

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 09/10/2012
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NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240
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F0000	<p>This visit was for the Investigation of Complaint IN00114329, Complaint IN00114740 and Complaint IN00116059.</p> <p>Complaint IN00114329 -- Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00114740 -- Substantiated. Federal/State deficiencies related to the allegations are cited at F309.</p> <p>Complaint IN00116059 -- Substantiated. Federal/State deficiencies related to the allegations are cited at F157, F250, F281 and F309.</p> <p>Unrelated deficiencies cited.</p> <p>Survey dates: September 6, 7 and 10, 2012</p> <p>Facility number: 000305 Provider number: 155625 AIM number: 100287200</p> <p>Survey team: Penny Marlatt, RN</p> <p>Census bed type: SNF/NF: 76 Total: 76</p> <p>Census Payor type:</p>	F0000	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 September 25, 2012.	

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.

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	<p>Medicare: 12 Medicaid: 59 Other: 5 Total: 76</p> <p>Sample: 8</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on September 17, 2012 by Bev Faulkner, RN</p>				

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F0157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review, the facility failed to ensure a licensed nurse notified the attending physician of a resident's change in condition and did not initiate treatment without a physician's</p>	F0157	- what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident no longer resides in facility. - how other residents	09/25/2012

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	<p>knowledge and orders for treatment. This deficient practice affected 1 of 5 residents reviewed for assessments and notification in a sample of 8. (Resident #F)</p> <p>Findings include:</p> <p>Resident #F's clinical record was reviewed on 9-7-12 at 9:27 a.m. Her diagnoses included, but were not limited to senile dementia and psychosis, high blood pressure, chronic pain and urinary frequency.</p> <p>In confidential interview with a concerned person on 9-7-12 at 3:09 p.m., she indicated she was informed on 8-5-12, Resident #F had an event in which her right arm was cold, purple in color and the resident cried out in pain when the arm was touched. She indicated she was unsure if a nurse had assessed (checked out) the resident's arm, but had been informed by another family member that LPN #1 had placed a warm compress on the resident's arm and massaged her hand because the fingers were clinched tight. She indicated she did not think LPN #1 had informed the resident's physician of these events. She indicated LPN #1 no longer was employed with the facility.</p> <p>In interview with LPN #2 on 9-10-12 at 2:07 p.m., she indicated on the afternoon</p>		<p>having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected. Staff was inserviced on 9/13/12 by the Director of Nursing regarding notifications of physician and resident's legal representative when there is an accident involving the resident or a change in the resident's condition. Charge nurses now attend morning meetings with the department manager to give shift reports to assure that management staff is aware of any new or worsening condition changes. - what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Staff was inserviced on 9/13/12 regarding notifications of physician and resident's legal representative when there is an accident involving the resident or a change in the resident's condition. Charge nurses now attend morning meetings with the department manager to give shift reports to assure that management staff is aware of any new or worsening condition changes. The interdisciplinary team review all events and monitor appropriate notification and communication with physicians and resident's legal representative. Audit of charts has been conducted to ensure that physician and POA have</p>		

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	<p>of 8-5-12, she was receiving the shift report from LPN #1. She indicated LPN #1 had informed her that the arm of Resident #F had been "kind of a purple color, like it was if you would go outside and get real cold." She indicated LPN #1 had indicated this occurred earlier in the shift when a family member was visiting. She indicated LPN #1 had told her she had placed a warm compress on the resident's arm and the arm seemed improved to LPN #1. LPN #2 indicated she asked LPN #1 if she had notified the physician in regard to this issue and LPN #1 indicated to her that she had not notified the physician. LPN #2 indicated she was surprised LPN #1 had not documented anything in the clinical record regarding the arm issue. LPN #2 indicated prior to the end of the shift report, Resident #F became unresponsive and was found by a staff member. She indicated she did not recall Resident #F's right arm appearing to be discolored during the subsequent code or during the postmortem care provided after she passed.</p> <p>In interview with the Director of Nursing (DON) on 9-7-12 at 8:40 a.m., she indicated several weeks after the passing of Resident #F, LPN #2 indicated to her that on the afternoon of her passing that the resident's arm had been cold and that</p>		<p>been notified of any change in condition. - 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 Change of Condition Continuous Quality Improvement tool will be completed to monitor and ensure that the deficient practice does not recur monthly for three months and quarterly thereafter by the DON/ADON and/or designee. This will be reviewed by the Quality Assurance Committee. If 90% compliance is not met, an action plan will be developed.</p>				

