STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 07/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE HEALTH CARE FACILITY	337 GRACE VILLAGE DR WINONA LAKE, IN 46590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	This visit was for a Recertification and State Licensure survey. Survey dates: July 21, 22, 23, 24, 25, and 28, 2014. Facility number: 000501 Provider number: 155635 AIM number: 100266260 Survey team: Diane Nilson, RN, TC Carol Miller, RN Tim Long, RN Rick Blain, RN, July 21, 22, 23, 24, and 28, 2014. Census Bed Type: SNF/NF: 63 SNF: 9 Residential: 51 Total: 123 Census Payor Type: Medicare: 7 Medicaid: 34 Other: 82 Total: 123 Residential sample: 6 These deficiencies reflect State findings	F000000		

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

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

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	cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on August 5, 2014, by Brenda Meredith, R.N.			
F000167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. Based on observations and interview, the facility failed to ensure the Indiana State Department of Health annual Recertification Survey for 2013 was available to the residents. This deficiency had the potential to affect 72 of 72 residents in the facility. Findings include: During the initial tour of the facility, on 7/21/14 at 9:30 a.m., the survey book was observed in the Healthcare unit on the wall by the nurse's station the Indiana	F000167	I. Corrective Action Taken For Affected Residents: No residents were identified as having been affected by the absence of the 2013 survey report from the binder. Although the 2013 report had not been posted in the binder, a copy of the report would have been able to have been quickly and easily produced for any resident to view upon request. The 2013 survey report is now in the binder. II. How Other Residents Potentially Affected Will Be Identified: As noted under the Summary Statement of Deficiencies (SOD),	08/27/2014

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	Department of Health annual Recertification Survey for 2013 was not available in the survey book. On 7/22/14 at 9:00 a.m., an observation of the survey book located on the Healthcare unit on the wall by the nurse's station, with the Director Nursing Service (DNS) present, the Indiana Department of Health 2013 annual Recertification Survey was not the survey book. On 7/25/15 at 8:30 a.m., an interview with the DNS indicated no one in particular is responsible for keeping the survey book current. 3.1-3(b)(1)		72 residents had the potential to have been affected. To the knowledge of administration, no residents requested to look at the survey binder since the 2013 survey was completed. III. Measures Implemented To Ensure Deficiency Does Not Recur: The SOD aptly indicated that the responsibility for keeping the survey binder current was not assigned to a particular individual or position. The responsibility for ensuring that current surveys are posted will be assigned to the facility administrator. The job description of the Administrator will be amended to include that specific responsibility. IV. How Corrective Measures Will Be Monitored To Ensure They Are Effective And Sustained: The Director of Nursing Services (DON), or her designee, will inspect the survey binder prior to each quarterly QA Committee meeting for a period of at least one year to ensure that the required postings are present. The findings will be reported to the QA Committee. If the findings demonstrate 100% compliance, the monitoring may cease. If the findings demonstrate anything less than 100% compliance, the Committee will determine another corrective measure and continue to monitor for the same period.	
F000314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES			

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	Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.			
	Based on observation, interview and record review, the facility failed to implement and monitor a health care plan for utilization of a hand splint for 1 of 3 residents (Resident #99) reviewed for pressure ulcers, resulting in a stage 3 pressure ulcer. Findings include: Resident #99's clinical record was reviewed on 7/21/14 at 12:54 P.M. Resident #99 was admitted to the facility from a hospital on 6/3/14 with diagnoses, including, but not limited to, cerebral vascular accident (CVA), left-sided hemiparesis, and contracture to left hand. The record indicated the resident was admitted to the facility on 6/3/14 and developed a stage 3 pressure ulcer (full thickness tissue loss) to his left thumb on 6/15/14. The record indicated the pressure ulcer for Resident #99 was healed on 7/16/14.	F000314	I. Corrective Action Taken For Affected Residents: At the time of the survey, the pressure ulcer that had developed on Resident #99's left thumb was noted to have healed. Resident #99 currently has a care plan in place to remove the carrot, wash the skin and perform passive range of motion (PROM) once per shift. An adhesive foam dressing is applied twice per week. Resident #99's skin remains in good condition. II. How Other Residents Potentially Affected Will Be Identified: Ten other residents were identified to have contractures in a resident review. Various braces or splints have been tried with these residents (and others may be tried) but none of them are currently utilizing an appliance. III. Measures Implemented To Ensure Deficiency Does Not Recur: After careful review of the surveyors' notations and examination of relevant facility policies, it was determined that several policies should be revised to provide additional instruction to	08/27/2014

