

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155412	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/04/2012
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NAME OF PROVIDER OR SUPPLIER GREENWOOD HEALTH AND LIVING COMMUNITY LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 937 FRY RD GREENWOOD, IN46142
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F0000	<p>This visit was for Investigation of Complaint IN00101683.</p> <p>Complaint IN00101683 Substantiated. No deficiencies related to the allegations are cited.</p> <p>Unrelated deficiencies cited.</p> <p>Survey dates: January 3 & 4, 2012</p> <p>Facility number: 000509 Provider number: 155412 AIM number: 100266620</p> <p>Survey team: Mary Jane G. Fischer RN</p> <p>Census bed type: SNF: 1 SNF/NF: 102 Total: 103</p> <p>Census payor type: Medicare: 21 Medicaid: 76 Other: 6 Total: 103</p> <p>Sample: 6</p>	F0000	<p>This plan of correction is to serve as Greenwood Health and Living Community's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Greenwood Health and Living Community or their management companies that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. Facility is requesting desk review/paper compliance.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F0282 SS=D	<p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 1/5/12 Cathy Emswiller RN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview and record review the facility failed to ensure a resident's plan of care and physician orders were followed in regard to elimination needs and infection control precautions for 2 of 6 sampled residents. [Residents "F" and "B"].</p> <p>Findings include:</p> <p>1. The record for Resident "F" was reviewed on 01-04-12 at 12:10 p.m. Diagnoses included but were not limited to Alzheimer's dementia - stage three, agitation, anxiety, diabetes, insomnia and constipation. These diagnoses remained current at the time of the record review.</p> <p>During an interview on 01-04-12 at 11:30 a.m., the Social Service Director employee #5 indicated the resident had recently displayed behaviors, which required an inpatient stay at a local area</p>	F0282	<p>F282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER PLAN OF CARE</p> <p>1. Resident "F"'s plan of care and physician orders regarding constipation are being follow. Resident "B"'s isolation was discontinued during the survey process as the infection was resolved.</p> <p>2. Current residents identified as having the potential for constipation, have had their care plans reviewed to reflect current interventions including administration of the bowel protocol per physician orders. Any identified concerns will be addressed. All residents requiring Infection Control Precautions have been identified and signage provided on the door per current policy and plan of care.</p> <p>3. The systemic change will include:</p> <p>a. The computerized BM Tracking report will be reviewed daily by the Unit Manager or designee for documentation of</p>	02/03/2012	

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	<p>hospital. The Social Service Director indicated the resident's spouse determined the behaviors were the direct effect of the resident being "constipated."</p> <p>A review of the "Resident Progress Notes," dated 12-30-11 at 9:30 a.m. indicated "[Spouse] called to give writer update. [Spouse] states that they would like to continue to keep [resident] for observation dt [due to] not having a bm [bowel movement]."</p> <p>A Progress Note dated 12-30-11 at 10:28 p.m. indicated "Res. [resident] readmit from [name of local area hospital]. Per hospital report called to writer, res. had 2 enemas today with results. Bowel sounds are neg. [negative] ABD [abdomen] is firm. Distended."</p> <p>At the time of the readmission to the facility the resident had physician orders which included Docusate [a stool softener] 100 mg [milligrams] every day, Miralax [laxative] 17 grams mixed in water every day with an "as needed" order of Milk of Magnesia 2 tablespoons every day for constipation.</p> <p>Review of the resident's current plan of care, dated 12-30-11 indicated the resident has the potential for constipation. A "goal" for this plan of care indicated</p>		<p>BMs. Based on report findings, the facility's bowel protocol, per current physician orders will be followed. Any concerns will be addressed.</p> <p>b. The facility's Infection Control Precautions Policy has been revised to reflect current standard of practice to place signage on the resident's door. Rounds will be conducted by the Infection Control Nurse to monitor for compliance as outlined below. Education will be provided to nursing staff regarding tracking of bowel movements and administration of medications per physician orders, plan of care and facility bowel protocol. In addition, education will include placing signage on the resident's door per the updated infection control precautions policy and procedure.</p> <p>4. The Director of Nursing and/or designee will review:</p> <p>a. The bowel management report for all residents in the facility's clinical stand-up meeting five times weekly. Residents identified as not having a bowel movement in 3 or more days, per the facility protocol, will have their medication administration record reviewed for administration of prn bowel medication per MD orders. This review of the MAR will occur 5 times a week for 4 weeks, then 3 times a week for 4 weeks, then weekly for 4 weeks, then monthly for a total of 12 months of monitoring. Any concerns will be</p>	