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	<p>LPN #1 had placed a warm compress on the arm.</p> <p>The DON provided a copy of the "24 Hour Report," for 8-5-12 on 9-10-12 at 3:25 p.m. This document indicated Resident #F's right arm was "cold to touch, discolored." This entry was untimed and unsigned.</p> <p>Review of the clinical record indicated there was an absence of any documentation on 8-5-12 regarding any issue with Resident #F's arm. This included a lack of documentation of an assessment of Resident #F's right arm, of treatment provided to the resident's arm or any communication with the physician regarding her arm on the day of her passing, 8-5-12.</p> <p>On 9-10-12 at 9:16 a.m., the DON provided a copy of a policy entitled, "Resident Change of Condition," with a revision date of 3-10. This policy indicated, "It is the policy of this facility that all changes in resident condition will be communicated to the physician and family/responsible party, and that appropriate, timely, and effective intervention occurs...Acute Medical Change: Any sudden or serious change in the resident's condition manifested by a marked change in physical or mental</p>				

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	<p>behavior will be communicated to the physician with a request for physician visit promptly and/or acute care evaluation. The licensed nurse in charge will notify the physician...The responsible party will be notified that there has been a change in the resident's condition and what steps are being taken. All nursing actions/interventions will be documented in the medical record as soon as possible after the resident needs have been met."</p> <p>On 9-10-12 at 3:57 p.m., the DON provided a copy of a policy entitled, "Charge Nurse Position Description," with a revision date of 7-31-05. This policy indicated, "...Immediately informs the resident, consults with physician and notifies the designated family member and/or legal representative when...a significant change in the resident's physical, mental or psychosocial status..."</p> <p>This Federal tag relates to Complaint IN00116059.</p> <p>3.1-5(a)(2)</p>				

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F0223 SS=B	<p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on interview and record review, the facility failed to ensure 4 of 5 residents reviewed for abuse were not subjected to verbal and/or physical abuse in a sample of 8. (Residents #C, #D, #G, and #H)</p> <p>Findings include:</p> <p>The Administrator provided information on 9-6-12 at 11:01 a.m., of two incidents of verbal and/or physical abuse allegations involving Resident #C and #D and Resident #G and #H.</p> <p>a. Review of the incident involving Resident #C and #D indicated on 8-9-12 at 3:48 p.m., a staff member heard shouting in the sunroom of the Memory Care Unit. Resident #C was found to be clapping her hands as she walked away from Resident #D who was found sitting on the floor. The residents were separated and each assessed for injury. No injuries were indicated. Appropriate and timely notifications were documented</p>	F0223	- what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Those residents who were affected are being monitored for behavior issues and are free from abuse.- 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 residents have the potential to be affected. Behavior Management training was completed with the staff on 9/20/12 by the Social Service Designee and Memory Care Facilitator. Abuse Prevention training was completed with the staff on 9/13/12 by the Social Service Designee and the Memory Care Facilitator.- what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Behavior Management training was completed with the staff on 9/20/2012 by the Social Service Designee and Memory Care Facilitator. Abuse	09/25/2012			

