

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 04/13/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GARDEN VILLA - BEDFORD	STREET ADDRESS, CITY, STATE, ZIP CODE 2111 NORTON LN BEDFORD, IN 47421
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: April 6, 7, 8, 9, 10, and 13, 2015.</p> <p>Facility number: 000040 Provider number: 155100 AIM number: 100274460</p> <p>Census bed type: SNF: 7 SNF/NF: 130 Total: 137</p> <p>Census payor type: Medicare: 8 Medicaid: 111 Other: 18 Total: 137</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 000	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. We respectfully request a desk review for the plan of correction submitted. Please review the attached documents with this plan of correction, as evidence of completion of this plan of correction and evidence of compliance.	
F 279 SS=D Bldg. 00	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise</p>			

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

TITLE

(X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155100	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/13/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER GARDEN VILLA - BEDFORD	STREET ADDRESS, CITY, STATE, ZIP CODE 2111 NORTON LN BEDFORD, IN 47421
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review, the facility failed to ensure a careplan was developed after assessment for a resident returning from outpatient surgery with a weight bearing boot which later exhibited skin breakdown for 1 of 1 resident reviewed for pressure ulcers (Resident #180) and failed to ensure a careplan was developed for residents who received an anti-psychotic medication for 2 of 5 residents reviewed for unnecessary medication use (Resident #176 and Resident #66).</p> <p>Findings include:</p> <p>1). Resident #180's clinical record was reviewed on 4/9/15 at 11:40 a.m. Diagnosis included, but were not limited</p>	F 279	<p>1.) A plan of care has been developed for resident #66 and resident #172 for the use of antipsychotic medications. The plan of care for resident #180 has been reviewed and updated in regards to the pressure area. The cam walker for resident #180 has been discontinued as of 4/15/15 as a result of a follow up appointment with the surgeon. Resident #180 has been released to fully weight bear on the left leg as tolerated. 2.) All residents that are prescribed psychoactive medications has the potential to be affected. The plan of care for all residents will be reviewed to ensure appropriate interventions are in place and for care plan accuracy for psychoactive medications. All residents have the potential to be affected</p>	05/13/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155100		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 04/13/2015	
NAME OF PROVIDER OR SUPPLIER GARDEN VILLA - BEDFORD				STREET ADDRESS, CITY, STATE, ZIP CODE 2111 NORTON LN BEDFORD, IN 47421			
(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>to: cerebrovascular accident (stroke).</p> <p>The current Minimum Data Set (MDS) assessment dated 1/27/15, indicated a Brief Interview for Mental Status score (BIMS) was 15, which indicated the resident was interviewable and cognitively intact. Resident #180 needed extensive assistance of 2 staff members for transfer, extensive assistance of 2 staff member for dressing, extensive assistance of 2 staff members for toileting, and at risk for pressure ulcer.</p> <p>On 4/10/15 at 11:00 a.m., with RN #5 present, observed Resident #180 in her wheelchair with a cam boot (post surgery immobilizer boot) on her left foot. Resident #180's toes were visible.</p> <p>Physician's written order dated 3/17/15, indicated "Cam walker on L [left] foot may be removed at night for sleeping only."</p> <p>Physician's telephone order dated 3/17/15, indicated, " Limited weight bearing in cam walker, ... cam walker on at all xs [times] except for bathing. ..."</p> <p>On 4/10/15 at 12:51 p.m., Unit 3's Manager provided documentation from manufacturer undated, which indicated, "... Like all lower extremity immobilizers</p>		<p>regarding pressure ulcer prevention. Wound risk assessments will be updated for all residents and the plan of care will be reviewed for all residents as well to ensure appropriate interventions are in place to prevent skin breakdown and for care plan accuracy. 3.) All new orders for psychoactive medications will be reviewed by DON and/or designee for three months to ensure that a plan of care has been developed and that the resident is being monitored for adverse reactions (Exhibit #1). If reviews are not 100% compliant, education will be immediate and reviews will be increased as needed. Education regarding prevention of skin breakdown will also be completed with all nursing staff (Exhibit #3). The care plans for residents with pressure ulcers will be reviewed weekly for three months by the DON and/or designee during the weekly client review meeting to ensure accuracy and that all appropriate interventions are in place (Exhibit #4). If reviews are not 100% compliant, education will be immediate and reviews will increase as needed. For all new admissions the wound risk assessment and plan of care pertaining to prevention of skin breakdown will be reviewed by the DON and/or designee for three months to ensure accuracy and that all appropriate interventions are in place (Exhibit</p>				

