls will be monitored and reviewed to determine if further intervention is applicable."</p> <p>On 7/23/16 at 2:00 P.M., the Assistant</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
--	--

(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
	<p>Director of Nursing (ADON) provided a policy titled "Fall Procedure," undated, and indicated the policy was the one currently used by the facility. The policy indicated "...Assess and evaluate resident after any fall and communicate with physician and family. Complete follow up per physician and policy..."</p> <p>During an interview, on 7/23/16 at 2:30 P.M., the ADON indicated the reason the resident fell was due to her dementia. The ADON indicated the nurse assessment of the falls did not evaluate for the root cause of her falls or provide new interventions to prevent a fall. The ADON indicated she had not noted any patterns to the resident's falls.</p> <p>2. The clinical record for Resident #31 was reviewed on 07/20/2016 at 3:30 P.M. Resident #31 was admitted to the facility, on 01/06/16 and readmitted on 04/15/16, with diagnoses, including but not limited to: chronic pain syndrome, traumatic hemorrhage of the cerebrum, insomnia, functional urinary incontinence, multiple fractures of the ribs, edema, osteoporosis, and weakness.</p> <p>The most recent Minimum Data Set (MDS) assessment, completed on 04/21/16, indicated Resident #31</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
--	--

(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
	<p>required extensive staff assistance for transfers and wheelchair locomotion.</p> <p>The care plan related to falls, initiated on 04/26/16, indicated the resident was at high risk for falls. The interventions included administer medications per physician's order, monitor and report any side effects and effectiveness, monitor fluid intake, safety checks as needed, monitor bowel record, fall assessment quarterly, increased nutrition and hydration - monitor, call light in reach, glasses on AM, clean and in good working order, off at night, non-skid socks, slippers or shoes, safety checks as needed, praise efforts with ADL's (Activities of Daily Living), extensive assist for transfers and mobility.</p> <p>Another fall care plan, initiated on 05/02/16, indicated the resident had a history of falls, and an unsteady gait interventions included call light in reach, remind to ask for assistance each time, non-skid socks, slippers or socks, 2 side rails up when in bed, safety checks as needed, personal alarm, bed alarm, low bed in low/floor position, report if resident is anxious or agitated to nurse, report if resident had any discomfort.</p> <p>During an interview, on 07/19/2016 at 9:49 A.M., the Assistant Director of</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
--	--

(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
	<p>Nursing (ADON) indicated Resident #31 had fallen one time in the past month. She indicated the resident had fallen, on 07/18/16 at 3:00 A.M., in her room and suffered abrasions to her right forehead area.</p> <p>Review of the nursing notes and fall incident reports from May through July 2016, indicated the resident had incurred multiple falls.</p> <p>On 05/01/16 at 5:21 A.M., the resident had slid out of bed and she did not incur any injuries.</p> <p>On 05/01/15 at 11:45 P.M., the resident had been found on the floor by her bed. The resident had stated she had to go to the bathroom. She suffered an abrasion to her right knee. On 05/02/16 a fall care plan was rewritten and interventions to add a personal and bed alarm, and complete safety checks and remind the resident to ask for assistance was added.</p> <p>On 05/24/16 at 8:43 A.M., Resident #31 was found lying beside her bed. She indicated she had slid out trying to get to the edge of her bed. She suffered an abrasion to her right eye and a small lesion above her right eye. The fall care plans were reviewed but there were no additional interventions implemented.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
--	--

(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
	<p>On 06/11/16 at 6:48 P.M., the resident was found on the floor in her bathroom. The resident stated she was on the toilet and fell from the toilet.</p> <p>During an interview, on 07/22/16 at 2:00 P.M., the ADON indicated there were no interventions newly implemented due to the fall on 5/21/16. The ADON indicated Resident #31 was left in the bathroom alone and then fell on 6/11/16. The ADON indicated the resident incurred a hematoma to her head and was sent to the emergency room to be evaluated for her head injury. There were no interventions added to the resident's care plan. The ADON indicated a "butterfly" program was initiated for Resident #31 and other resident's at fall risk to alert staff not to leave these residents in the bathroom alone.</p> <p>07/1816 at 3:15 A.M., Resident #31 slipped out of her bed, hit her forehead on the floor, and was noted to be incontinent. She suffered an abrasion to her right forehead. There were no interventions implemented to address the resident's most recent fall.</p> <p>During an interview, on 07/22/16 at 2:00 P.M., the ADON indicated there were no interventions newly implemented due to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
--	--