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	<p>to the physician, family and/or power of attorney, as well as to the facility Administrator. Timely reporting of the occurrence was documented to the Indiana State Department of Health. Appropriate and timely follow up was documented for each resident.</p> <p>b. Review of the incident involving Resident #G and #H indicated on 9-5-12 at 8:16 a.m., a staff member witnessed Resident #G slapping Resident #H on the hand, while Resident #H held onto the pants of Resident #G. The residents were separated and each assessed for injury. No injuries were indicated. Appropriate and timely notifications were documented to the physician, family and/or power of attorney, as well as to the facility Administrator. Timely reporting of the occurrence was documented to the Indiana State Department of Health. Appropriate and timely follow up was documented for each resident.</p> <p>On 9-6-12 at 11:01 a.m., the Administrator provided a copy of a policy entitled, "Abuse Prohibition, Reporting, and Investigation," which was indicated to be the current policy in use. This policy indicated, "[Name of facility corporation] will not permit residents to be subjected to abuse..."</p>		<p>Prevention training was completed with the staff on 9/13/2012 by the Social Service Designee and Memory Care Facilitator.- 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</p> <p>An Abuse - Resident to Resident Continuous Quality Improvement tool will be completed monthly for 3 months and quarterly thereafter by Social Service and/or desigee. This will be reviewed by the Quality Assurance Committee. If 90% compliance is not met, an action plan will be developed.</p>		

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	3.1-27(a)(1) 3.1-27(b)			

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F0250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on interview and record review, the facility failed to ensure medically-related social services were provided in a timely manner for the institution of a "Do Not Resuscitate" (DNR) code status of a resident in which the family had requested assistance. This delay in assistance resulted in a resident receiving CPR (cardiopulmonary resuscitation) when the resident became unresponsive, and later passing away. This affected 1 of 3 residents reviewed for social service intervention in a sample of 8. (Resident #F)</p> <p>Findings include:</p> <p>Resident #F's clinical record was reviewed on 9-7-12 at 9:27 a.m. Her diagnoses included, but were not limited to senile dementia and psychosis, high blood pressure, chronic pain and urinary frequency. Review of her code status indicated she was a "full code," and this was dated 4-25-11. A scanned copy of a document entitled, "Out of Hospital Do Not Resuscitate Declaration and Order," was located in the clinical record. The</p>	F0250	- 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 residents have the potential to be affected. Social Service Staff were provided additional training regarding expectations related to review of code status, documentation requirements, and timeliness of tasks by the Administrator on 9/24/12. Review of resident's records indicated that all necessary documentation was current for all resident's code status. - what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Social Service Staff were provided additional training regarding expectations related to review of code status, documentation requirements, and timeliness of tasks. All DNR change requests are now discussed in morning meeting with management staff to ensure that management staff are aware	09/25/2012	

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	<p>document was dated and signed by Resident F's power of attorney ((POA) on 7-12-12 and was signed by the physician without a date. The date on the document indicated it had been faxed to the facility on 8-25-12 from an unknown location.</p> <p>In interview with the Administrator on 9-7-12 at 12:40 p.m., she indicated she was unaware of a DNR code status for Resident #F until the documentation was provided to her earlier the same date. She indicated she was unaware there might have been an issue with the family in regard to the code status as the family had not addressed this issue with the facility. She indicated she had spoken with the Social Services Designee (SSD) and she had shared that she had been working with the family since 7-3-12 in regard to this issue. She indicated a family member had contacted the SSD on that date (7-3-12) and wished to change the code status to a DNR. She indicated the SSD had not documented this information in the resident's clinical record, but did have information on her calendar about the DNR. The Administrator indicated, "I couldn't believe she hadn't documented that information." She indicated she had instructed the SSD to "make a copy of the information and write up a statement about it."</p>		<p>of requested changes to current code status, care plans are updated, and changes are completed in an appropriate time frame. - 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 Advance Directive/Code Status Continuous Quality Improvement tool will be completed monthly for three months and quarterly thereafter by Social Service and/or designee. This will be reviewed by the Quality Assurance Committee. If 90% compliance not met, an action plan to address will be developed.</p>		

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	In interview with the SSD on 9-7-12 at 2:12 p.m., she provided a written summary of events surrounding the assistance with the DNR for Resident #F. She indicated the POA had contacted her on 7-3-12 to discuss a family decision to change the code status from full code to DNR. She indicated she mailed the paperwork as requested to the POA, after explaining the DNR paperwork over the phone and putting a "sign here" sticker on the document. She indicated she could not recall if she explained to the POA the need to have two witnesses also sign the document prior to returning the document to the facility. She indicated she could not recall if she explained the document would not go into effect until the physician had signed the document and the facility had the paperwork back in their facility. She indicated she mailed the document on 7-5-12 to the POA. In review of the SSD's written statement and her calendar, she indicated she had checked with the medical records staff on 7-24-12 and the document had not been returned in the mail. She indicated on 7-27-12, the DNR paperwork was received and forwarded to the physician's office for his signature. She indicated she checked one week later on 8-3-12 and the facility had not received the DNR paperwork back yet. She indicated she could not recall if she had checked on the			