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	<p>"Resident will not experience complications related to constipation." "Approaches" included "administer medications per MD [Medical Doctor] order, and monitor effectiveness, document frequency and character of bowel movements, encourage fluids, and observe for sings of constipation (decreased bowel sounds/abdominal pain/distention/decreased appetite/fever/etc)."</p> <p>A review of the "Vital Signs" electronic charting related to bowel movements for the resident indicated that from the time the resident was readmitted to the facility, 12-30-11, thru 01-04-11 the resident did not have a bowel movement.</p> <p>Review of the Medication Administration Record for January 2012, indicated that although the resident continued to received the routine medications, the nursing staff did not provide the Milk of Magnesia to aide in the resident's elimination needs.</p> <p>2. The record for Resident "B" was reviewed on 01-03-12 at 11:50 a.m. Diagnoses included but were not limited to chronic diarrhea + [positive] c-diff [clostridium difficile], fatigue and a history of urinary tract infections. These diagnoses remained current at the time of</p>		<p>addressed.</p> <p>b. All resident's rooms who require infection control precautions will be observed by the Infection Control nurse or designee, to evaluate isolation signage placement five times weekly for 4 weeks, then weekly thereafter. Any concerns will be addressed.</p> <p>5. Completion date: February 3, 2012</p>		

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	<p>the record review.</p> <p>A physician order dated 12-22-11 instructed the nursing staff to "test stool for c-diff."</p> <p>The results of the laboratory testing of the stool specimen indicated the resident had the gastrointestinal infection - "clostridium difficile."</p> <p>A review of the resident's current plan of care dated 12-27-11 indicated the resident had positive results for the c-difficile infection. Interventions to this plan of care included "contact isolation precautions."</p> <p>Review of the facility policy on 01-04-12 at 9:00 a.m., and titled "Isolation - Categories of Transmission - Based Precautions," dated as revised October 2009, indicated the following:</p> <p>"Contact Precautions"</p> <p>"g. Signs - use color coded signs and/or other measure to alert staff of the implementation of Transmission-Based Precautions, while respecting the privacy of the resident. Orange [bold type] is the color code for contact precautions."</p> <p>"(1) Place an orange sign at the doorway instructing visitors to report to the nurses'</p>			

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	<p>station before entering the room."</p> <p>"(2) Place an orange sticker indicating Contact Precautions on the head of the resident's bed and on the front of the resident's chart."</p> <p>During an observation on 01-03-12 at 2:00 p.m., and again on 01-04-12 at 9:30 a.m., the resident's door lacked signage to alert the staff and visitors to report to the Nurses Station before entering the resident's room.</p> <p>With the Director of Nurses in attendance on and during interview on 01-04-12 at 10:00 a.m., the Director of Nurses verified the resident's door as well as the bed lacked the appropriate signage.</p> <p>Review of the Resident's clinical record also lacked the color coded sticker to alert the nursing staff of the appropriate precautions needed to care for the resident.</p> <p>3.1-35(g)(1)</p>				