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 04/13/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GARDEN VILLA - BEDFORD	STREET ADDRESS, CITY, STATE, ZIP CODE 2111 NORTON LN BEDFORD, IN 47421
--	--

(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>... should be monitored frequently for ... skin irritation or wound management. ..."</p> <p>There was no care plan provided for care of Resident #180's cam walker.</p> <p>On 4/10/15 at 12:51 p.m., the Unit 3's Manager provided documentation with no name, no date, and indicated it was information for the cam walker recently faxed over from the surgeon's office. The documentation indicated, "... Like all lower extremity immobilizers, ...monitor frequently for ... skin irritation or wound management. ..."</p> <p>On 4/10/15 at 12:50 p.m., Unit 3's Manager indicated there was no care plan available to address how to provide care and prevent skin breakdown for Resident #180's cam walker (post surgery immobilizer boot).</p> <p>On 04/10/15 9:10 a.m., the Assistant Director of Nursing (ADON) indicated they do not have a policy for when to initiate care plans. "We usually developed a care plan within 7 days."</p> <p>2a. The clinical record was reviewed for Resident #172 on 4/9/2015 at 10:00 a.m. Diagnoses included, but were not limited to psychosis and dementia with behavioral disturbance.</p>		<p>#5). If reviews are not 100% compliant, education will be immediate and reviews will increase as needed. 4.) The results of the reviews will be presented at the monthly QA meeting, when results show 100% compliance for 90 consecutive days the monthly reviews will be changed to as needed.</p>	

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 04/13/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GARDEN VILLA - BEDFORD	STREET ADDRESS, CITY, STATE, ZIP CODE 2111 NORTON LN BEDFORD, IN 47421
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>The annual Minimum Data Set (MDS) assessment dated 2/5/2015, assessed Resident #172 as taking an anti-psychotic medication the last 7 out of 7 days.</p> <p>Physician's order dated 3/1/2015, indicated Resident #172's medications included but, were not limited to: haloperidol tablet (an anti-psychotic used to treat schizophrenia, acute psychosis, and for tics and vocal utterances of Tourette's syndrome) 1 milligram three times a day for dementia with behavioral disturbances. Original start date of 6/19/2014. Olanzapine tablet (an anti-psychotic used to treat mental disorders, such as schizophrenia or bipolar disorders) 2.5 milligrams every day at 3:00 p.m., with an original start date of 4/16/2014, and olanzapine tablet 5 milligrams every night at bedtime for psychosis with an original start date of 4/4/2014.</p> <p>On 4/9/2015 at 2:30 p.m., Registered Nurse #4 (RN #4) provided Resident 172's current and undated care plan. No care plan had been initiated for the use of anti-psychotic medications for Resident #172.</p> <p>On 4/9/2015 at 11:10 a.m., an interview with RN #4 indicated Resident #172 did not have a care plan for the use of</p>			

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 04/13/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GARDEN VILLA - BEDFORD	STREET ADDRESS, CITY, STATE, ZIP CODE 2111 NORTON LN BEDFORD, IN 47421
--	--

(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>anti-psychotic medications.</p> <p>The Wolters Kluwer Nursing 2015 Drug Handbook, 35th edition, copyright 2015, Black Box Warning for haloperidol include: "Elderly patients with dementia-related psychosis treated with atypical or conventional anti-psychotics are at increased risk for death. Anti-psychotics aren't approved for the treatment of dementia-related psychosisAlert: Watch for signs and symptoms of neuroleptic malignant syndrome (extrapyramidal effects, hyperthermia, autonomic disturbance), which is rare but commonly fatal."</p> <p>2b. The clinical record was reviewed for Resident #66 on 4/9/2015 at 1:00 p.m. Diagnoses included, but were not limited to Alzheimer's disease, anxiety and dementia.</p> <p>The annual Minimum Data Set (MDS) assessment dated 2/1/2015, assessed Resident #66 as taking an anti-psychotic the last 7 out of 7 days.</p> <p>Physician's order dated 3/1/2015, indicated Resident #66's medications included but, were not limited to: Risperdal tablet (an anti-psychotic medication used to treat schizophrenia and bipolar disorder) 0.25 milligram</p>			

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 04/13/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GARDEN VILLA - BEDFORD	STREET ADDRESS, CITY, STATE, ZIP CODE 2111 NORTON LN BEDFORD, IN 47421
--	--