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	<p>status of the DNR paperwork with the POA or medical records between 7-5-12 and 7-24-12. On 8-5-12, Resident #F became unresponsive and required CPR which was unsuccessful. The SSD indicated she could not give a reason for not documenting the information about the DNR in the resident's clinical record, "I guess my only excuse is I got busy and just didn't get it done. I guess it makes it look like there wasn't anything there."</p> <p>In a confidential interview with a concerned person on 9-7-12 at 3:09 p.m., she indicated the initial discussion with the SSD regarding the family's decision to change the code status to DNR took place the "first part of July" 2012.</p> <p>A "Social Services" job specific orientation list was provided by the Director of Nursing on 9-10-12 at 9:14 a.m. This policy had a revision date of 11/11. It indicated, under the heading of "Policy and Procedure Review," one of the job requirements are "Advanced Directives (review with each progress note, care planning)"</p> <p>A policy entitled, "Do Not Resuscitate," with a revision date of 3-12, was provided by the Administrator on 9-7-12 at 12:57 p.m. This policy indicated, "...The OUT OF HOSPITAL DO NOT</p>				

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	<p>RESUSCITATE DECLARATION AND ORDER form must be signed/dated by the physician. The OUT OF HOSPITAL DO NOT RESUSCITATE DECLARATION AND ORDER FORM must be signed and dated by the resident/representative and two witnesses who are not resident's parent, spouse, or child...A resident cannot be considered a DNR until the OUT OF HOSPITAL DO NOT RESUSCITATE DECLARATION AND ORDER form has been signed/dated by the resident/representative, two witnesses and the attending physician. The admitting nurse/designee will inform the resident/representative at the time of admission that the resident will be considered a FULL CODE until the OUT OF HOSPITAL DO NOT RESUSCITATE DECLARATION AND ORDER form is signed/dated and a signed physician's order has been received..."</p> <p>This Federal tag relates to Complaint IN00116059.</p> <p>3.1-34(a)</p>				

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F0281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.</p> <p>Based on interview and record review, the facility failed to ensure a licensed nurse (LPN #1) notified the attending physician of a resident's change in condition and did not initiate treatment without a physician's knowledge and orders for treatment. This deficient practice affected 1 of 5 residents (Resident # F) reviewed for assessments and notification in a sample of 8.</p> <p>Findings include:</p> <p>Resident #F's clinical record was reviewed on 9-7-12 at 9:27 a.m. Her diagnoses included, but were not limited to senile dementia and psychosis, high blood pressure, chronic pain and urinary frequency.</p> <p>In confidential interview with a concerned person on 9-7-12 at 3:09 p.m., she indicated she was informed on 8-5-12, Resident #F had an event in which her right arm was cold, purple in color and the resident cried out in pain when the arm was touched. She indicated she was unsure if a nurse had assessed (checked out) the resident's arm, but had been informed by another family member that</p>	F0281	- what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident no longer resides at 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 residents have the potential to be affected. The nurse involved is no longer employed at the facility. Staff was inserviced regarding notifications of physician and resident's legal representative when there is an accident involving the resident or a change in the resident's condition and obtaining physician's orders for treatment by the Director of Nursing on 9/13/2012. Charge nurses now attend morning meetings with the department manager to give shift reports to assure that management staff is aware of any new or worsening condition changes. An audit of charts has been conducted to ensure that physicians and POA's have been notified of changes in condition. - what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;	09/25/2012			

