STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155026	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/15/2011
NAME OF PROVIDER OR SUPPLIER GREENWOOD VILLAGE SOUTH		STREET ADDRESS, CITY, STATE, ZIP CODE 295 VILLAGE LANE GREENWOOD, IN46143	

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F0000	This visit was for the Recertification and State Licensure survey. This visit was in conjunction to the Post Survey Revisit (PSR) for Complaint IN00098697 and IN00099021 completed on 11/3/11. This visit was in conjunction to the PSR for Complaint IN00096244 completed on 10/11/11. Survey dates: December 11, 12, 13, 14 and 15, 2011 Facility number: 000010 Provider number: 155026 AIM number: 100453660 Survey Team: Leia Alley, RN, TC Marcy Smith, RN Barbara Hughes, RN Patty Allen, BSW Karina Gates, BS (December 12, 13, 14, 15) Courtney Mujic, RN (December 12, 13, 15) Beth Kolasa, RN (December 12, 13, 14) Dinah Jones, RN (December 13, 14, 15) Census bed type:	F0000	Preparation and execution of this plan of correction in no way constitutes an admission or agreement by Greenwood Village South of the truth of the facts alleged in this statement of deficiencies and plans of correction. In fact, Greenwood Village South reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts, and conclusions that form the basis of the deficiency. This plan of correction serves as the credible allegation of compliance by 1/06/12. This statement of deficiencies and plan of correction will be reviewed at the monthly Quality Assurance/Assessment Committee Meeting for the survey ending 12/15/11.	

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

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

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	SNF: 30 SNF/NF: 71 Residential: 147 Total: 248 Census payor type: Medicaid: 29 Medicare: 16 Other: 203 Total: 248 Sample: 21 Residential Sample: 10 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2 Quality review completed on December 21, 2011 by Bev Faulkner, RN			

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F0279 SS=D	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on record review and interview, the facility failed to develop a comprehensive plan of care for 3 of 13 residents reviewed for development of comprehensive care plans in a sample of 21 residents. Residents A, 50, and 80. Findings Included: 1. The record for Resident A was reviewed on 12/12/11 at 2:00 p.m. Diagnoses for Resident A included but were not limited to, dementia and Parkinson's (a disorder of the brain that leads to shaking and tremors),	F0279	**F279 CORRECTIVE ACTION Resident A's plan of care has been reviewed and updated to include a plan of care for communication and dental care. Resident # 50's plan of care has been reviewed and updated to include a plan of care for dental care. Resident #80's plan of care has been reviewed and updated to include a plan of care for urinary incontinence and communication. The MDS Coordinators will utilize an additional function to aid in care plan determination decision making using VISION MDS software system. Licensed Nurse staff received training regarding care plan**	01/06/2012

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	A Minimum Data Set (MDS) was reviewed on 12/12/11 at 3 p.m., for Resident A. The MDS results suggested that a comprehensive plan of care was required in the areas of communication and dental care. Information regarding both care plans was requested from the Director of Nursing (DON) and Administrator at the exit meeting on 12/13/11 at 4:30 p.m. During an interview with the DON on 12/14/11 at 9:00 a.m., she indicated they did not have these care plans for Resident A. During an interview with the MDS Coordinator on 12/14/11 at 10:25 a.m., she indicated the missing plans of care for this resident were created on 12/14/11, in the morning. 2. The record of Resident #80 was reviewed on 12/14/11 at 9:00 a.m.		**initiation/updating. OTHER RESIDENTS AFFECTED MDS Coordinator staff will review and update (as deemed necessary) all resident care plans during the next quarterly schedule (January-February-March 2012). SYSTEMIC CHANGE The MDS Coordinator and/or designee will attend daily clinical meeting (M-F) where twenty four hour reports and new physician orders are reviewed. Upon completion of the MDS (admission; quarterly; annual; change of condition; or other scheduled assessment), the Director of Nursing and or designee will review with the MDS coordinator the resident's plan of care. MONITORING The Director of Nursing (and or designee) will audit 8 charts weekly x 6 months to verify the resident's plan of care has been updated to be reflective of changes in physician orders and condition. The results of the audits will be reviewed at the facility's quality assurance and improvement meetings. COMPLETION DATE January 6, 2012**	