(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
	<p>the fall on 5/21/16. The ADON indicated Resident #31 was left in the bathroom alone and then fell on 6/11/16. The ADON indicated the resident incurred a hematoma to her head and was sent to the emergency room to be evaluated for her head injury. There were no interventions added to the resident's care plan. The ADON indicated a "butterfly" program was initiated for Resident #31 and other resident's at fall risk to alert staff not to leave these residents in the bathroom alone.</p> <p>3.1-45(a)(2)</p>			
F 0329 SS=D Bldg. 00	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 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</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
--	--

(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
	<p>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 observation, record review and interviews, the facility failed to ensure there was adequate indications to support the continued use of an antipsychotic medication for 1 of 5 residents reviewed for unnecessary medications. (Resident #41)</p> <p>Finding includes:</p> <p>On 07/20/16 at 8:29 A.M., Resident #41 was observed during an interview. Resident #41 had no idea how long he had lived at the facility and could only say he had a good breakfast.</p> <p>The clinical record for Resident #41 was reviewed on 07/20/2016 at 3:40 P.M. Resident #41 was admitted to the facility, on 02/06/11, with diagnoses, including but not limited to: major depressive disorder, intracranial injury, dementia,</p>	F 0329	<p>F329 – Drug regimen is free from unnecessary drugs I. <u>Corrective action taken for affected residents:</u> Resident#41 has been reviewed by the behavior management team including the pharmacist and the nurse practitioner. It was confirmed that the antipsychotic med is appropriate for the resident's condition and symptoms. The resident's physician has updated his diagnosis to include vascular dementia with behavioral disturbances to help treat aggressive behaviors. Targeted indications are hitting, kicking,biting and/or other physically abusive behaviors. The behavior management team did also recommend implementing a dosage reduction.</p> <p>II. <u>How other residents potentially affected will be identified:</u> All other residents with prescriptions for psych meds are also being reviewed by the behavior</p>	08/25/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
--	--

(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
	<p>GERD, glaucoma, anxiety disorder, vascular dementia with behavioral disturbance, epilepsy and Alzheimer's disease.</p> <p>The current physician's orders for medications included the antipsychotic medication, Olanzapine 10 milligrams (mg) one tablet at bedtime for delusions. The medication had been initiated on 05/15/15, after an inpatient psychiatric hospital stay.</p> <p>The care plan related to behavior issues focused on agitation, yelling out and anger issues but did list the diagnosis of delusions as part of the problem. The interventions were not specific to delusional behavior.</p> <p>During an interview, on 07/22/16 at 9:56 A.M., RN (Registered Nurse) #7 indicated Resident #41 displayed physically aggressive behaviors, such as hitting and slapping staff during care times and meal times. She indicated the resident was also very verbally aggressive and would yell at staff to "Shut up" and "Get out of here [his room]." She indicated just prior to having seizure activity Resident #41 did become verbally repetitive with food and staff assistance requests. RN #7 did not mention any delusional behavior</p>		<p>management team to ensure they have appropriate diagnoses documented in the clinical record. The same residents are also being reviewed for the potential to gradually reduce the dosages of any psych meds they are on. III. <u>Measures implemented to ensure deficiency does not recur:</u> The root cause of the cited deficiency is insufficient training of nurses on the need for specific documentation required to support the need for certain meds and lack of a good system of accountability. All nurses will be in-serviced on the documentation requirements related to the use of antipsychotic meds including charting of behaviors and having an appropriate diagnosis present in the record. (AttachmentA) The behavior management team will continue to review all antipsychotic med use on a monthly basis and include a review of facility documentation in the meeting to ensure the clinical record supports the recommended treatment. The ADON will be responsible to monitor all antipsychotic medication orders within the week of receipt and confirm appropriateness of use including documentation and diagnosis. IV. <u>How corrective measures will be monitored:</u> The DON, or her designee, will review the documentation and diagnoses of all residents on an antipsychotic</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
--	--