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	<p>LPN #1 had placed a warm compress on the resident's arm and massaged her hand because the fingers were clinched tight. She indicated she did not think LPN #1 had informed the resident's physician of these events. She indicated LPN #1 no longer was employed with the facility.</p> <p>In interview with LPN #2 on 9-10-12 at 2:07 p.m., she indicated on the afternoon of 8-5-12, she was receiving the shift report from LPN #1. She indicated LPN #1 had informed her that the arm of Resident #F had been "kind of a purple color, like it was if you would go outside and get real cold." She indicated LPN #1 had indicated this occurred earlier in the shift when a family member was visiting. She indicated LPN #1 had told her she had placed a warm compress on the resident's arm and the arm seemed improved to LPN #1. LPN #2 indicated she asked LPN #1 if she had notified the physician in regard to this issue and LPN #1 indicated to her that she had not notified the physician. LPN #2 indicated she was surprised LPN #1 had not documented anything in the clinical record regarding the arm issue. LPN #2 indicated prior to the end of the shift report, Resident #F became unresponsive and was found by a staff member. She indicated she did not recall Resident #F's right arm appearing to be discolored</p>		<p>Staff was inserviced regarding notifications of physician and resident's legal representative when there is an accident involving the resident or a change in the resident's condition and obtaining orders for treatment on 9/13/12 by the Director of Nursing. Charge nurses now attend morning meetings with the department manager to give shift reports to assure that management staff is aware of any new or worsening condition changes. The interdisciplinary team review all events and monitor appropriate notification and communication with physicians and resident's legal representative. - 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 Change of Condition Continuous Quality Improvement tool will be completed to monitor and ensure that the deficient practice does not recur monthly for three months and quarterly thereafter by the DOS/ADOS and/or designee. This will be reviewed by the Quality Assurance Committee. If 90% compliance not met, and action plan will be developed.</p>		

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	<p>during the subsequent code or during the postmortem care provided after she passed.</p> <p>In interview with the Director of Nursing (DON) on 9-7-12 at 8:40 a.m., she indicated several weeks after the passing of Resident #F, LPN #2 indicated to her that on the afternoon of her passing that the resident's arm had been cold and that LPN #1 had placed a warm compress on the arm.</p> <p>The DON provided a copy of the "24 Hour Report," for 8-5-12 on 9-10-12 at 3:25 p.m. This document indicated Resident #F's right arm was "cold to touch, discolored." This entry was untimed and unsigned.</p> <p>Review of the clinical record indicated there was an absence of any documentation on 8-5-12 regarding any issue with Resident #F's arm. This included a lack of documentation of an assessment of Resident #F's right arm, of treatment provided to the resident's arm or any communication with the physician regarding her arm on the day of her passing, 8-5-12.</p> <p>On 9-10-12 at 9:16 a.m., the DON provided a copy of a policy entitled, "Resident Change of Condition," with a</p>						

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	<p>revision date of 3-10. This policy indicated, "It is the policy of this facility that all changes in resident condition will be communicated to the physician and family/responsible party, and that appropriate, timely, and effective intervention occurs...Acute Medical Change: Any sudden or serious change in the resident's condition manifested by a marked change in physical or mental behavior will be communicated to the physician with a request for physician visit promptly and/or acute care evaluation. The licensed nurse in charge will notify the physician...The responsible party will be notified that there has been a change in the resident's condition and what steps are being taken. All nursing actions/interventions will be documented in the medical record as soon as possible after the resident needs have been met."</p> <p>On 9-10-12 at 3:57 p.m., the DON provided a copy of a policy entitled, "Charge Nurse Position Description," with a revision date of 7-31-05. This policy indicated, "As a member of the interdisciplinary team, the Unit Charge Nurse assumes planning, responsibility, and accountability for resident care of a designated unit for one shift and in accordance with Federal and State regulations and company/facility policies, procedures and care plans...Monitors</p>				