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	Diagnoses for Resident #80 included, but were not limited to, end stage Alzheimer's Disease and urinary retention. Review of an annual Minimum Data Set (MDS) for 12/1/11 for Resident #80 indicated care areas for urinary incontinence and communication were triggered for needing care plans. No documentation was found in Resident #80's record of care plans for urinary incontinence or communication. Further information was requested from the Director of Nursing on 12/14/11 at 4:45 p.m. regarding care plans for urinary incontinence and communication being written, as indicated by the most recent MDS. On 12/15/11 at 9:00 a.m., the DON provided care plans for urinary incontinence and communication. These had been created and were effective 12/14/11. 3. The clinical record of Resident #50 was reviewed on 12/12/11 at 10:00 A.M. A review of the Minimum Data Set (MDS) Care Area Assessment (CAA) Summary, dated 10/23/11, for Resident #50, triggered a dental care area to be developed in a care plan related to a			

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	nursing assessment located in the nursing notes on 6/18/11. Nursing notes on this date indicated that dentures were placed on 6/18/11 for Resident #50 and pain was being monitored. The CAA Analysis of Findings on the 10/23/11 MDS was also marked "yes" indicating a care plan would be developed. During an interview with the DON on 12/12/11 at 2:30 P.M., she indicated that a dental care plan for Resident #50 could not be found, and that it should have been developed as marked on the CAA Summary. She indicated she would immediately see that the dental plan of care was developed and placed in the chart of this resident. On 12/13/11 at 3:30 P.M., a copy of the dental care plan created for Resident #50 was received and provided for review. 3.1-35(c)(1)			

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F0280 SS=A	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. 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. Based on clinical record review and an interview, the facility failed to update the care plan to reflect a diet plan change from a mechanical to pureed diet, for 1 of 13 residents reviewed for care plan updates in a sample of 21. Resident # 50 Findings include: The clinical record of Resident #50 was reviewed on 12/12/11 at 10:00 A.M. The Annual MDS CAA Summary, dated 10/23/11, indicated a care area of Nutritional Status triggering development of a care plan. A review of the physician's recap, dated 12/1/11, indicated this resident was to receive a pureed diet per physician order dated 11/18/11. This	F0280	**F280 CORRECTIVE ACTION Resident # 50's plan of care has been reviewed and updated to reflect a diet plan change from mechanical to pureed diet. The Dietary Service Manager has been received training regarding updating the resident's plan of care associated with changes in therapeutic diets. MDS Coordinators and Licensed Nurse staff have received training regarding care plan initiation/updating. OTHER RESIDENTS AFFECTED The Dietary Service Manager and or designee will review and update as necessary the record and care plan of current residents receiving therapeutic diets SYSTEMIC**	01/06/2012

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	resident's nutritional care plan indicated this resident was receiving a mechanically altered diet effective 7/26/11, and that this resident was at risk for nutrition due to gradual weight loss discussed in an IDT (Interdisciplinary Team) risk meeting on 9/23/11. The most current nutritional care plan was not updated to reflect the resident's physician order of 11/18/11 for a pureed diet. An interview was conducted with the DON on 12/13/11 at 3:50 P.M. who indicated the facility is currently changing care plans when new orders are received and that she didn't know how it was done prior to her recent employment or why the new diet order for pureed food was not listed. 3.1-35(d)(2)(B)		**CHANGE Nursing Management personnel will forward copies of physician orders related to dietary services orders to the Dietary Service Manager or designee at the daily (M-F) clinical meeting. The Dietary Service Manager and or designee will review all dietary service related physician orders and diet communication slips and review and update the resident's plan of care as necessary. MONITORING The Director of Nursing (and or designee) will audit 8 charts weekly x 6 months to verify the resident's plan of care has been updated to be reflective of changes in physician orders. The results of the audits will be reviewed at the facility's quality assurance and improvement meetings. COMPLETION DATE January 6, 2012**	
F0282 SS=D	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 record review and interview, the facility failed to ensure blood sugar tests were done and blood pressure and heart rates were checked as ordered by the physician for 3 of 12 residents reviewed for physician's orders being followed in a sample of 21. (Residents #84, #66 and #10)	F0282	**F282 CORRECTIVE ACTION The facility is unable to correct past due blood sugar tests, blood pressure and heart rate readings for Residents #84, #66, and #10. Resident #84, #66, and #10's Medication and Treatment Administration recordkeeping will be audited**	01/06/2012