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F0309 SS=D	<p>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>Based on record review and interview the facility failed to ensure a resident's elimination needs were met, in that when a resident had a diagnosis of constipation, the nursing staff failed to ensure the facility bowel program was utilized for 1 of 1 resident's reviewed for constipation in a sample of 6. [Resident "F"].</p> <p>Findings include:</p> <p>The record for Resident "F" was reviewed on 01-04-12 at 12:10 p.m. Diagnoses included but were not limited to Alzheimer's dementia - stage three, agitation, anxiety, diabetes, insomnia and constipation. These diagnoses remained current at the time of the record review.</p> <p>During an interview on 01-04-12 at 11:30 a.m., the Social Service Director employee #5 indicated the resident had recently displayed behaviors, which required an inpatient stay at a local area hospital. The Social Service Director indicated the resident's spouse determined the behaviors were the direct effect of the resident being "constipated."</p>	F0309	<p>F309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <ol style="list-style-type: none"> Resident "F" is receiving care per the facility's bowel program. Current residents identified as having the potential for constipation, have had their care plans reviewed to reflect current interventions including administration of the bowel protocol per physician orders. Any identified concerns will be addressed. The systemic change will include: <ol style="list-style-type: none"> The computerized BM Tracking report will be reviewed daily by the Unit Manager or designee for documentation of BMs. Based on report findings, the facility's bowel protocol, per current physician orders will be followed. Any concerns will be addressed. <p>Education will be provided to nursing staff regarding tracking of bowel movements and administration of medications per physician orders and plan of care.</p> <ol style="list-style-type: none"> The Director of nursing and/or designee will review the 	02/03/2012

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	<p>A review of the "Resident Progress Notes," dated 12-30-11 at 9:30 a.m. indicated "[Spouse] called to give writer update. [Spouse] states that they would like to continue to keep [resident] for observation dt [due to] not having a bm [bowel movement]."</p> <p>A Progress Note dated 12-30-11 at 10:28 p.m. indicated "Res. [resident] readmit from [name of local area hospital]. Per hospital report called to writer, res. had 2 enemas today with results. Bowel sounds are neg. [negative] ABD [abdomen] is firm. Distended."</p> <p>At the time of the readmission the resident had physician orders which included Docusate [a stool softener] 100 mg [milligrams] every day, Miralax [laxative] 17 grams mixed in water every day with an "as needed" order of Milk of Magnesia 2 tablespoons every day for constipation.</p> <p>Review of the resident's current plan of care, dated 12-30-11 indicated the resident has the potential for constipation. A "goal" for this plan of care indicated "Resident will not experience complications related to constipation." "Approaches" included "administer medications per MD [Medical Doctor] order, and monitor effectiveness,</p>		<p>bowel management report for all residents in the facility's clinical stand-up meeting five times weekly. Residents identified as not having a bowel movement in 3 or more days per the facility protocol will have their medication administration record reviewed for administration of prn bowel medication per MD orders. This review of the MAR will occur 5 times a week for 4 weeks, then 3 times a week for 4 weeks, then weekly for 4 weeks, then monthly for a total of 12 months of monitoring.. Any concerns will be addressed.</p> <p>5. Completion date: February 3, 2012</p>		

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	<p>document frequency and character of bowel movements, encourage fluids, and observe for sings of constipation (decreased bowel sounds/abdominal pain/distention/decreased appetite/fever/etc)."</p> <p>A review of the "Vital Signs" electronic charting related to bowel movements for the resident indicated that from the time the resident was readmitted to the facility on 12-30-11 thru 01-04-11 the resident did not have a bowel movement.</p> <p>Review of the Medication Administration Records for December 2011 and January 2012, indicated that although the resident continued to received the routine medications, the nursing staff did not provide the Milk of Magnesia to aide in the resident's elimination needs.</p> <p>Review of the facility "Management of Constipation," policy on 01-04-12 at 1:00 p.m. and dated as revised 8/10 indicated the following:</p> <p>"It is the policy of this facility to assist resident to maintain regular bowel movements, at least every 3 days or per the resident's normal pattern. Laxative should be considered when there is no bowel movement for 3 or more days."</p>				

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	<p>"Procedure: It shall be the responsibility of the charge nurse for each unit to monitor the documentation of bowel movements every shift,"</p> <p>"The Nursing assistants will indicate which resident's have had bowel movement via documentation in the computerized Point of Care system,"</p> <p>"The night shift nurse will print a BM Monitoring Report from the Point of Care System nightly and provide for the following shifts with the 24 hour report sheets,"</p> <p>"The evening shift nurse will offer the PRN [as needed] laxative to any resident who has not had a BM in 3 days. If the laxative is refused, this will be recorded on the BM report and in the nurses notes of the applicable patient. Laxative (MOM 30 c.c.) [Milk of Magnesia] will be offered on the 3rd day,"</p> <p>"If the resident has not had a BM within 24 hours after receiving MOM (or refusal of MOM), a (Dulcolax) suppository will be offered/given. Refusal of the (Dulcolax) suppository will be recorded on the BM report and in the nurses notes of the applicable patient,"</p> <p>"If the resident has not had a BM within</p>			