(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
	<p>displayed by Resident #41.</p> <p>During an interview, on 07/20/16 at 3:30 P.M., the Assistant Director of Nursing (ADON) indicated since Resident #41 was started on the Olanzapine in May 2015 he had not had a gradual dose reduction of the medication. She indicated the psychiatric nurse practitioner had indicated a dose reduction was contraindicated.</p> <p>A review of a psychiatric note by the nurse practitioner, dated 02/18/16, indicated the following statement: "resident continues to have behaviors and a reduction would cause increased instability."</p> <p>A review of all of the psychiatric and facility documentation, from 06/20/15 through 04/22/2016, indicated there was no notation or documentation of any delusional behaviors for Resident #41. There was no documentation of any paranoid type verbalization or outburst associated with the documented physically and verbally aggressive behaviors.</p> <p>During an interview, on 07/22/16 at 11:15 A.M., the ADON indicated the resident had not displayed any delusional type behaviors.</p>		<p>med weekly for a minimum of 2 months to ensure GDR policy has been followed and documentation is present in the clinical record. A monitoring tool will be used to document the results of the chart reviews, track the rate of compliance and to report to the QA Committee. (Attachment E) Provided compliance is greater than 95%, the monitoring process may be reduced to a monthly frequency for chart review for an additional 4 months. A compliance rate of 95% must be achieved and maintained or the monitoring will be extended and additional corrective actions will be enacted by the QA Committee.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
--	--

(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 0371 SS=F	<p>On 07/22/16 at 11:15 A.M., the ADON provided the facility policy and procedure, titled "Medication, Anti-Psychotic," undated, and indicated this was the one currently used by the facility. The policy and procedure included the following: "1. All residents for whom anti-psychotic drugs are considered necessary must have documented in clinical record the disorder being treated and the specific target behaviors for which the medication is being used...1. There must be a specific plan for staff to monitor, quantitatively, document and assess the identified target behaviors. Data should be evaluated by the interdisciplinary team at least twice annually while discussing risk/benefits of continued used and potential reduction...."</p> <p>3.1-48(a)(4)</p> <p>483.35(i) FOOD PROCURE,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
--	--

(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
Bldg. 00	<p>STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, record review, and interviews, the facility failed to ensure food was stored, served and prepared in a sanitary manner in 1 of 1 kitchen and 3 of 3 nourishment refrigerators. This had the potential to affect 78 of 78 residents who consume food in the facility.</p> <p>Findings include:</p> <p>On 7/18/16 from 6:45 P.M.-7:15 P.M., during the initial kitchen tour, with the Dietary Assistant and the Dietary Manager the following was observed:</p> <p>A record of the Dishmachine Temperatures for July 2016 was hanging on the wall across from the dishmachine. A review of the Dishmachine Temperature Log indicated on 7/5/16 no temperature was documented for the evening shift, on 7/7/16 no temperature was documented for the day shift, on 7/8/16 no temperature was documented for day shift, on 7/11/16 no temperature was documented for the evening shift, on 7/12/16 no temperature was documented for day or evening shift, on 7/13/16 no</p>	F 0371	<p>F371 – Food storage and sanitation I. <u>Corrective action taken for affected residents:</u> No residents were identified by the survey team as having been affected by any of the findings specified. Some dates were missing on the logs of dish machine and refrigerator/freezer temps –those that were present on the logs were all within required values. Temps taken subsequent to the survey have remained within required parameters and no temps have been missed. The oven with an unidentified brown sticky substance on the surface was cleaned immediately. Undated/unlabeled food and beverages identified by the survey team were discarded immediately. New containers with lids were ordered for the ice scoops. II. <u>How other residents potentially affected will be identified:</u> All residents served food from the kitchen could potentially have been affected. No residents were identified to have displayed signs or symptoms of a food borne illness. III. <u>Measures implemented to ensure deficiency does not recur:</u> Root cause analysis shows that</p>	08/25/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
--	--