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	Findings included: 1. The record of Resident #66 was reviewed on 12/13/11 at 9:00 a.m. Diagnoses for Resident #66 included, but were not limited to, diabetes mellitus and history of stroke with left arm paresis. A recapitulated physician's order for December, 2011, with an original order date of 9/26/11 indicated Resident #66 was to receive Accuchecks (a finger stick blood test to measure glucose) twice daily. A care plan for Resident #66, dated 10/16/11, indicated "I am risk for nutrition being a diabetic." A goal was "My blood sugars will be stable x 90 days even though I am on a regular diet." Interventions included "My blood sugars will be monitored by nursing." Review of a Medication Record and a Blood Sugar Flow Sheet for October, 2011, did not include Accucheck results for 10/4/11 at 6:00 a.m. or 10/14/11 at 4:00 p.m. On 12/13/11 at 11:30 a.m., the Director of Nursing (DON) indicated she had no further information regarding the missing		**daily (M-F) by Nursing Management personnel. Licensed Nurse staff have received training regarding completion and documentation standards associated with blood sugar testing; evaluation of resident blood pressure and heart rate readings. OTHER RESIDENTS AFFECTED Medication and Treatment Administration recordkeeping will be audited daily by Nursing Management personnel. SYSTEMIC CHANGE The results of daily Medication and Administration recordkeeping audits will be reviewed at the daily (M-F) clinical meeting for the next six months. The Director of Nursing Services or her designee will address and monitor any identified opportunities for improvement through the auditing process for the next six months. MONITORING The Director of Nursing (and or designee) will audit 8 charts weekly x 6 months to verify that blood glucose, and/or blood pressure and/or heart rates are being completed. The results of the audits will be reviewed at the facility's quality assurance and improvement meetings. COMPLETION DATE January 6, 2012**	

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	Accucheck results on 10/4/11 and 10/14/11. Review of a Medication Record and a Blood Sugar Flow Sheet for November, 2011, did not include Accucheck results for 11/14/11 and 11/16 in the a.m. and 11/16, 11/18, and 11/23, 2011 in the p.m. On 12/13/11 at 11:30 a.m., the DON indicated she had no further information regarding the above missing Accucheck results for October and November, 2011. 2. The record of Resident #84 was reviewed on 12/12/1 at 9:00 a.m. Diagnoses for Resident #84 included, but were not limited to, diabetes mellitus and Alzheimer's Disease's A care plan for Resident #88, dated 10/9/11, indicated a problem of "I am at risk for fluctuating blood glucose levels related to diabetes." A goal was "I will be free from signs and symptoms of hyperglycemia/hypoglycemia daily..." Interventions included "Accuchecks as ordered..." A recapitulated physician's order for December, 2011, with an original order date of 7/18/11, indicated Resident #84 was to receive Accuchecks twice daily,			

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	every other week. Review of Medication Records and Blood Sugar Flow Sheets for October, 2011 and November, 2011, did not include Accucheck results for 10/10/11 at 4:00 p.m., 11/17/11 at 4:00 p.m. and 11/20/11 at 4:00 p.m. On 12/13/11 at 11:30 a.m., the DON indicated she was not able to find any Accucheck results for 4:00 p.m., blood sugars on 10/10, 11/17 and 11/20, 2011. 3. The clinical record for Resident #10 was reviewed on 12/12/11 at 3:00 p.m. The diagnosis for Resident #10 included, but was not limited to: atrial fibrillation, middle cerebral infarct, and paroxysmal atrial fibrillation. A recapitulation of the November and December Physician Orders, indicated an order for weekly blood pressure and pulse every Tuesday. A review of the Medication Administration Record for November and December indicated that this order was incomplete by blank spaces on 11/6/11, 11/15/11, 11/22/11, 11/29/11, and 12/6/11. In an interview with the DON on 12/14/11 at 9:00 a.m., she indicated that she was			

