

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155100	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/09/2016
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NAME OF PROVIDER OR SUPPLIER GARDEN VILLA - BEDFORD	STREET ADDRESS, CITY, STATE, ZIP CODE 2111 NORTON LN BEDFORD, IN 47421
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Compliant IN00200567.</p> <p>Complaint IN00200567 - Unsubstantiated due to lack of evidence.</p> <p>Survey dates: June 1, 2, 3, 6, 7, 8, and 9, 2016.</p> <p>Facility number: 000040 Provided number: 155100 AIM number: 100274460</p> <p>Census bed type: SNF: 4 NF: 133 Total: 137</p> <p>Census Payor type: Medicare: 7 Medicaid: 112 Other: 18 Total: 137</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Q.R. completed by 14466 on June 13,</p>	F 0000	Preparation and submission of this plan of correction does not constitute an admission or agreement by Garden Villa of the conclusions of this survey. We respectfully submit this plan of correction as proof of our compliance with the State and Federal regulations, and per the laws that mandate the submission of this plan of correction. Please review the attached documents with this plan or correction, as evidence of completion of this plan and evidence of compliance.	

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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F 0156 SS=D Bldg. 00	<p>2016.</p> <p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the</p>				

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	<p>amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and</p>			

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	<p>certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>Based on interview and record review, the facility failed to ensure a resident was provided 48 hours notice for non-coverage of skilled services for 2 of 3 residents reviewed for Advance Beneficiary Notice of Medicare Non-Coverage. (Resident #48 and Resident #174).</p> <p>Findings include:</p> <p>1. On 6/8/2016 at 12:00 p.m., the receptionist provided a "Notice of Medicare Non-Coverage" letter for Resident #48. The letter indicated Resident #48's skilled services would end on 2/8/2016. The letter was signed by Resident #48 on 2/8/2016.</p> <p>During an interview on 6/8/2016 at 11:18</p>	F 0156	<p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:</p> <p>All Medicare residents who no longer have a skilled need but have Medicare days have the potential to be affected. Nursing Administration, Social Services and Therapy Director have been educated on the criteria for issuing an ABN letter.</p>	06/27/2016

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	<p>a.m., the Social Services Assistant indicated, Resident #48 was a last minute ordeal, because she was torn between going home with home health or going on hospice. The letter was signed the same day.</p> <p>2. On 6/8/2016 at 12:00 p.m., the receptionist provided a "Notice of Medicare Non-Coverage" letter for Resident #174. The letter indicated Resident #174's skilled services would end on 3/10/2016. The letter was signed by Resident #174, but was not dated.</p> <p>During an interview on 6/8/2016 at 11:20 a.m., the Social Services Assistant indicated she didn't realize the letter had not been dated when she had Resident #174 sign it. She was unsure what date the letter had been signed.</p> <p>On 6/9/2016 at 11:15 a.m., the Administrator indicated the facility does not have a policy related to the Medicare Advance Beneficiary Notice of Non-Coverage letters.</p> <p>Medicare Advance Beneficiary Notice of Non-Coverage Second Edition dated April 2011 indicated, "A Medicare provider must give a completed copy of this notice to beneficiaries receiving services from a skilled nursing facilities</p>		<p>What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>Medicare residents will be discussed biweekly in the Medicare meeting for the need of ABN notices.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur:</p> <p>The ABN notices will be monitored in the biweekly Medicare meetings and the results of the audit will be brought to the monthly QAPI meeting.</p> <p>By what date the systemic changes will be completed: 6/27/16</p>	

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F 0278 SS=D Bldg. 00	<p>... not later than 2 days before termination of services..."</p> <p>3.1-4(a)</p> <p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual</p>			

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	<p>who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on interview and record review, the facility failed to ensure the accuracy of the Minimum Data Set (MDS) assessment for 1 of 34 residents reviewed for accuracy of the MDS. (Resident #79)</p> <p>Findings include:</p> <p>Resident #79's clinical record was reviewed on 6/9/2016 at 9:00 a.m. Diagnoses included, but were not limited to congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD).</p> <p>Resident #79's Physician's Order, dated 4/18/2016, indicated, " ... Admit to hospice"</p> <p>Resident #79's Hospice Physician Certification of Terminal Illness dated for a certification period of 4/18/2016</p>	F 0278	<p>F278</p> <p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Resident # 79 MDS was modified to reflect 6 months or less to live</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:</p> <p>Any resident receiving hospice benefits have the potential to be affected and the current MDS were reviewed to ensure that J1400 is coded as yes.</p> <p>What measure will be put into place</p>	06/27/2016			

