STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR GROVE VILLAGE	1021 E CENTRAL AVE GREENSBURG, IN 47240

(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
F000000	This visit was for the Investigation of Complaint IN00127058. Complaint IN00127058 - Substantiated. Federal/state deficiency related to the allegations is cited at F514. Survey dates: April 15, 16 and 17, 2013 Facility number: 000305 Provider number: 155625 AIM number: 100287200 Survey team: Penny Marlatt, RN Census bed type: SNF/NF: 64 Total: 64 Census Payor type: Medicare: 8 Medicaid: 51 Other: 5 Total: 64 Sample: 3 Arbor Grove Village was found to be in substantial compliance with 42 CFR Part 483 Subpart B in regard to the Investigation of Complaint	F000000		

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/17/2013
NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240	

(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
	IN00127058. This deficiency reflects state findings cited in accordance with 410 IAC 16.2. Quality review 4/19/13 by Suzanne Williams, RN			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/17/2013
NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240	

(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
F000514 SS=A	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on interview and record review, the facility failed to ensure a resident identified with a pressure area on the heel had consistent documentation of the affected area for 1 of 3 residents reviewed for pressure areas in a sample of 3. (Resident #A) Findings include: Resident #A's clinical record was reviewed on 4-15-13 at 2:03 p.m. His diagnoses included, but were not limited to, Alzheimer's disease, high cholesterol, anemia, cellulitis of the left hand and bridge of nose and prostate cancer. Review of Resident #A's admission nursing assessment, dated 3-16-13,	F000514	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation and requests a desk review in lieu of a Post Complaint Survey Revisit on or after April 22, 2013. - what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; This resident no longer resides in the facility. - how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All	04/22/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/17/2013
NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240	

(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
	indicated the resident's skin had lacerations to both thighs, which the resident indicated came from his cats at home. Additionally, it indicated his left hand was slightly warm to touch, red and swollen. There were no other indications of abnormalities to the skin on the assessment. The assessment indicated he was at risk for developing skin breakdown related to his diagnoses of anemia, cancer, refusal of care and memory problems. Review of Resident #A's weekly summary indicated on 3-21-13 at 12:47 p.m., his skin was warm, dry, pink with no other skin issues, other than the cellulitis of the left hand. A "Shower Report," dated 3-26-13 with no time listed, indicated Resident #A received a shower on this date with a shampoo and oral care provided. It indicated in the "Comments" section, "No New Area," referring to no new skin issues. This document was signed by CNA #1 and QMA #1. In interview with the Director of Nursing on 4-17-13 at 10:55 a.m., she indicated Resident #A would have received his shower during the morning hours. On 3-26-13 at 3:14 p.m., a "Non-Pressure Wound Skin		residents have the potential to be affected by the alleged deficient practice. A 100% skin sweep was conducted on all residents on 4/22/2013. Any skin issues identified during the skin sweep were immediately addressed by the nursing staff. Inservicing was conducted with nursing staff on 4/17/2013 by the Staff Development Coordinator and the Director of Nursing regarding accurate documentation, identifying and reporting skin issues, and proper skin assessments. CNA skills validations for showers were completed by the SDC by 4/22/2013. what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Inservicing was conducted with nursing staff on 4/17/2013 by the Staff Development Coordinator and the Director of Nursing Services regarding accurate documentation, identifying and reporting skin issues, and proper skin assessments. CNA and licensed nurse co-sign shower sheets .CNA Skills Validations were completed by 4/22/2013 by the SDC. Skin sweeps will be conducted weekly by nursing staff for 4 weeks and then monthly thereafter. Shower sheets will now be audited daily for accuracy by the ADNS and/or designee. The skin sweeps and shower	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/17/2013
NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240	

(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
	Evaluation" document indicated a new area of a "fluid-filled area" was identified as a "blister to Right heel." The measurement of the affected area was indicated as 7.3 cm (centimeters) by 8.3 cm (or approximately 2.75 inches by 3.25 inches). Associated nursing progress notes, dated 3-26-13 at 3:22 p.m., indicated the resident's physician and POA (power of attorney) had been notified of the new skin area with new orders received from the physician which included a skin prep to the blister area and to elevate his heels off of the bed. In interview with LPN #1 on 4-16-13 at 4:16 p.m., she indicated she had conducted Resident #A's skin assessments during his stay at the facility. She indicated she did not recall any other skin related issues, other than the blister which she indicated developed on 3-26-13, time not indicated. In interview with the Executive Director and Director of Nursing on 4-17-13 at 10:55 a.m., both were queried as to why the documentation from early the morning of 3-26-13 to early afternoon the same date would reflect no new areas of skin concerns to a rather large blister. The Executive Director indicated the resident did have many underlying		sheet audits will be overseen by the Director of Nursing Services and/or designee. This is the responsibility of the Director of Nursing Services and/or designee. - how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and This will be monitored through the Skin Management CQI which will be completed weekly times four weeks and monthly times six months. The results of this audit will be reviewed by the Quality Assurance Committee. If the results of the CQI audit are less than the 90% benchmark, an action plan will be developed and implemented. - by what date the systemic changes will be completed. These changes will be completed by 4/22/2013. 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/17/2013
NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240	

(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
	health conditions. This Federal tag relates to Complaint IN00127058. 3.1-50(a)(1) 3.1-50(a)(2)			