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	unable to locate the missing blood pressures and pulse results for the above listed dates and was unable to determine if the physician orders were completed. 3.1-35(g)(2)			
F0309 SS=E	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on record review and interview, the facility failed to ensure the effectiveness of PRN (as needed) pain medication was evaluated after administration for 5 of 8 residents reviewed for receiving PRN pain medication in a sample of 21. (Residents #'s C, D, E, F, and H) Findings included: 1. The record of Resident E was reviewed on 12/12/11 at 9:00 a.m. Diagnoses for Resident E included, but were not limited to, osteoarthritis and Alzheimer's disease. Review of a Minimum Data Set (an	F0309	**F309 CORRECTIVE ACTION The facility is unable to correct past due effectiveness of PRN pain medication for Residents # C, D, E, F, and H. Resident # C, D, E, F and H's Medication Administration recordkeeping—inclusive of prn medication administration will be audited daily (M-F) by Nursing Management personnel. Licensed Nurse staff have received training regarding administration of prn medication; pre and post pain assessment of residents by Omnicare consultant pharmacist. OTHER RESIDENTS AFFECTED Medication Administration recordkeeping-inclusive of prn medication administration will**	01/06/2012

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	assessment tool) for 11/10/11 indicated Resident E's cognitive/decision making status was "decisions poor, cues/supervision required." A recapitulated physician's order for December, 2011, with an original order date of 11/27/09, indicated Resident E could receive Tylenol, 650 milligrams (mg) every 4 hours as needed for pain. Review of a Medication Record for Resident E for October, 2011, indicated she received Tylenol 650 mg on 10/4/11 at 8:00 a.m.; on 10/19/11, no time indicated, and on 10/26/11 at 8:45 a.m. for complaints of pain. The record did not indicate whether or not the Tylenol was effective in relieving her pain on these dates. Review of a Medication Record for Resident E for November, 2011, indicated she received Tylenol 650 mg. on 11/1/11 at 10:00 p.m.; 11/8/11 at 8:45 a.m., and 11/30/11 at 2:00 p.m. for pain. The record did not indicate whether or not the Tylenol was effective in relieving her pain on these dates. On 12/13/11 at 11:30 a.m., the Director of Nursing (DON) indicated she had no further information regarding whether the Tylenol given to Resident E on 10/4,		**be audited daily (M-F) by Nursing Management personnel. SYSTEMIC CHANGE The results of daily Medication and Administration recordkeeping audits will be reviewed at the daily (M-F) clinical meeting for the next six months. The Director of Nursing Services or her designee will address and monitor any identified opportunities for improvement through the auditing process for the next six months. MONITORING The Director of Nursing (and or designee) will audit 8 charts weekly x 6 months to verify that prn pain medication effectivenss are being completed. An Omnicare Consultant Pharmacist will audit medication prn pre and post assessment of 8 residents per month. The results of the audits will be reviewed at the facility's quality assurance and improvement meetings. COMPLETION DATE January 6, 2012**	

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	10/19, 10/26, 11/1, 11/8 and 11/30, 2011 was effective in relieving the resident's pain. 2. The record of Resident F was reviewed on 12/12/11 at 1:00 p.m. Diagnoses for Resident F included, but were not limited to, dementia and osteoporosis. A recapitulated physician's order for December, 2011, with an original order date of 12/6/10, indicated Resident F could receive Tylenol, 650 mg. every 4 hours as needed for pain. Review of a Medication Record for Resident F for November, 2011, indicated she received Tylenol on 11/2/11 at 7:30 a.m., and 11/18/11 at 1:00 p.m., for complaints of leg pain. The record did not indicate whether or not the Tylenol was effective in relieving her pain on these dates. On 12/13/11 at 11:30 a.m., the DON indicated she had no further information regarding whether the Tylenol given to Resident F on 11/2/11 and 11/18/11 was effective in relieving the resident's pain. 3. A review of record for Resident C on 12/12/11 at 10:30 A.M., indicated that pre			

