

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155783	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/07/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000  Bldg. 00	<p>This visit was for the Investigation of Complaint # IN00172134.</p> <p>Complaint #IN00172134 - Substantiated. State deficiencies related to the allegations are cited at R117.</p> <p>Survey Date: May 7, 2015</p> <p>Facility number: 002661 Provider number: 155783 AIM number: 201056540</p> <p>Census bed type: NF: 9 SNF/NF: 45 Residential: 47 Total: 101</p> <p>Census by payor type: Medicare: 34 Medicaid: 5 Other: 15 Total: 54</p> <p>Sample: 7</p> <p>Greenleaf Health Campus was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaint</p>	F 000		

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:  155783	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  05/07/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 000 Bldg. 00	# IN00172134. These deficiencies reflect state findings in accordance with 410 IAC 16.2-5.  These state findings are cited in accordance with 410 IAC 16.2-5.	R 000		
R 117 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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155783	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/07/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>(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 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 review and interview, the facility failed to ensure a staff person with CPR (Cardiopulmonary Resuscitation) and First Aid certification was on staff for 2 of 3 shifts reviewed for Staffing and Employee Records. This deficient practice had the potential to affect 47 of 47 resident's currently residing in Assisted Living.</p> <p>Finding includes:</p> <p>On 5-9-15 at 6:00 P.M., the "Elkhart (Greenleaf Living Center) Nursing Legacy Daily Attendance Report," dated Thursday May 07, 2015, was reviewed. The Daily Attendance Report indicated the following: *Evening shift: LPN (Licensed Practical Nurse) #1 and CNA's (Certified Nursing Assistant) #2, #3, #4 and #5. *Night Shift: LPN #7 and QMA (Qualified Medication Aide) #6.</p> <p>On 5-9-15 at 6:10 P.M., the Licensure Book for employees was reviewed. The Licensure book lacked documentation to</p>	R 117	<p>1. No noted ill effects to 47 Assisted living residents noted. 2. We have audited all licensed staff for Assisted living and they have been set up for training. We have adjusted staff to ensure each shift has a certified CPR person on duty. 3. All Licensed staff are being recertified for CPR/first aide. The facility will offer CPR training every year to keep all assisted living licensed staff in compliance. 4. We have a scheduling system that we can track this information and will run monthly to ensure everyone is up to date. We will bring to Quality Assurance monthly x 3 months and if 100% compliance obtained will consider system working.</p>	06/05/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155783	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/07/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>show LPN #1 and #7, CNA's # 2, #3, #4 and #5, and QMA #6 had CPR and First Aid certification.</p> <p>On 5-9-15 at 6:35 P.M., an interview was conducted with the Executive Director of the facility. The Executive Director indicated the facility had recently conducted training in CPR and First Aid but did not have documentation available to indicate the employees were certified.</p> <p>On 5-9-15 at 6:45 P.M., a current policy titled, "Assisted Living Guidelines Staff Training Requirements," dated 12/2010, provided by the Executive Director was reviewed. The policy indicated the following: "Purpose: To ensure the staff caring for residents have the necessary training and knowledge to meet the needs of the residents. 1. Prior to working independently staff shall receive orientation and training which shall include but may not be limited to: q. CPR in applicable states...."</p> <p>On 5-9-15 at 6:50 P.M., a current policy titled, " Assisted Living Guidelines Staffing Requirements," dated 12/2010, provided by the Executive Director was reviewed. The policy included the following: "Purpose: To ensure compliance with State requirements for staffing....Procedure: 1. The campus shall</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155783	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/07/2015
NAME OF PROVIDER OR SUPPLIER  GREENLEAF HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 E BEARDSLEY ELKHART, IN 46514		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>schedule staff 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....2. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents and State regulatory requirements...."</p> <p>This Residential tag relates to Complaint IN00172134.</p>				