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	<p>through 6/16/2016, and signed by the Hospice Medical Director or Designee on 4/21/2016, indicated, " ... I certify to the best of my medical knowledge that the above mentioned patient is terminally ill with a life expectancy of six months or less ..."</p> <p>Resident #79's Admission Minimum Data Set (MDS) assessment dated 5/9/2016, indicated, " ... Health Conditions ... Prognosis ... Does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months? ... No ... "</p> <p>On 6/8/2016 at 1:42 p.m., the MDS coordinator indicated they have always been told if the doctor doesn't specifically say somewhere in the chart that the resident has less than 6 months to live, they are to code the MDS as No.</p> <p>On 6/9/2016 at 12:10 p.m., the Director of Nursing (DON) indicated the Hospice Physician Certification of Terminal Illness was not in Resident #79's chart when the MDS was completed on 5/9/2016. The hospice agency faxed over the certification on a later date. She further indicated there had not been a correction request of the MDS dated 5/9/16, nor had they completed a</p>		<p>or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>Residents who are receiving hospice will be reviewed to ensure that the physician statement/certification is in place during ARD.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur:</p> <p>J1400 will be monitored for all hospice residents when assessments are completed and the results will be reviewed during QAPI monthly.</p> <p>By what date the systemic changes will be completed: 6/27/16</p>				

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F 0281 SS=D Bldg. 00	<p>significant change MDS assessment after the Hospice Physician Certification of Terminal Illness was received, but they would be able to do that.</p> <p>On 6/9/2016 at 9:35 a.m., the DON indicated the facility did not have a policy related to coding of the MDS for residents who have a life expectancy of less than 6 months. She provided at that time a copy of the Resident Assessment Instrument (RAI) Version 3.0 Manual, Section J1400: Prognosis dated October of 2015, and indicated the facility used the RAI manual when coding the MDS. The RAI manual indicated, " ... Code 1, yes: if the medical record includes physician documentation: 1). that the resident is terminally ill; or 2). the resident is receiving hospice services"</p> <p>3.1-31(d)</p> <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. Based on observation, interview, and record review, the facility failed to ensure staff administered a gastrostomy tube</p>	F 0281	F281 What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:	06/27/2016

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	<p>(g-tube / a tube through the abdomen wall and into the stomach) medication (Resident #112) and an inhaler medication (Resident #61) as the facility policy and the Geriatric Medication Handbook indicated for 2 of 8 residents observed for medication administration.</p> <p>Findings include:</p> <p>1.) On 6/9/16 at 10:07 a.m., RN #2 was observed to pull out Resident #112's following medications:</p> <p>aspirin (non-steroidal anti-inflammatory medication) 81 mg (milligrams) 1 tab. bupropion (antidepressant medication) 75 mg 1 tab. clonazepam (antianxiety medication) 0.5 mg 1/2 tab. ranitidine (antacid medication) 150 mg 1 tab. tramadol (pain reliever) 50 mg 1 tab.</p> <p>RN #2 was observed to individually crush and pour each medication into a medication cup. The RN indicated she was going to keep them all separate and flush in between medications. RN #2 was observed to individually pour the not dissolved crushed medications into a syringe attached to the g-tube and flush with water in between each medication. The g-tube was observed to have large</p>		<p>Resident # 112 had no adverse effects from the administration of medications per g-tube. Resident # 61 had no adverse effects from the administration of the inhaler. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: Any resident receiving medications per G tube have the potential to be effected and any resident receiving MDI inhalers have the potential to be effected. Education was provided to all nurses and QMAs on the facility policy and procedure for administering medications per g tube and the facility policy and procedure for the MDI inhalers. What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Weekly medication pass observations will be completed weekly for 4 weeks, including all shifts and on the weekend made for residents receiving medications per g tube as well as resident receiving MDI inhalers for the proper administration. If 100% compliant, audits will decrease to weekly for two months, including all shifts and on the weekend If not 100% compliant, continued education will be provided and audits will be increased as needed to ensure facility policy and procedures for administration are followed. How the corrective action will be</p>				