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	and post pain evaluations were not completed for administration of (2.5mg/167mg/5ml) 15ml of Lortab PRN for pain on 10/12, 10/19, 11/08, 11/15, 11/28, and 12/12/ 2011. Diagnoses for Resident C included, but were not limited to, coronary artery disease related to a coronary artery bypass, congestive heart failure and diabetes mellitus. During an interview with the DON on 12/14/11 at 2:30 P.M., she indicated the pre and post pain assessment for Resident #C for pain medicine administration of 15 ml Lortab PRN (2.5mg/167mg/5ml) could not be found for the dates of 10/12, 10/19, 11/08, 11/15, 11/28 and 12/12/2011. 4. A review of record for Resident D on 12/14/11 at 12:30 P.M., indicated that pre and post pain evaluations were not completed for administration of 400 mg of Ibuprofen PRN for pain on 12/12/11. The physician's order also included a notation to watch for heartburn. Diagnoses for Resident #D included, but were not limited to, osteoporosis, lumbar pain and GERD (gastroesophageal reflux disease). During an interview with the DON on			

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	12/14/11 at 2:30 P.M., she indicated the pre and post pain assessment for Resident #D for administration of 400 mg of Ibuprofen PRN for pain could not be found for the date of 12/12/11. 5. The record for Resident H was reviewed on 12/13/11 at 11:15 a.m. Diagnoses Included but were not limited to dementia, history of falls, syncope (fainting), and hospice care (end of life care). A physicians recapitulated order for 12/2011 indicated 2 orders for pain medication as needed. The first medication was Acetaminophen (Tylenol) 650 mg suppository. Insert 1 suppository rectally every 4 hours as needed for mild pain or fever. The second medication listed was Morphine 100 mg/5 mg (20 mg/ml) Solution. Give 0.5 ml (10 mg) sublingually every 2 hours as needed for pain/shortness of breath. The Medication Administration Record (MAR) for November, 2011, was reviewed. The MAR indicated Resident H received the morphine on November 9th, 14th, 19th, 20th, 22nd, 24th, 25th,			

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	and 28th. No information was available regarding the assessment of the pain level before the morphine was administered, or that the acetaminophen had been tried and didn't work. Further information about the pain medication was requested from the DON (Director of Nursing) on 12/13/11, during the exit conference at 4:30 p.m. During an interview on 12/14/11 at 9:00 a.m., the DON indicated no further information was available about the pain medications being administered. A facility policy, received from the DON on 12/13/11 at 9:00 a.m., dated 1/5/05 and updated 7/26/06, titled "Policy: General Guidelines for Administering Medication," indicated "...Using the MAR (Medication Administration Record)...6. When PRN [as needed] medications are administered the following must be documented:...C. Results achieved from giving the dose and the time the results were noted..." This deficiency was cited on 11/3/11. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-37(a)			

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F0323 SS=D	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 and interview, the facility failed to ensure safety devices were pulled in place on syringe needles before carrying the syringes with exposed needles down the hall and into resident rooms. This occurred during 3 of 7 injection observations during 3 of 20 medication pass observations. (Residents G, K, and J) Findings include: During an medication administration observation on 12/13/11 at 11:00 a.m., LPN #2 drew up morphine sulfate into a syringe and did not pull up the safety device on the syringe after drawing up the medication. LPN #2 then walked in the Dogwood hallway, with the exposed needle, to Resident G's room and	F0323	**F323 CORRECTIVE ACTION LPN #2 was re-educated and counseled 12-16-11. The facility is unable to correct past practices employed by LPN #2 during medication administration pass for Residents # G, K, J. Licensed Nurse staff have received training from Omnicare consultant pharmacist regarding concerning the use of safety devices on needles. OTHER RESIDENTS AFFECTED Nursing management personnel and or designee complete 4 insulin administration observations on weekly basis x 6 months to evaluate the use of safety devices on needles. SYSTEMIC CHANGE Employees who are observed not following**	01/06/2012