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	On 6/3/14 a Braden Scale skin risk assessment was performed and a score of 14 was obtained which indicated Resident #99 was at moderate risk for pressure ulcers. Review of an admission health care plan, dated 6/3/14, indicated: Potential for impairment of skin integrity related to Clostridium Difficile (C-diff) and diarrhea, as evidenced by excoriated groin, scrotum and bottom. The goal was for the resident to not develop any pressure ulcer, open area or excoriations. The interventions for CNAs was to encourage fluids, inspect skin every shift, and report skin issues to the nurses. The interventions for the nurses were for weekly skin assessments if skin issues present and to notify the physician and obtain treatment orders. Review of Resident #99's nurse's notes included a daily muscular/skeletal assessments from 6/3/14 throughout development of the stage 3 pressure ulcer to the left thumb on 6/15/14. The daily assessment generally noted contracture left hand, partial loss of movement noted. The daily assessments included comments on whether the resident had pain or no pain. The daily assessments did not include any mention of the condition of the skin for the left hand		nursing staff specific to appliances used with contractures. The Skin Protocol Policy was revised to state that 1) a nurse will assess skin weekly in a contractured area, 2) that aides will have skin care and appliance care instructions added to their assignment sheets and 3) that CNAs who give showers will inspect skin and report to the nurses on any new skin issues found. (See Attachment A) The Range of Motion Policy was revised to provide instructions to remove an appliance, cleanse the area and inspect the area for skin breakdown. (See AttachmentB) The Care Plan Policy was revised to state that a nurse will add tasks to CNA assignment sheets and Treatment Administration Records (TARs) as appropriate at the time the nurse updates a Care Plan. (See Attachment C) When a task is added to a CNA assignment sheet, it automatically provides a means for the aide to document their care relative to that task. (*Note: revisions to attached policies are highlighted in yellow.) In addition to the policy revisions, an admission checklist item will be added to remind nurses to create a CNA task for contracture care if a resident is admitted with a contracture. When instruction and/or in-services are furnished to nursing staff from therapy staff, the therapy department will be responsible to maintain	

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	contracture. Review of Resident #99's nursing notes indicated daily skin assessments were completed from admission on 6/3/14 to the development of the pressure ulcer to the left thumb on 6/15/14. On 6/3/14, a new admission skin assessment was completed which noted "skin problems: excoriation groin, scrotum, buttocks; mole(s) located over body incision(s) right groin well approximated, staples intact. Has surgical wound(s) present in past 7 days. Bruises 5.0 x 3.0 cm [centimeters] bruise to left hand; 2.5 x 2.5 cm bruise to right antecubital space; 1.0 x 1.0 cm bruise to right forearm; 1.0 x 0.2 cm scab to right forearm; small pink spot to right side of face by ear where resident has picked measuring 0.5 x 0.3 cm." The daily skin assessments starting 6/4/14 noted no new skin issues noted . The daily skin assessments did include comments on the surgical wound, bruises, excoriation and a skin tear that occurred to the left elbow on 6/5/14. The daily skin assessments did not include specific assessments of Resident #99's left hand contracture. The final daily assessment done by nursing before noting the development of the pressure ulcer on 6/15/14 was documented on 6/14/14 at 5:09 P.M.		documentation of who attended and what material was covered. All nursing staff will be in-serviced on the policy revisions outlined above. IV. How Corrective Measures Will Be Monitored To Ensure They Are Effective And Sustained: The DON, or her designee, will verify that all nursing staff are trained on the policy revisions and will conduct a monthly audit to ensure that all policy revisions have been followed as they pertain to care planning and documenting of skin conditions. The Staff Development Coordinator will complete routine audits of admissions to verify that CNA assignments were added when appropriate and that CNAs are documenting accordingly. These audits will continue on a monthly frequency for a minimum of six months and then quarterly for the next six months. The results of the audits will be reported to the QA Committee. If less than 100% compliance is found, the QA Committee will recommend additional measures and the monitoring will continue until such time as compliance remains at 100% or a revised goal is met as determined by the QA Committee.	

