

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155743	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/04/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GREEN-HILL MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 501 N LINCOLN AVE FOWLER, IN 47944
--	--

(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 the Investigation of Complaint IN00191000.</p> <p>This visit was done in conjunction with the Post Survey Revisit (PSR) to the Investigation of Complaint IN00187414 completed on January 6, 2016.</p> <p>Complaint IN00191000-Substantiated. No deficiencies related to the allegations are cited.</p> <p>Unrelated deficiency is cited.</p> <p>Survey date: February 3 & 4, 2016</p> <p>Facility number: 000288 Provider number: 155743 AIM number: 100287380</p> <p>Census bed type: SNF/NF: 36 Total: 36</p> <p>Census Payor type: Medicare: 1 Medicaid: 25 Other: 10 Total: 36</p> <p>Sample: 3</p>	F 0000	<p>Submission of this Plan of Correction does not constitute an admission to or an agreement with facts alleged on the survey report.</p> <p>Submission of this Plan of Correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies.</p> <p>The Plan of Correction is prepared and submitted because of requirements under State and Federal law.</p> <p>Please accept this Plan of Correction as our credible allegation of compliance.</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: 155743	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/04/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GREEN-HILL MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 501 N LINCOLN AVE FOWLER, IN 47944
--	--

(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 0327 SS=G Bldg. 00	<p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 26143, on February 10, 2016.</p> <p>483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION</p> <p>The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.</p> <p>Based on record review and interview, the facility failed to ensure a resident received sufficient fluid intake to maintain proper hydration and failed to assess a resident for dehydration after the resident's Physician ordered a treatment for the dehydration related to a critical BUN (kidney function test), for 1 of 1 resident reviewed for dehydration in a total sample of 3. (Resident #C)</p> <p>Finding includes:</p> <p>During the initial tour of the facility on 02/03/16 at 11:30 a.m., the Assistant Director of Nursing (ADoN) indicated Resident #C had a bruise on her hand related to attempts to insert an IV (intravenous) for fluids.</p>	F 0327	<ol style="list-style-type: none"> 1. Resident C is receiving sufficient fluid to maintain proper hydration and is not experiencing any signs or symptoms of dehydration. 2. All residents have the potential to be affected. The residents were reviewed and if it was noted that they were not receiving sufficient fluids to prevent dehydration, they were assessed and the MD contacted. 3. The nurses have been re-educated on completing dehydration assessments, assessing, and documenting signs and symptoms of dehydration. The nursing staff have been re-educated on providing sufficient fluids to the residents. A monitoring form has been implemented. 	02/06/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155743	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/04/2016
NAME OF PROVIDER OR SUPPLIER GREEN-HILL MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 501 N LINCOLN AVE FOWLER, IN 47944		
(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 #C's record was reviewed on 02/03/15 at 3:50 p.m. The resident's diagnoses included, but were not limited to hypertension and intellectual impairment.</p> <p>A Nutritional Assessment Form, dated 07/28/15, indicated the resident's fluid needs were 1869 ml (milliliters) per day.</p> <p>A Dehydration Screen, dated 10/06/15, indicated no signs and symptoms of dehydration were noted.</p> <p>The Quarterly Minimum Data Set assessment, dated 11/19/15, indicated the resident's cognition was not assessed and the resident required extensive assistance for eating.</p> <p>A care plan, dated 12/09/15, indicated the resident had a risk for altered nutrition and hydration. The goal indicated the resident would maintain adequate hydration status. The interventions included to encourage fluids and to assess for signs and symptoms of dehydration (dry skin, dry mucous membranes, fever, changes in urine output or characteristics).</p> <p>The resident had the following fluid intakes documented, seven days prior to</p>		<p>4. The DON or designee will beresponsible for reviewing 3 residents and completing the monitoring form dailyon scheduled work days as follows: dailyfor two weeks, weekly for two weeks, then monthly thereafter to ensureresidents are receiving sufficient fluids to maintain proper hydration and thatthey are being assessed for dehydration as indicated. Should a concern be noted, immediatecorrective action will occur. Results ofthese reviews and any corrective actions will be discussed during thefacility's monthly QA meetings on an ongoing basis for a minimum of 6 monthsand the plan adjusted if indicated.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155743	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/04/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GREEN-HILL MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 501 N LINCOLN AVE FOWLER, IN 47944
--	--