(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
	<p>temperature was documented for evening shift, on 7/14/16 no temperature was documented for day shift and on 7/16/16 no temperature was documented for the day shift. Reach in cooler #1 was observed to have a plastic pitcher half full of lemonade with no date on it. In the large walk in cooler on top of a metal shelf a tan plastic container with clear plastic wrap on the top of it was observed with black olives inside the container, the container was not dated. There was a container of salad dressing that was opened and undated and a large plastic bag of shredded cheddar cheese that was open and was undated. The bottom oven of the double convection oven was observed to have a thick brown sticky substance all across the bottom of it.</p> <p>During an interview, on 7/18/16 at 7:05 P.M., Dietary Assistant, Employee #1 indicated the convection oven should be cleaned once a week on Saturdays. She indicated the cook that was scheduled on this past Saturday evening did not clean the oven.</p> <p>During an interview, on 7/18/16 at 7:15 P.M., Employee #1 indicated the Dietary Department was responsible for stocking and removing the outdated food items in the nourishment refrigerators on the nursing units, and the nursing staff was</p>		<p>cited deficiencies were a result of inadequate training and an insufficient system of accountability for employees responsible for carrying out duties related to logging temperatures, dating and labeling of food and beverages, and cleaning kitchen equipment. All kitchen staff have received a refresher in-service on the policies and procedures for each of those topics. (Attachment F) New employees will receive training in these key areas during orientation and all dietary employees will also receive this training at least once annually. The Dining Services Manager, or her designee, will check temperature logs daily on the dish machine and walk-ins, check all opened food items in the walk-ins for proper labeling daily and inspect kitchen equipment daily for cleanliness. Nursing staff are responsible for checking and logging refrigerator/freezer temps on nursing units daily. Nursing staff have been in-serviced as a reminder of their responsibility to check temps and how to label/date any food in the refrigerators/freezers in med rooms and nourishment rooms when opened. (Attachment A) The Dining Services Manager, or her designee, will check the contents of the refrigerators/freezers on the nursing units daily when they make their rounds and discard</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
--	--

(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
	<p>responsible for cleaning and checking the temperatures of the nourishment refrigerators.</p> <p>On 7/18/16 from 7:20 P.M.-7:30 P.M., an observation of the nourishment refrigerators on the nursing units was conducted with the Dietary Assistant during which the following was observed:</p> <p>On Hallway 5, a plastic pitcher half full of lemonade had a date on the lid of 7/3/16. There was a ham and cheese sandwich wrapped in plastic with no name or date on it.</p> <p>The nourishment refrigerator for Hallways 1, 2 and 3 was observed to have: One 46 ounce container of grape juice that was half full and undated. One 46 ounce container of apple juice was half full and undated. One 46 ounce container of cranberry juice was half full and undated. There was a plastic ice scoop container mounted on the wall behind the ice machine no lid was observed and a metal scoop was observed inside the container. Review of the Hall 1, 2 and 3 Nourishment Cleaning log, dated 7/3/16-7/17/16, indicated no temperatures were documented for the refrigerator or the freezer on 7/2/16, 7/4/16, 7/8/16, 7/9/16,7/10/16, 7/11/16</p>		<p>any items that are found opened without proper dates and labels. IV. <u>How corrective measures will be monitored:</u> Dining Services Manager will utilize a monitoring tool, a log, on which to document the results of the daily inspections. (Attachment G) The log will be used daily for at least 30 days, and weekly for at least 6 months. The DON, or her designee will also use a similar monitoring tool to track the logging of refrigerator temps and food labeling in med rooms and nourishment rooms on the units. (Attachment H) Monitoring will continue beyond 6 months until temperature logging, food labeling and equipment cleaning is maintained at a minimum of 95% compliance. Monitoring logs will be reviewed in QA meetings held quarterly to determine the rate of compliance and whether or not additional monitoring or corrective actions are necessary.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
--	--

(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
	<p>and 7/12/16.</p> <p>On the Rehab hallway, a 46 ounce white plastic container was 1/4 full of strawberry yogurt the best use by date on the top of the container was 7/7/16, there was no open date on the container of yogurt. One 46 ounce container of vegetable juice was half full and no open date. One 46 ounce container of grape juice was half full and no open date. One 46 ounce container of cranberry juice was half full and no open date. Review of the Rehab hallway nourishment cleaning log, dated July 2016, indicated no refrigerator or freezer temperatures were documented on 7/1/16, 7/3/16, 7/4/16, 7/9/16 and 7/10/16.</p> <p>During an interview, on 7/19/16 at 9:15 A.M., the Dietary Assistant indicated if food is found in the refrigerator and was not dated or labeled it should be discarded. She indicated food should not be used after 5 days, the dishmachine temperature log should be filled in twice a day and the nourishment refrigerators should have the temperatures checked and documented daily by the nursing staff.</p> <p>On 7/19/16 at 11:35 A.M., a PM Cook Cleaning schedule was received from the Dietary Manager. The form indicated the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
--	--