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	administered the medication. LPN #2 walked out of the resident's room and did not pull up the safety device on the syringe before walking in Dogwood hallway with an exposed needle, to dispose the syringe. During an medication administration observation on 12/13/11 at 11:07 a.m., LPN #2 drew up insulin into a syringe and did not pull up the safety device on the syringe after drawing up the medication. LPN #2 then pushed Resident K's wheelchair into their room with the exposed needle in one of her hands that was pushing the resident's wheelchair in Dogwood hallway. LPN #2 administered the insulin to Resident K and walked out of the room without pulling up the safety device on the syringe and walked down Dogwood hall, with the exposed needle, to dispose the syringe. During an medication observation on 12/13/11 at 11:19 a.m., LPN #2 drew up insulin into a syringe and did not pull up the safety device on the syringe after drawing up the medication. LPN #2 then pushed Resident J's wheelchair into their room with the exposed needle in one of her hands that was pushing the resident's wheelchair in Dogwood hallway. In an interview with the DoN on 12/14/11		**appropriate safety procedures when using sharps devices will immediately receive 1 on 1 training and revalidation observation of necessary corrections. MONITORING Nu rsing management personnel and or designee will complete 4 insulin administration observations on weekly basis x 6 months to evaluate the use of safety devices on needles. An Omnicare Consultant Pharmacist will observe four insulin administration observations monthly to evaluate the use of safety devices on needles. The results of the audits will be reviewed at the facility's quality assurance and improvement meetings. COMPLETION DATE January 6, 2012**	

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	at 9:52 a.m., the DoN indicated that her expectation was that staff were to use safety devices on needles when walking in common areas of the facility. 3.1-45(a)(1)			

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F0441 SS=D	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation, interview, and record review, the facility failed to ensure infection control procedures were followed by not disinfecting a glucometer (blood glucose meter) between residents	F0441	**F441 CORRECTIVE ACTION LPN #1 was re-educated and counseled 12-20-11. C.N.A. #3 identification is unknown. Facility staff were inserviced**	01/06/2012

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	when obtaining an Accucheck (measurement of blood glucose) for 2 of 5 residents observed to receive Accucheck testing during 2 of 20 medication pass observations. The facility failed to ensure staff did not touch resident's food with unwashed and ungloved hands during a meal observation affecting 1 of 4 residents randomly observed.. (Residents J, K, and, #18) Finding include: 1. During an observation on 12/12/11 at 10:25 a.m., LPN #1 performed an Accucheck on Resident J and then walked out of the room and placed the glucometer back in their pocket without disinfecting the glucometer. At 11:10 a.m. on 12/12/11, LPN #1, pulled the glucometer out of their pocket and performed an Accucheck on Resident K without disinfecting the glucometer prior to use. After the Accucheck procedure, LPN #1 placed the glucometer back in their pocket and walked out of the resident's room. LPN #1 then pulled the glucometer from their pocket and placed the glucometer back in the med cart without disinfecting the machine. Between the two Accucheck procedures indicated, LPN #1 provided medications to other residents and did not disinfect the glucometer between uses. In an interview with LPN #1 on 12/13/11		**on proper cleaning policy and procedures of a glucometer. Facility staff were inserviced on appropriate manner to prepare resident trays following acceptable infection control practices. OTHER RESIDENTS AFFECTED Nursing management personnel and or designee observe 4 blood sugar checks using a glucometer on weekly basis x 6 months. Nursing management personnel or designee will observe 4 meal services on weekly basis observing infection control practices x 6 months. SYSTEMIC CHANGE Additional glucometer machines have been ordered to provide two for each medication cart—to allow licensed nurse access to one additional machine to use while other glucometer cleaned and drying thoroughly. A meal service monitoring tool was developed and will be utilized during observations. An annual LN procedure competency fair will be scheduled and held for LN staff (last held October, 2011). New LN hires will complete glucometer competency evaluation during probationary period. New nursing hires will receive dining service orientation**	