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	<p>delivery of care and services throughout shift to ensure needs are met, tasks are completed, including complete and accurate resident documentation...Insures compliance on unit with resident rights...Provides direct patient care, administers medications and specialized treatments...according to physician orders...Immediately informs the resident, consults with physician and notifies the designated family member and/or legal representative when...a significant change in the resident's physical, mental or psychosocial status..."</p> <p>The Indiana State Board of Nursing, 2009, indicates in 848 IAC 2-3-2, "Responsibility as a member of the health team: Sec. 2. The licensed practical nurse shall do the following:</p> <p>(1) Function within the legal boundaries of practical nursing practice based on the knowledge of statutes and rules governing nursing.</p> <p>(2) Accept responsibility for individual nursing actions and continued competence.</p> <p>(3) Communicate, collaborate, and function with other members of the health care team to provide safe and effective care.</p> <p>(4) Seek education and supervision as necessary from registered nurses and/or other members of the health care team</p>			

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	<p>when implementing nursing techniques or practices.</p> <p>(5) Respect the dignity and rights of the patient/client."</p> <p>This Federal tag relates to Complaint IN00116059.</p> <p>3.1-35(g)(1)</p>				

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F0309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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.</p> <p>A. Based on interview and record review, the facility failed to ensure timely processing of physician orders for urinalysis and treatment for UTI for 2 of 3 residents reviewed for UTI's (urinary tract infections) in a sample of 8. (Resident #B and #C)</p> <p>B. Based on interview and record review the facility failed to ensure an assessment was conducted in regard to a change of condition in relation to the color and temperature of a resident's arm for 1 of 5 residents reviewed for assessments. (Resident #F)</p> <p>Findings include:</p> <p>A.1. Resident # B's clinical record was reviewed on 9-6-12 at 2:30 p.m. Her diagnoses included, but were not limited to left femur fracture, morbid obesity, UTI and cardiomegaly.</p> <p>Review of the nursing notes indicated on 7-6-12 at 5:17 p.m., a physician order was</p>	F0309	- what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; One resident no longer resides at the facility, and other residents not identified due to the nature of the survey. - 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 residents have the potential to be affected. Staff was inserviced regarding notifications of physician and resident's legal representative when there is an accident involving the resident or a change in the resident's condition and obtaining orders for treatment on 9/13/12 by the Director of Nursing. A lab monitoring program has been put in place with a lab tracking system which is overseen by Medical Records and/or designee. Chart audit has been completed to ensure all residents with UTI's have had physician notification, lab orders completed, and physician notified of results when applicable.- what	09/25/2012	

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	received to obtain a urinalysis (UA) with a culture and sensitivity to rule out a UTI. It indicated the UA was to be obtained via an in and out catheter (temporary catheter to obtain the urine specimen). Nursing notes indicated the urine specimen for the UA was obtained after 2 attempts on 7-7-12 at 1:05 a.m. Nursing notes indicate the resident was symptomatic with UTI-specific related issues, until the morning of 7-11-12 when the physician ordered an antibiotic for the UTI. Nursing notes on 7-6-12 at 9:37 a.m., indicated the resident was continent of bowel and bladder and utilized the bedpan; on 7-7-12 at 1:05 a.m., indicated the resident's urine was cloudy yellow and odorless with signs and symptoms of confusion and urinary frequency, along with back and leg pain; on 7-7-12 at 12:12 p.m., urine remained cloudy, but odorless with no complaints of urinary frequency and no complaints of pain or discomfort; continued on 7-8-12 throughout the day without complaints of urinary frequency, but urine remained cloudy and odorless. On 7-9-12, nursing notes indicated no urinary issues, but at 11:00 p.m., did indicate "discharge noted in brief." No further description was indicated of the discharge. Notes indicated no additional urinary related problems with the exception of cloudy, odorless urine until the physician's orders		measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Staff was inserviced regarding notifications of physician and resident's legal representative when there is an accident involving the resident or a change in the resident's condition and obtaining orders for treatment on 9/13/12 by the Director of Nursing. A lab monitoring program has been put in place with a lab tracking system which is overseen by Medical Records and/or designee. Chart audit has been completed to ensure all residents with UTI's have had physician notification, lab orders completed, and physician notified of results when applicable.- 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 Labs/Diagnostics Continuous Quality Improvement tool will be completed monthly for 3 months and quarterly thereafter Medical Records and/or designee. This will be reviewed by the Quality Assurance Committee. If 90% compliance not met, an action plan will be developed.				