(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
	<p>oven was cleaned by a Dietary staff member on Saturday 7/16/16.</p> <p>On 7/19/16 at 11:35 A.M., the Dietary Manager provided a policy titled "Refrigeration Food Storage," undated, and indicated the policy was the one currently used by the facility. The policy indicated "...Procedure: Food storage areas will be cleaned on a weekly basis as indicated on cleaning schedules...Anything stored in the refrigerator MUST BE COVERED, LABELED & DATED...Foods shall be rotated on a first in, first out basis. Product is to be tossed by the manufacturer out date or kitchen standard, whichever comes first. Leftover food shall be kept no longer than 3 days...."</p> <p>On 7/19/16 at 11:40 A.M., the Dietary Manager provided a policy titled "Cleaning of Convection Ovens," undated, and indicated the policy was the one currently used by the facility. The policy indicated "...Convection ovens shall be cleaned weekly by the charge cooks each shift...The am charge cook will be responsible for cleaning the top convection oven once a week. The PM charge cook will be responsible for cleaning the bottom oven once a week. If either oven has a spill/mess before the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
--	--

(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
	<p>scheduled cleaning day the cook will spot clean the mess immediately...."</p> <p>On 7/19/16 at 11:45 A.M., the Dietary Manager provided a policy titled "Dish Machine Temperatures," undated, and indicated the policy was the one currently used by the facility. The policy indicated "... Dish machine temperatures shall be taken twice daily by the person assigned to wash the dishes each shift. The person assigned to wash the dishes is responsible for checking & documenting the dish machine temperatures for their shift. Once for am shift and once for PM shift. If the dish machine is not functioning properly, and/or if the temperatures are not in the safe range then a call will be placed to maintenance immediately...."</p> <p>On 7/19/16 at 11:50 A.M., the Dietary Manager provided a policy titled "Refrigerator Temperatures in Nourishment Rooms," undated, and indicated the policy was the one currently used by the facility. The policy indicated "...Internal temperatures of refrigerators should be documented nightly by the nursing staff. The nursing staff is responsible for checking and documenting the refrigerator temperatures nightly. If any of the refrigerators are not functioning properly, and/or if the temperatures are not in the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
--	--

(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 9999 Bldg. 00	safe range then a call will be placed to maintenance immediately...." 3.1-21(i)(3)	F 9999	F9999 – Final observations I. <u>Corrective action taken for affected residents:</u> A report detailing the two falls with fractures for Resident #85 was submitted to ISDH on 7/23/16. II. <u>How other residents potentially affected will be identified:</u> Recent falls were reviewed for all residents and no falls with fractures were found that were not reported to ISDH. III. <u>Measures implemented to ensure deficiency does not recur:</u> The old policy regarding reportable incidents has been replaced with the current ISDH policy that was revised effective 7/15/15. Nursing staff were provided a notice of the change in reporting all fractures and given a	08/25/2016
	3.1-28 STAFF TREATMENT OF RESIDENTS (a) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. (c) 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 other officials in accordance with state law through established procedures, including to the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
--	--

(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
	<p>state survey and certification agency.</p> <p>This state rule is not met as evidenced by:</p> <p>Based on observation, record reviews and interviews, the facility failed to have an updated policy in regards to reporting fractures to the Indiana State Department of Health and therefore, failed to report 2 falls resulting in fractures for Resident #85.</p> <p>Finding includes:</p> <p>On 7/21/16 at 10:35 A.M., Resident #85 was observed in the activity room. The resident had a hard cast or splint on her left forearm. The cast or splint was covered with an ace bandage.</p> <p>On 7/22/16 at 10:11 A.M., a review of the clinical record for Resident # 85 was conducted. The record indicated the resident was admitted on 3/10/16. The resident's diagnoses included, but were not limited to: Alzheimer's disease, depressive disorder, restless, agitation, peripheral vascular disease, hypothyroidism and recent hip replacement.</p> <p>An Admission MDS (Minimum Data Set) Assessment, dated 3/18/16, indicated the resident's BIMS (Brief Interview</p>		<p>copy of the updated policy. State reportables are submitted by the ADON and by the DON or Administrator in her absence.</p> <p>IV. <u>How corrective measures will be monitored:</u> DON, or her designee, will utilize a monitoring tool to ensure that falls with fracture have been reported to ISDH. A log of all falls will be kept and those resulting in fractures will be checked off when the report has been submitted to ISDH. (Attachment I) Results of the monitoring will be presented in quarterly QA meetings. A 95% rate of compliance must be achieved and maintained in order for the monitoring frequency to be reduced after 6 months.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
--	--