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	at 2:00 p.m., LPN #1 indicated that he forgot to disinfect the glucometer between performing Accuchecks on Resident J and K on 12/12/11. In an interview with DoN on 12/14/11 at 9:50 a.m., she indicated that her expectation is that the glucometer is disinfected properly and according to their policy between uses. In a policy received on 12/12/11 at 3:30 p.m., from the DoN, the policy indicates, "...Always ensure that blood glucose meters intended for reuse are cleaned and disinfected between resident uses...Clean and disinfect reusable equipment between uses according to the manufacturer's instructions and current infection control standards of practice." 2. On 11/11/11 at 12:30 P.M., during a lunch observation, CNA #3 was observed assisting Resident #18 while sitting at a table with 3 other residents. CNA #3 was observed touching resident trays and plates and various items on a cabinet top and failed to wash hands before removing Resident #18's bread from a wrapper with her bare hands and placing it on his plate where she applied butter. CNA #3 was interviewed on 11/11/11 at 12:45 P.M., and indicated that she		**training. MONITORING Nursin g management personnel and or designee will observe 4 blood sugar checks using a glucometer on weekly basis x 6 months. Nursing management personnel or designee will observe 4 meal services on weekly basis utilizing meal service monitoring tool x 6 months. The results of the audits will be reviewed at the facility's quality assurance and improvement meetings. COMPLETION DATE January 6, 2012**	

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	realized she had touched the bread with her bare hands, as she was assisting with serving of lunch trays, but had not been trained by the facility as to how to handle resident's food. She indicated that from past experience she thought handling food with bare hands may not be appropriate. 3.1-18(b)			
R0000	The following residential finding was cited in accordance with 410 IAC 16.2-5.	R0000	Preparation and execution of this plan of correction in no way constitutes an admission or agreement by Greenwood Village South of the truth of the facts alleged in this statement of deficiencies and plans of correction. In fact, Greenwood Village South reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts, and conclusions that form the basis of the deficiency. This plan of correction serves as the credible allegation of compliance by 1/06/12. This statement of deficiencies and plan of correction will be reviewed at the monthly Quality Assurance/Assessment Committee Meeting for the survey ending 12/15/11.	

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R0298	(2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days. Based on interview and record review, the facility failed to ensure a pharmacist drug regimen review was done at least every 60 days for 2 of 7 residents reviewed for timely pharmacist review in a total sample of 9. (Resident #138 and #30) 1. The clinical record for Resident #138 was reviewed on 12/14/11 at 10:45 a.m. The diagnoses for Resident #138 included, but were not limited to: hypertension, hypothyroidism, anxiety, sinusitis, edema, and insomnia. The 3/30/11 M.D. order indicated on this date, the facility was to begin passing medications for Resident #138. No pharmacist review could be found in the clinical record for Resident #138.	R0298	**R 298 CORRECTIVE ACTION Resident's # 138 and # 30 have had their drug regimen reviewed by the consultant pharmacist. OTHER RESIDENTS AFFECTED All other residents have had their drug regimen reviewed by the consultant pharmacist. SYSTEMIC CHANGE The consultant pharmacist will review all resident's drug regimen at least every 60 days. The practice of reviewing the drug regimen's quarterly has been discontinued. MONITORING T he Director of Residential Services will monitor 4 medical records weekly for the next 6 months to ensure drug regimens have been reviewed by the consultant pharmacist at least every 60 days. The results of the audits will be**	01/06/2012

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	During interview with the Residential Services Director on 12/14/11 at 3:55 p.m., she indicated no pharmacist review had been done for Resident #138 since the facility began her medication administration on 3/30/11. 2. Resident #30's clinical record was reviewed on 12/13/2011 at 2:20 p.m. Diagnoses included but were not limited to the following; spinal stenosis, osteoarthritis, hypertension, hypothyroidism, coronary artery disease, and sleep apnea. A pharmacist consultation report was dated 9/26/2011. Interview with the Director of Residential Services on 12/15/2011 at 11:45 a.m., indicated the pharmacist consultation report, dated 9/26/2011, was the most recent pharmacist drug regimen review completed for Resident #30. Additionally, the facility had only been doing the reviews every 90 days and now are currently working with the pharmacy to ensure that the reviews will be completed every 60 days. Review of a policy entitled Pharmaceutical Services for Residential Care was provided by the Director of Residential Services on 12/15/2011 at 9:30 a.m. The policy indicated, "a		**reviewed monthly at the facility's quality assurance and improvement meetings COMPLETION DATE January 6, 2012**	

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	consultant pharmacist will review the drug regimen of all residents at least every 60 days in compliance with the Indiana state regulation."			