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	Review of nurse's notes, from 6/15/14 at 9:04 P.M., indicated a stage 3 pressure ulcer to Resident #99's left thumb measuring 2.0 cm x 2.2 cm with a depth of 0.3 cm. The wound was noted as having a very foul odor with moderate greenish-yellow drainage/exudate. Pain was noted at the wound site. The wound was noted to be dark, tan. The physician was notified on 6/15/14 at 4:00 P.M. and orders were received to start treatment of Mepilex to left thumb every 3 days and as needed if loose or soiled. Physician's orders were also obtained on 6/15/14 at 4:00 P.M. to start Norco (a pain medication) every 6 hours as needed for pain. Resident #99 was seen by Occupational Therapy (OT) and Physical Therapy (PT) on 6/5/14. The OT evaluation and plan of treatment from 6/5/14 short term goals included, but was not limited to, the resident was to be fitted for appropriate left hand splint to manage contracture and decrease risk of skin breakdown. The assessment summary impressions noted Resident #99 presented with contracted left upper extremity (LUE). He tolerated very little passive range of motion (PROM) due to a high level of pain. The resident had a carrot splint which was mostly hanging out of his hand, really doing nothing to manage the contracture.			

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	OT was noted to have attempted to fully remove the splint but the resident could not tolerate it due to pain. The plan indicated therapy was to fit the resident for an appropriate splint. On 6/11/14 a weekly skilled therapy review note indicated staff were to try to keep the carrot splint in Resident #99's left hand. A PT therapy progress report for dates of service 6/5/14-6/13/14 indicated under assessment summary: Patient and caregiver training: Instructed patient and primary caregivers in safe transfer techniques, self care/skin checks and positioning/pressure relieving techniques in order to increase safety and decrease need for assistance and increase safety and reduce the risk of further medical complications that may result from impairments/condition with variable carryover demonstrated by caregivers, facilitating the need for further instruction and analysis of caregiver implementation of and patient response to instructions/techniques. On 6/13/14 a health care plan was initiated for: Potential for CVA related to diagnosis of previous CVA and left sided weakness. The goal was for no injury to affected side or body part, no skin			

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	breakdown. Interventions for Certified Nursing Assistant"s (CNA's) included but were not limited to: good hygiene to left hand then place carrot in left hand; report changes to nurses. Interventions for nurses were: Support affected extremity with sling or arm/leg rest in wheelchair; keep items in reach; administer medications per physician's order; observe for side effects and effectiveness; notify physician of any side effect or if not effective; monitor/report signs/symptoms of weakness, slurred speech, changes in level of consciousness, changes in mental status, to the physician; monitor blood pressure per policy or physician's order and notify physician if abnormal. An interview with LPN #6, the MDS (Minimum Data Set assessment)/Care Plan nurse, on 7/23/14 at 2:00 P.M., indicated before the pressure ulcer development on 6/15/14, there was no documentation of the CNA's attempting to use the carrot splint before 6/15/14. An interview with LPN #1, on 7/23/14 at 2:10 P.M., indicated before the pressure ulcer development to the left thumb was noted on 6/15/14, the nurses were doing skin assessments but not assessing the left hand contracture in particular.			