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	<p>for an antibiotic were obtained on 7-11-12 at 1:40 a.m.</p> <p>Review of the UA results indicated on 7-7-12 at 7:42 a.m., the laboratory received the urine specimen for processing. It indicated on 7-9-12 at 7:04 a.m., the laboratory indicated the results were processed, indicating gram negative bacilli of more than 100,000 with the identification and susceptibility results to follow. Review of the lab results and the nursing notes did not indicate the physician was notified of this information. The culture and sensitivity report for the UA conducted on 7-7-12 did not indicate a date in which the test had been completed. It indicated only the date of the UA. However, a nursing note on 7-11-12 at 1:40 a.m., indicated the physician ordered an antibiotic for a UTI.</p> <p>In interview with the Director of Nursing on 9-7-12 at 9:32 a.m., she indicated she did know why the nursing staff had not documented notification of the physician in regard to the lab results. She indicated the facility has been encouraging the physicians to treat any UTI's conservatively due to concerns with over treatment. She indicated she was unaware as to why it took from the 7th to the 11th for a treatment to be ordered for Resident #B.</p>						

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	<p>A.2. Resident #C's clinical record was reviewed on 9-10-12 at 9:33 a.m. Her diagnoses included, but were not limited to Alzheimer's disease, high blood pressure, chronic pain and a history of UTI.</p> <p>Review of the nursing notes indicated on 8-9-12 at 3:40 p.m., the resident was involved in an altercation with another resident in which Resident #C pushed the other resident down onto the floor. This event had been preceded by occurrences of throwing things at staff and down the hall in the days preceding the altercation. The interdisciplinary team (IDT) notes of 8-10-12 at 9:12 a.m., indicated in conversation with the family regarding these events, the family indicated the behaviors could be related to UTI's. IDT notes at this time indicated, "IDT feels that the POA's wish should be honored and resident should be checked for UTI." No further documentation was indicated regarding UTI testing until a notation on 8-13-12 at 11:19 a.m., which indicated, "Resident is scheduled for a UA test today." Another entry, dated 8-13-12 at 2:20 p.m., indicated, "Res[ident] has increased verbal aggression with staff and other residents. Family has requested a UA. Notified [name of attending physician] and received new order to get</p>			

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	<p>UA with C/S [culture and sensitivity] if indicated." Nursing notes indicated the urine specimen was obtained and the physician initiated antibiotic therapy, effective 8-13-12. Review of the lab report indicated the lab received the urine specimen on 8-13-12 at 4:54 p.m. and preliminary results were received on 8-14-12 at 7:09 a.m. of greater than 100,00 of gram negative bacilli, presumed to be E. coli. The E.coli was confirmed as the causative organism on a non-specified date from the specimen obtained on 8-13-12.</p> <p>In interview with the DON on 9-10-12 at 11:01 a.m., she indicated she could not explain "...why there was a delay in getting the UA ordered and collected. Maybe it was on a weekend. I realize that is not a good excuse, but it does sometimes slow things down."</p> <p>B. 1. Resident #F's clinical record was reviewed on 9-7-12 at 9:27 a.m. Her diagnoses included, but were not limited to senile dementia and psychosis, high blood pressure, chronic pain and urinary frequency.</p> <p>In confidential interview with a concerned person on 9-7-12 at 3:09 p.m., she indicated she was informed on 8-5-12, Resident #F had an event in which her</p>				

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	<p>right arm was cold, purple in color and the resident cried out in pain when the arm was touched. She indicated she was unsure if a nurse had assessed (checked out) the resident's arm, but had been informed by another family member that LPN #1 had placed a warm compress on the resident's arm and massaged her hand because the fingers were clinched tight. She indicated she did not think LPN #1 had informed the resident's physician of these events. She indicated LPN #1 no longer was employed with the facility.</p> <p>In interview with LPN #2 on 9-10-12 at 2:07 p.m., she indicated on the afternoon of 8-5-12, she was receiving the shift report from LPN #1. She indicated LPN #1 had informed her that the arm of Resident #F had been "kind of a purple color, like it was if you would go outside and get real cold." She indicated LPN #1 had indicated this occurred earlier in the shift when a family member was visiting. She indicated LPN #1 had told her she had placed a warm compress on the resident's arm and the arm seemed improved to LPN #1. LPN #2 indicated she asked LPN #1 if she had notified the physician in regard to this issue and LPN #1 indicated to her that she had not notified the physician. LPN #2 indicated she was surprised LPN #1 had not documented anything in the clinical</p>			