(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 order for IV fluids: 01/25/16-840 ml 01/26/16-360 ml 01/27/16-no fluid intake recorded 01/28/16-360 ml 01/29/16-no fluid intake recorded 01/30/16-720 ml 01/31/16-360 ml</p> <p>The Nurses' Progress Notes, dated 01/26/16 at 12:00 p.m., 2:00 p.m., and 01/27/16 at 2:00 p.m. indicated the resident had been yelling out with interventions attempted.</p> <p>A Nurses' Progress Note, dated 01/28/16 at 2:00 p.m., indicated the Physician had ordered a Chem Profile (electrolytes/kidney function) and CBC (complete blood count).</p> <p>A Nurses' Progress Note, dated 01/29/16 at 4:00 p.m. indicated the resident continued to yell and pain medication was given.</p> <p>A Nurses' Progress Note, dated 01/29/16 at 6:00 p.m., indicated the resident continued to yell, was repositioned in bed and was resting.</p> <p>A Nurses' Progress Note, dated 01/31/16 at 11:00 p.m., indicated the resident had blood drawn from the right hand.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155743	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/04/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GREEN-HILL MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 501 N LINCOLN AVE FOWLER, IN 47944
--	--

(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 Nurses' Progress Note, dated 02/01/16 at 12:00 p.m., indicated the laboratory notified the facility of a critical BUN (kidney function) of 71 (normal 9.8-20.1) and the Physician was notified.</p> <p>A laboratory result, dated 02/01/16, indicated a BUN of 71 and Creatinine (kidney function) of 2.2 (normal 0.6-1.1).</p> <p>A Physician's Order, dated 02/01/16, indicated an IV to be started of normal saline at 50 ml per hour for eight hours and to recheck the resident's BMP (electrolytes) after the IV is finished.</p> <p>A Nurses' Note, dated 2/2/16 at 10:00 a.m., indicated the IV had been infused, the resident had no yelling and appeared comfortable.</p> <p>The oral fluid intake during and after the IV treatment was recorded as: 02/01/16-360 ml 02/02/16-500 ml 02/03/16-560 ml</p> <p>There were no dehydration assessments completed on the resident before, during, or after the resident was treated with the IV fluids.</p> <p>The resident's BMP was completed on</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155743	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/04/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GREEN-HILL MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 501 N LINCOLN AVE FOWLER, IN 47944
--	--

(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>02/03/16 and the BUN was 47 and Creatinine was 1.2.</p> <p>A faxed noted from the Physician, dated 02/03/16, indicated the IV fluids were administered due to dehydration, as exhibited by a BUN of 71.</p> <p>During an interview on 02/03/16 at 3:45 p.m., the ADoN indicated there were no dehydration assessments completed on the resident prior to, during, and after the IV treatment for dehydration. The ADoN indicated they encourage the resident to drink fluids.</p> <p>During an interview on 02/04/16 at 10:00 a.m., the ADoN indicated, "according to the intake form", the resident was not getting adequate liquids. The ADoN indicated the resident's Physician had seen the resident the day he ordered the laboratory tests. She indicated the Physician had not written a Progress Note.</p> <p>A facility policy, dated 10/2014, titled, "Dehydration Risk, Screening for Signs/Symptoms", received from the RN Corporate Consultant as current, indicated, "Early detection of a resident exhibiting signs/symptoms of dehydration will prompt the nursing personnel to initiate</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155743	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/04/2016
NAME OF PROVIDER OR SUPPLIER GREEN-HILL MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 501 N LINCOLN AVE FOWLER, IN 47944		
(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>intervention...Facility personnel will observe for resident's risk for development of dehydration in an effort to ensure prompt initiation of necessary intervention(s)...1. Dehydration Screen shall be completed by a licensed nursing personnel...quarterly...and as deemed necessary..."</p> <p>3.1-46(b)</p>				