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	An interview with CNA #2, on 7/23/14 at 2:20 P.M., indicated Resident #99 had the carrot splint for his left hand when he was first admitted. CNA #2 indicated the CNA's would clean and dry his left hand and then place the carrot back in the hand. CNA #2 indicated before 6/15/14 the resident would take the carrot splint out of his hand at least daily when she worked with him. CNA #2 indicated the CNA's had no place to document the use of the carrot splint. CNA #2 indicated the carrot splint was not on the CNA assignment sheet before the development of the pressure ulcer on 6/15/14. An interview with PTA (Physical Therapy Assistant) #4 / Rehabilitation Director, on 7/23/14 at 2:20 P.M., indicated Resident #99 had left arm and hand contracture's when he was admitted and indicated he had a carrot splint when he was admitted. PTA #4 indicated the resident did not like to wear the carrot splint and would take it out a lot. He noted therapy was trying to get the left hand loose enough for a spring loaded brace. PTA #4 indicated they educated staff for the use of the carrot splint and noted nurse's were educated with the expectation they would educate all of the CNAs and nurses, including weekend staff.			

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	An interview with Director of Nursing Services (DNS), on 7/24/14 at 1:30 P.M., indicated the facility had no specific interventions to prevent the pressure ulcer to the left thumb before the development of the pressure ulcer on 6/15/14. On 7/25/14 at 11:00 A.M., an interview with PTA #5 indicated Resident #99 had a carrot splint upon admission which was given to the therapy department, which the resident had been using at a different long term care facility. PTA #5 indicated therapy saw the resident daily from 6/5/14 through 6/15/14 and indicated an Occupational Therapy Aide (COTA) and a PTA would work together typically to do PROM to the left arm and hand and then try to insert the carrot splint to prevent skin breakdown. PTA #4 indicated Resident #99 was very resistive to the carrot splint. An interview with the DNS, the Assistant Director of Nursing Services (ADNS), and RN #3 on 7/25/14 at 11:00 A.M. indicated they did not know anything about the carrot splint for Resident #99 before the development of the pressure ulcer on 6/15/14. The ADNS noted the carrot splint was on the CVA care plan of 6/13/14 but it was not put on the CNA assignment sheet. The ADNS indicated			

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	CNA's can look at care plans on the computer but are not expected to look at them, it is not a policy. The ADNS indicated CNA's cannot be held responsible for following a care plan if the task is not on their assignment sheets. The ADNS indicated on 6/13/14 when the CVA care plan was written the carrot splint should have been added to the CNA assignment sheets. The ADNS indicated when the CVA care plan of 6/13/14 was written, the nurses should have been tracking and documenting the use of the carrot splint but they were not. The ADNS indicated nurses were doing daily documentation of the contracture under the muscular skeletal along with daily skin assessments. An observation was made on 7/23/14, 2:30 P.M. of Resident #99's dressing change to his left thumb by LPN #1 and RN #3. The pressure ulcer to the resident's left thumb was resolved, the skin was intact. 3.1-40(a)(1) 3.1-40(a)(2)			

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F000456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. Based on observation, record review and interview, the facility failed to ensure grab bars were in safe condition for 1 of 35 residents observed for safety equipment in the bathroom. Finding includes: Resident #64's bathroom was observed on 7/22/14 at 10:08 a.m. The grab bars over the toilet and the toilet seat were very loose and wobbly. The resident indicated the grab bars could be tighter. The long grab bar on the wall to the left of the toilet was also loose on the end farthest from the toilet. The Maintenance Director was interviewed, on 7/22/14 at	F000456	I. Corrective Action Taken For Affected Residents: The grab bars in the bathroom of Resident #64 were inspected and tightened by maintenance personnel immediately following the notification that they were loose. II. How Other Residents Potentially Affected Will Be Identified: No other residents were identified to have been potentially affected by the deficiency cited. However, grab bars in all other resident and public bathrooms have also been inspected by maintenance personnel. III. Measures Implemented To Ensure Deficiency Does Not Recur: The facility employs more than adequate numbers of	08/27/2014