(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>every morning with an original start date of 3/25/2014, and Risperdal 0.25 milligrams, 1/2 tablet (0.125 mg) at bedtime with an original start date of 3/25/2014, for dementia with behaviors and alprazolam tablet (an anti-anxiety used to treat anxiety disorders, panic disorders, and anxiety) 0.25 milligrams, 1 tablet at bedtime and 2 tablets before showers.</p> <p>On 4/9/2015 at 2:00 p.m., License Practical Nurse #1 (LPN #1) provided the current and undated care plan for Resident #66. No care plan had been initiated for the use of anti-psychotic medications for Resident #66.</p> <p>On 4/09/2015 at 1:36 p.m., an interview with LPN #1 indicated she doesn't know how they monitor for side effects on anti-psychotics and anti-anxiety medications. She indicated the staff is familiar with the resident so it would be noticeable if the resident acted differently and they would chart findings in the nurses notes.</p> <p>On 4/10/2015 at 9:10 a.m., the Assistant Director of Nursing (ADON) indicated the facility does not have a policy for care plans. They are usually developed within 7 days but that varies at times.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155100	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/13/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER GARDEN VILLA - BEDFORD	STREET ADDRESS, CITY, STATE, ZIP CODE 2111 NORTON LN BEDFORD, IN 47421
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314 SS=D Bldg. 00	<p>The Wolters Kluwer Nursing 2015 Drug Handbook, 35th edition, copyright 2015, Black Box Warning for Risperdal include: " Elderly patients with dementia-related psychosis treated with anti-psychotics are at increased risk for death. Drug isn't approved to treat elderly patients with dementia-related psychosisAlert: Watch for evidence of neuroleptic malignant syndrome (extrapyramidal effects, hyperthermia, autonomic disturbance), which is rare but can be fatal."</p> <p>3.1-35(a)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES 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 ensure a resident admitted without pressure ulcers did not acquire pressure ulcers when preventable for 1 of 1 resident reviewed for pressure ulcers. (Resident</p>	F 314	1.) The wound risk assessment and plan of care has been reviewed and updated for resident #180 to ensure appropriate interventions are in place to promote wound healing and to prevent further skin breakdown. The cam walker for	05/13/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155100		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 04/13/2015	
NAME OF PROVIDER OR SUPPLIER GARDEN VILLA - BEDFORD				STREET ADDRESS, CITY, STATE, ZIP CODE 2111 NORTON LN BEDFORD, IN 47421			
(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>#180)</p> <p>Findings include:</p> <p>Resident #180's clinical record was reviewed on 4/9/15 at 11:40 a.m. Diagnosis included, but were not limited to: cerebrovascular attack (stroke).</p> <p>The current Minimum Data Set (MDS) assessment dated 1/27/15, indicated a Brief Interview for Mental Status score (BIMS) was 15, which indicated the resident was interviewable and cognitively intact. Resident #180 needed extensive assistance of 2 staff members for transfer, extensive assistance of 2 staff member for dressing, extensive assistance of 2 staff members for toileting, and at risk for pressure ulcer. Resident #180 was admitted with no open areas.</p> <p>On 4/10/15 at 11:00 a.m., with RN #5 present, Resident #180's bottom great left toe was observed to have a quarter sized black area. The left 2nd toe's bottom was observed to be healing from an old sore.</p> <p>Physician's written order dated 3/17/15, indicated "Cam walker on L [left] foot may be removed at night for sleeping only."</p>		<p>resident #180 has been discontinued as of 4/15/15 as a result of a follow up appointment with the surgeon. Resident #180 has been released to fully weight bear on the left leg as tolerated. 2.) All residents have the potential to be affected. The wound risk assessment and plan of care will be reviewed for all residents to ensure appropriate interventions are in place and to prevent skin breakdown. 3.) Education will be completed with all nursing staff regarding prevention of skin breakdown (Exhibit #3). Education will be completed with all nurses regarding completion of the weekly skin assessment sheet (Exhibit #6). The care plans for residents with pressure ulcers will be reviewed weekly by DON and/or designee during the weekly client review meeting for three months to ensure accuracy and that all appropriate interventions are in place (Exhibit #4). If not 100% compliant, education will be immediate and reviews will increase as needed. For all new admissions the wound risk assessment and plan of care pertaining to prevention of skin breakdown will be reviewed by DON and/or designee for three months to ensure accuracy and that all appropriate interventions are in place (Exhibit #5). If not 100% compliant, education will be immediate and reviews will increase as needed. Weekly skin assessment sheets will be</p>				