(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
	<p>Mental Status) score was 5, severe dementia. The assessment indicated the resident needed the extensive assist of one person to dress and use the toilet. The resident required the limited assist of one person with transfers and walking.</p> <p>A fall report indicated the resident had a witnessed fall on 7/7/16 at 8:55 A.M. The report indicated the resident was found sitting on the floor in her room. The report indicated the resident was unable to recall what happened but indicated to staff her left hip area hurt. The resident was bleeding from her left side of head from a laceration which measured 1.3 centimeters (cm). The report indicated the resident's physician was notified and the staff received a new order to send the resident to a local Emergency Room (ER) for an evaluation. The report indicated the incident was not reported to the State.</p> <p>The clinical record indicated the resident returned to the facility, on 7/10/16 at 1:20 P.M., after receiving a left hip arthroplasty (surgical procedure to treat a hip fracture).</p> <p>Another Fall Report, dated 7/14/16, indicated the resident had an unwitnessed fall at 8:15 P.M. The report indicated the resident was found in her room, lying on her back, on the floor. The resident did</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
--	--

(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
	<p>not complain of pain, therefore the report indicated no apparent injury. The report indicated the incident was not reported to the State.</p> <p>A Nursing note, dated 7/15/16 at 3:48 P.M., indicated the physician was in the building and examined the resident due to swelling of her left wrist. The physician ordered an x-ray of the left wrist and hand.</p> <p>A Radiology Report, dated 7/15/16, indicated the resident had an acute impacted, intra-articular distal radius fracture and mildly displaced ulnar styloid process fracture.</p> <p>On 7/16/16 at 9:44 A.M., a call was made to the on-call physician regarding the x-ray findings for Resident #85. The on-call physician directed the staff to send the resident to ER for evaluation of a fracture and application of cast/splint.</p> <p>A form titled "Emergency Department Chart," dated 7/16/16, indicated the resident had a Colles fracture (a type of broken wrist) of the left wrist. The report indicated the resident presented to ER for care of the fracture and the resident could not give any history because of her chronic mental status. The report indicated the fracture was stabilized in</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
--	--

(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
	<p>the department with a Sugar tong orthoglass splint and ace wraps (to stabilize the forearm and wrist).</p> <p>On 7/22/16 at 3:35 P.M., the Assistant Director of Nursing (ADON) provided a policy titled "Incident Reporting," undated and indicated the policy was the one currently used by the facility. The policy indicated "...Procedure: 1. When a reportable incident occurs, the DON [Director of Nursing] or ADON will be immediately notified...The Administrator will also be notified immediately... 4. Incidences which qualify as a reportable are as follows...Injuries of unknown source...Significant injuries (i.e. large areas of contusions, burns greater than first degree, fractures sustained by a totally dependent resident, etc...."</p> <p>During an interview, on 7/23/16 at 2:30 P.M., the Assistant Director of Nursing indicated the resident's two fall's, with injury of fractures, where not self reported by the facility due to the resident not being dependent on care per the MDS (Minimum Data Set) assessment. The ADON indicated she was not aware of a new incident reporting policy, issued in July of 2015. The ADON was not aware that all fractures were to be report to the Indiana State Department of Health.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
--	--

(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
--------------------	--	---------------	---	----------------------

R 0000 Bldg. 00	<p>An Indiana State Department of Health, Incident Reporting Policy, dated 7/15/15, indicated "...C. Types of incidents reportable under State rules only...5. MAJOR ACCIDENTS - unexpected or unintentional events resulting in any fracture or other outcomes that require medical treatment beyond basic first aid or ER/physician evaluation... Examples: ALL fractures...."</p> <p>3.1-28(a) 3.1-28(c)</p>			
	<p>This visit was for a State Residential Licensure Survey.</p> <p>Residential Census: 51</p> <p>Sample: 7</p> <p>This State findings is cited in accordance with 410 IAC 16.2-5.</p>	R 0000	<p>Submission and implementation of this plan of correction shall not constitute an admission by Grace Village Health Care to any allegations of deficiency as contained</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
--	--