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	<p>particles of crushed medication and RN #2 used the bulb syringe in attempt to flush the medication through. After the medication administration RN #2 indicated she usually crushes each medication up and then dissolved them all together so the medications go down by force of gravity. She further indication she uses the bulb syringe if the tubing gets clogged, however she doesn't like to get extra air down in their stomachs.</p> <p>On 6/9/16 at 11:21 a.m., Resident #112's clinical record was reviewed. Diagnosis included, but were not limited to: severe TBI (traumatic brain injury), ADHD (Attention Deficit Hyperactivity Disorder), and g-tube.</p> <p>On 6/9/16 at 12:09 p.m., the DON provided the facility policy, "Enteral Nutrition: Medication Administered Via Nasogastric Tube/Nasoduodenal Tube/ Gastrostomy Tube," undated, and indicated it was the policy currently being used by the facility. The policy indicated, "... 11. Giving Medications: ... b. Give tablets finely pulverized and dispersed well in warm water via gravity."</p> <p>A review of the "Geriatric Medication Handbook," on 6/9/16 at 1:07 p.m., indicated for Enteral Tube Medication Administration, "Crush</p>		<p>monitored to ensure the deficient practice will not recur: Results of the above audits will be presented at the monthly QA meeting, when results show compliance for 90 days consecutively the monthly reviews will be changed as needed. By what date the systemic changes will be completed: 6/27/16</p>	

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	<p>immediate-release tablets into a fine powder then dissolve in at least 15 ml (milliliters) of warm purified or sterile water."</p> <p>2.) On 6/9/16 at 1:40 p.m., LPN #1 was observed to remove Resident #61's Symbicort (a metered dose bronchodilator inhaler that relaxes muscles in the airways and increases air flow to the lungs) inhaler and instruct the resident to breathe in after the medication was dispersed into the aerochamber (a holding chamber connected to the mouthpiece of the inhaler). The LPN did not instruct the resident to exhale before dispersing the medication into the chamber and the LPN was observed to disperse an additional spray into the aerochamber in less than 30 seconds after the first spray.</p> <p>On 6/9/16 at 2:08 p.m., Resident #61's clinical record was reviewed. Diagnoses included, but was not limited to COPD (chronic obstructive pulmonary disorder).</p> <p>June 2016, physician orders indicated Symbicort (4/23/16 start date) inhale 2 puffs twice daily.</p> <p>On 6/9/16 at 2:58 p.m., the DON provided the facility policy, "Administering Medications through a</p>			

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F 0371 SS=E Bldg. 00	<p>Metered Dose Inhaler," revised September, 2003, and indicated it was the policy currently being used by the facility. The policy indicated, "... 14. Administer medication: ... d. Ask the resident to inhale and exhale deeply for a few breath cycles. On the last cycle, instruct the resident to exhale deeply ... 15. Repeat inhalation, if ordered If the medication is a bronchodilator, allow at least two minutes between inhalations..."</p> <p>A review of the "Geriatric Medication Handbook," on 6/9/16 at 3:07 p.m., indicated for Inhaled Medications, "... 14. Ask resident to breathe out ... 18. If another puff of the same or different medication is required, wait 1-2 minutes them repeat procedure..."</p> <p>3.1-35(g)(1)</p> <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 and interview, the facility failed to ensure damaged cans of dietary supplements were removed from storage for 13 of 35 cans observed.</p>	F 0371	F 371 What corrective actions will be accomplished for those residents	06/27/2016

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(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>Findings include:</p> <p>On 6/1/16 at 10:30 a.m., unit 4 kitchenette cabinets were observed to contain 35 Osmolite High Protein Nutrition with expiration date December 1, 2016. Thirteen of 35 cans were heavily dented.</p> <p>On 6/6/16 at 11:00 a.m., the Dietary Manager indicated the dietary staff is responsible for stocking the unit kitchenette areas and when dented cans are delivered they are sent back to their point of origin and not used for resident nutrition.</p> <p>On 6/9/16 at 1:45 p.m., it was observed that unit 4 kitchenette cabinets continued to contain 35 Osmolite High Protein Nutrition with expiration date December 1, 2016. Thirteen of 35 cans were heavily dented.</p> <p>On 6/9/16 at 2:00 p.m., the facility administrator indicated the facility has no written policy regarding the disposition of damaged dietary goods.</p> <p>3.1-21(i)(3)</p>		<p>found to have been affected by the deficient practice:</p> <p>The dented Osmolite cans in the cabinet on Unit 4 were disposed of.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:</p> <p>All pantries were observed and dented cans were disposed of. Central supply was educated on the acceptance of dented cans of nutritional products.</p> <p>What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>Central Supply was educated on the acceptance of dented cans nutritional products, and the need to return any damaged product to the manufacturer.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur:</p> <p>The pantries will be monitored</p>				

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			<p>weekly x 4 then monthly x 4 for the presence of dented cans of nutritional supplements. The results will reviewed monthly during the QAPI meeting</p> <p>By what date the systemic changes will be completed: 6/27/16</p>		