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	24 hours after receiving the suppository, an <sic> (Fleets) enema may be offered/given. If no results are received within 12 hours of the enema, the physician will be notified." 3.1-37(a)				

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F0441 SS=E	<p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview and record review the facility failed to ensure an effective Infection Control program, in that when a resident had a diagnosis of Clostridium difficile, the nursing staff</p>	F0441	<p>F441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 1. Resident "B"'s isolation was discontinued during the survey process as the infection was</p>	02/03/2012

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	<p>failed to ensure appropriate signage to alert the staff and visitors to report to the nurses station for instruction prior to entering the resident's room for 1 of 4 sampled resident's.</p> <p>This deficient practice had the potential to effect 19 resident's who resided on the Unit. [Resident "B"].</p> <p>Findings include:</p> <p>The record for Resident "B" was reviewed on 01-03-12 at 11:50 a.m. Diagnoses included but were not limited to chronic diarrhea + [positive] c-diff [clostridium difficile], fatigue and a history of urinary tract infections. These diagnoses remained current at the time of the record review.</p> <p>A physician order dated 12-22-11 instructed the nursing staff to "test stool for c-diff."</p> <p>The results of the laboratory testing of the stool specimen indicated the resident had the gastrointestinal infection - "clostridium difficile."</p> <p>A review of the resident's current plan of care dated 12-27-11 indicated the resident had positive results for the c-difficile infection. Interventions to this plan of care included "contact isolation</p>		<p>resolved.</p> <p>2. All residents requiring Infection Control Precautions have been identified and signage provided on the door per current policy and plan of care.</p> <p>3. The systemic change is that the facility's Infection Control Precautions Policy has been revised to reflect current standard of practice to place signage on the resident's door and rounds conducted by the Infection Control Nurse to monitor compliance with the updated policy as outlined below.</p> <p>Education will be provided for nursing staff regarding placing signage on the resident's door per the updated infection control precautions policy.</p> <p>4. The Infection Control Nurse or designee will review all resident's rooms that require infection control precautions to evaluate isolation signage placement five times weekly for 4 weeks, then weekly thereafter. Any concerns will be addressed.</p> <p>5. Completion date: February 3, 2012</p>		

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	<p>precautions."</p> <p>Review of the facility policy on 01-04-12 at 9:00 a.m., and titled "Isolation - Categories of Transmission - Based Precautions," dated as revised on October 2009, indicated the following:</p> <p>"Contact Precautions"</p> <p>"In addition to Standard Precautions, implement Contact Precautions for resident known or suspected to be infected or colonized with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident care items in the resident's environment."</p> <p>"Examples of infections requiring Contact Precautions include, but are not limited to: (2) Diarrhea associated with Clostridium difficile."</p> <p>"g. Signs - use color coded signs and/or other measure to alert staff of the implementation of Transmission-Based Precautions, while respecting the privacy of the resident. Orange [bold type] is the color code for contact precautions."</p> <p>"(1) Place an orange sign at the doorway instructing visitors to report to the nurses'</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155412	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/04/2012
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	<p>station before entering the room."</p> <p>"(2) Place an orange sticker indicated Contact Precautions on the head of the resident's bed and on the front of the resident's chart."</p> <p>During an observation on 01-03-12 at 2:00 p.m., and again on 01-04-12 at 9:30 a.m., the resident's door lacked signage to alert the staff and visitors to report to the Nurses Station before entering the resident's room.</p> <p>With the Director of Nurses in attendance on and during interview on 01-04-12 at 10:00 a.m., the Director of Nurses verified the resident's door as well as the bed lacked the appropriate signage.</p> <p>Review of the Resident's clinical record also lacked the color coded sticker to alert the nursing staff of the appropriate precautions needed to care for the resident.</p> <p>3.1-18(b)(2)</p>			