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NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240			
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	<p>record regarding the arm issue. LPN #2 indicated prior to the end of the shift report, Resident #F became unresponsive and was found by a staff member. She indicated she did not recall Resident #F's right arm appearing to be discolored during the subsequent code or during the postmortem care provided after she passed.</p> <p>In interview with the Director of Nursing (DON) on 9-7-12 at 8:40 a.m., she indicated several weeks after the passing of Resident #F, LPN #2 indicated to her that on the afternoon of her passing that the resident's arm had been cold and that LPN #1 had placed a warm compress on the arm.</p> <p>The DON provided a copy of the "24 Hour Report," for 8-5-12 on 9-10-12 at 3:25 p.m. This document indicated Resident #F's right arm was "cold to touch, discolored." This entry was untimed and unsigned.</p> <p>Review of the clinical record indicated there was an absence of any documentation on 8-5-12 regarding any issue with Resident #F's arm. This included a lack of documentation of an assessment of Resident #F's right arm.</p> <p>This Federal tag relates to Complaint</p>						

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	IN00114740 and IN00116059. 3.1-37(a)				

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F0371 SS=E	<p>483.35(i) FOOD PROCURE, 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 Based on observation, interview and record review, the facility failed to ensure dietary staff did not use bare hands to serve food products during the process of serving a meal. This affected at least 9 of 18 residents served in the main dining area for the breakfast meal on 9-7-12 and involved Dietary Staff #1)</p> <p>Findings include:</p> <p>During the breakfast meal service in the main dining area on 9-7-12, between 7:25 a.m. and 7:34 a.m., Dietary Staff #1 was observed to pick up 2 biscuits with bare hands, and split each biscuit in half, prior to plating the biscuits and placing gravy on the biscuits.</p> <p>In interview with Dietary Staff #1 on 9-7-12 at 7:31 a.m., Dietary Staff #1 indicated she normally uses her ungloved hands to split the biscuits open. She indicated she had been told not to go from one task to another while wearing gloves. She indicated she could have opened the biscuits with tongs or another kitchen</p>	F0371	- what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The dietary staff member was educated during the meal service and immediately corrected the practice prior to serving more residents. Now food is not touched by bare hands during meal service. - 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 residents who eat in the main dining room have the potential to be affected. Food handling and serving skills validations and inservicing were completed on 9/10/12 by the Dietary Manager. - what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Food handling and serving skills validations and inservicing were completed on 9/10/12 by the Dietary Manager. Dietary Manager to monitor staff during meal service to ensure proper food sanitation practices are in	09/25/2012			

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	<p>utensil.</p> <p>In interview with the Director of Nursing on 9-10-12 at 3:58 p.m., she indicated the Dietary Manager had shared with her that Dietary Staff #1 only served the residents in the main dining area on the morning of 9-7-12. She indicated at least 50 percent or more of the 18 residents in the main dining area that morning were served biscuits, but was unsure of the exact number.</p> <p>The Director of Nursing provided a copy of a policy entitled, "General Food Preparation and Handling" on 9-10-12 at 9:14 a.m. This policy indicated a revision date of 4/11. This policy indicated, ".Food will be prepared and served with clean tongs, scoops, forks, spoons, spatulas, or other suitable implements so as to avoid bare hand contact of prepared foods..."</p> <p>3.1-21(i)(3)</p>		<p>place.- 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 Meal Observation Continuous Quality Improvement tool will be completed monthly for three months and quarterly thereafter by the Dietary Manager and/or designee. This will be reviewed by the Quality Assurance Committee. If 90% compliance not met, an action plan will be developed.</p>		