(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
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every		in the "Summary Statement of Deficiencies" or agreement with claims made therein, rather, this plan is submitted in accordance with State and Federal requirements. Grace Village Administration requests paper compliance for this Plan of Correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
--	--

(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
	<p>additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record reviews and interviews, the facility failed to ensure at least one staff member, per shift, had First Aid Certification.</p> <p>Finding includes:</p> <p>On 7/25/16, a review of all 32 Assisted Living staff members was conducted and none of the Assisted Living staff members were certified in First Aid. Six of the 32 staff members were currently certified in CPR (Cardiopulmonary Resuscitation). The staffing schedule for the Assist Living area was reviewed from 7/22/16 thru 7/28/16 for licensed personnel. There were 27 employees, over 3 shifts who worked in the Assisted Living area from 7/22/16 thru 7/28/16 and no staff members were First Aid certified.</p> <p>On 7/25/16 at 9:45 A.M., the Assistant Director of Nursing (ADON) provided a policy titled "Emergency Care," undated, and indicated the policy was the one currently used by the facility. The policy indicated "...Emergency medical care refers to the care given to resident in order to meet that resident's urgent, critical or life threatening needs... 7.</p>	R 0117	<p>R117 – Personnel Deficiency</p> <p>I. <u>Corrective action taken for affected residents:</u> No residents were identified as having been affected by the periodic absence of a first aid certified employee. All QMA's and nurses who work on the Assisted Living Unit have already completed (or will soon complete) first aid certification. Administration notes that a nurse is onsite at all times to respond to any emergencies. If the nurse is not already present on the Assisted Living Unit at anytime, he/she is on a connected Nursing Unit and still responsible to respond to emergency needs on the Assisted Living Unit.</p> <p>II. <u>How other residents potentially affected will be identified:</u> No residents were identified as having been affected by the periodic absence of a first aid certified employee. All QMA's and nurses who work on the Assisted Living Unit have already completed (or will soon complete) first aid certification. Administration notes that a nurse is onsite at all times to respond to any emergencies. If the nurse is not already present on the Assisted Living Unit at anytime, he/she is on a connected Nursing Unit and still responsible to respond to emergency needs on the Assisted Living Unit.</p>	08/25/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
--	--

(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
	<p>Facility staff will perform only those emergency procedures for which they are trained and qualified: CPR and Emergency Treatment Procedures...."</p> <p>During an interview, on 7/25/16 at 2:15 P.M., the ADON indicated the Hall 5, (located in the healthcare section of the facility) nurses were considered part of the Assist Living staff. The DON provided a list of 9 nurses working the week of 7/22/16 thru 7/28/16. Of those 9 employees, all 9 had their CPR certification and 0 (zero) had a First Aid certificate.</p> <p>During an interview, on 7/26/16 at 9:40 A.M., the Human Resources Director indicated she was not aware the Assist Living area needed to have at least one employee per shift with a First Aid certification.</p> <p>On 7/26/16 at 9:45 A.M., a current policy titled "Grace Village Employee Policy and Procedure," dated January 1, 2015, was received from the Human Resources Director. The policy indicated "...Employee personnel files will contain the following sections of collected data, which includes but is not limited to... 6. Certificates of required training, license verifications, etc...."</p>		<p>III. <u>Measures implemented to ensure deficiency does not recur:</u> Facility will require all QMA's and nurses who work on the Assisted Living Unit to be certified in first-aid to avoid the possibility that a shift could potentially be covered by only non-first aid certified personnel. First aid certification/recertification classes are provided onsite at least annually and on an as needed basis at no cost to employees. Human Resources department will ensure that all Assisted Living employees requiring first aid certification are given reminders of the due dates of their recertification and maintain a copy of their certificate in their personnel files. Assisted Living QMA's and nurses will not be permitted to work unless/until they have current first aid certification on file. (Attachment A) IV. <u>How corrective measures will be monitored:</u> DON, or her designee, will utilize a check off list monitoring tool to ensure that any nurses scheduled to work on the Assisted Living Unit have a current first aid certification. Nursing staff first aid certifications will be confirmed weekly for 30 days and monthly thereafter for a period of at least 6 months provided 95% compliance is achieved and maintained. Results of the monitoring will be presented in quarterly QA meetings. The QA committee will determine if further corrective</p>	

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

PRINTED: 09/06/2016

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 07/26/2016
NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590		
(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	
			action is necessary.		