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	10:16 a.m., and indicated the grab bar over the toilet would be tightened, and the anchor on the grab bar on the wall was loose and needed to be tightened. The Quarterly Minimum Data Set, dated 5/12/14, was reviewed on 7/28/14 at 9:15 a.m., and indicated the resident required supervision of one staff for transfers, and ambulation in the room, and limited assistance of one staff for toileting. The Assistant Director of Nursing Services was interviewed, on 7/28/14 at 9:28 a.m., and indicated Resident #64 required a one person assist for toileting, but sometimes took himself. She indicated the facility did not have a policy for maintenance of the grab bars, but if staff saw something which needed to be fixed, they were supposed to fill out a work order for maintenance. 3.1-19(bb)		maintenance personnel and schedules them in such a way that there is at least one member of the maintenance staff onsite 24/7. Although weekly room checks have long been a required maintenance task, all of the specific items that must be checked had not been designated on a checklist to document inspections. A checklist (including bathroom grab bars) will now be used to facilitate thorough room inspections and ensure that no essential components are overlooked. All direct care staff also have a responsibility to immediately report any unsafe condition or equipment they notice to their direct supervisor, who will initiate a work order. Any potentially affected residents of an unsafe condition or piece of equipment must be appropriately protected from the hazard until it is resolved. A work order involving resident safety will take priority over any other work orders in the system and is to be completed as quickly as is practicable. All new employees will be instructed on this procedure as part of their department orientation and all existing employees will be assigned an in-service reminding them of this procedure. IV. How Corrective Measures Will Be Monitored To Ensure They Are Effective And Sustained: The Director of Environmental Services (DES) will review	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 07/28/2014
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			monthly, for at least 6 months, the room inspection checklists to ensure they are being utilized accordingly. Additionally, he will conduct a quality review of a minimum of 3 resident rooms per month to verify that inspections have been thorough and accurate. The DES will report directly to the QA Committee quarterly on the rate of compliance found. If the findings demonstrate 100% compliance, the monitoring may cease. If the findings demonstrate anything less than 100% compliance, the Committee will determine what additional or modified corrective measure will be implemented and continue to monitor for at least 6 more months.	
R000000	This state finding is cited in accordance with 410 IAC 16.2-5.	R000000		
R000217	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident.			

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	(2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.			
	Based on record review and interview, the facility failed to ensure a resident's Change in Condition Service Plan was signed. This deficiency affected 1 of 6 residents reviewed for service plans. (Resident #7) Finding includes: Resident #7's chart was reviewed on 7/28/14 at 10:30 A.M. resident #7's diagnoses included, but were not limited to, depression, senile delusions and macular degeneration. A Change in Condition Service Plan, dated 5/19/14, indicated there was no documentation that Resident #7's representative had signed the Change in	R000217	I. Corrective Action Taken For Affected Residents: Resident #7's representative will review and sign the Change in Condition Service Plan. II. How Other Residents Potentially Affected Will Be Identified: All resident service plans will be reviewed to ensure that any Change in Condition Service Plans have been signed by the resident or their representative. III. Measures Implemented To Ensure Deficiency Does Not Recur: A formal policy will be written to describe the requirements for Service Plans and Changes to those Plans including the point that they must be signed and dated by the resident or the resident's representative. The Social Service/Admissions Coordinator for Assisted Living and all	08/27/2014

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	Condition Service Plan. During an interview on 7/28/14 at 12:00 P.M., Social Service #7 indicated the Change in Condition Service Plan, dated 5/19/14, was done because Resident #7 had returned from a psychiatric hospital. Social Service #7 further indicated the initial service plans are always signed by either the resident or the resident's representative. Social Service #7 was unaware that a Change in Condition Service Plan had to be signed by Resident #7's representative. During an interview on 7/28/14 at 2:30 P.M., the Director of Nursing Service (DNS) indicated Resident #7 would not be able to sign her own plans due to Resident 7's health. The DNS further indicated the facility did not have a policy or procedure for Service Plans		relevant nursing staff will be in-serviced on the policy. IV. How Corrective Measures Will Be Monitored To Ensure They Are Effective And Sustained: The Director of Social Services and Admissions, or her designee, will conduct monthly audits for 6 months to ensure that all Change in Service Plans have been signed and dated according to policy. She will report her findings to the QA Committee. The QA Committee will allow the monitoring to cease after that point provided 100% compliance has been demonstrated. Otherwise, the QA Committee will recommend additional corrective actions and continued monitoring on a monthly basis until 100% compliance is achieved.	