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 04/13/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GARDEN VILLA - BEDFORD	STREET ADDRESS, CITY, STATE, ZIP CODE 2111 NORTON LN BEDFORD, IN 47421
--	--

(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>Physician's telephone order dated 3/17/15, indicated, "Limited weight bearing in cam walker, ... cam walker on at all xs [times] except for bathing. ..."</p> <p>On 4/10/15 at 12:51 p.m., Unit 3's Manager provided documentation from manufacturer undated, which indicated, "... Like all lower extremity immobilizers ... should be monitored frequently for ... skin irritation or wound management. ..."</p> <p>On 4/10/15 at 12:51 p.m., the Unit 3's Manager provided documentation with no name, no date, and indicated it was information for the cam walker recently faxed over from the surgeon's office. The documentation indicated, "... Like all lower extremity immobilizers, ...monitor frequently for ... skin irritation or wound management. ..."</p> <p>On 4/10/15 at 12:50 p.m., Unit 3's Manager indicated there was no care plan available to address how to provide care and prevent skin breakdown for Resident #180's cam walker (post surgery immobilizer boot).</p> <p>The Treatment record, dated 3/1/15-3/31/15, and 4/7/15, indicated the weekly skin assessments were initialed as completed every Tuesday.</p>		<p>reviewed by the DON and/or designee three times weekly for four weeks to ensure completion. If 100% compliant, reviews will be reduced to weekly for two months. If reviews are not 100% compliant, education will be immediate and reviews will increase as needed. 4.) Results of the above audits will be presented at the monthly QA meeting, when results show 100% compliance for 90 days consecutively the monthly reviews will be changed to as needed.</p>	

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 04/13/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GARDEN VILLA - BEDFORD	STREET ADDRESS, CITY, STATE, ZIP CODE 2111 NORTON LN BEDFORD, IN 47421
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>The Weekly Skin Assessment sheets dated 3/17, 3/24, 3/31, and 4/7/15 lacked documentation indicating a skin assessment was completed for Resident #180. Unit 3's manager indicated no one had documented on those days and she would fix it. Unit 3's manager provided a revised Weekly Skin Assessment sheet for 3/17, 3/24, 3/31, and 4/7/15. "We chart by exception." She indicated, if there was a skin condition identified it would be on the wound report sheet. There was no documentation of skin condition being monitored while Resident #180 wore the cam walker.</p> <p>Care plan, dated 4/2/15, indicated "Stage 1 to bottom of L [left] 2nd toe secondary to cam walker... Goal will resolve without complications ..Interventionstreatment as ordered, weekly skin assessment. ..."</p> <p>Care plan dated 4/2/15, indicated, "US [unstageable] to bottom side of L [left] great toe secondary to cam walker ...Interventionstreatment as ordered, weekly skin assessment ..."</p> <p>Review of the wound report, dated 4/2/15, indicated, "Stage 1 (skin not broken) left 2nd toe 0.4 x 0.2 x <0.1 red base and pink peri wound margins and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155100	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER GARDEN VILLA - BEDFORD			STREET ADDRESS, CITY, STATE, ZIP CODE 2111 NORTON LN BEDFORD, IN 47421		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329 SS=D Bldg. 00	<p>left great toe unstageable (meaning that the stage is not clear) 1.9 x 1.4 x 0 black base and white peri wound margin."</p> <p>Review of wound report, dated 4/7/15, indicated, "stage 1 left 2nd toe 0.3 x 0.2 x <0.1 red base and pink peri wound margins, unstageable left great toe 1.9 x 1.4 x 0 black base and white peri wound margin."</p> <p>On 04/06/2015 at 11:56 a.m., Unit 3's manager indicated Resident #180 had an unstageable area the bottom side of left big toe and stage 2 pressure ulcer on the bottom of the left second. "We think it was caused by the cam walker." Sheep skin was put in place to prevent further breakdown.</p> <p>3.1-40(a)(1)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any</p>				

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 04/13/2015	
NAME OF PROVIDER OR SUPPLIER GARDEN VILLA - BEDFORD				STREET ADDRESS, CITY, STATE, ZIP CODE 2111 NORTON LN BEDFORD, IN 47421			
(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>combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review, the facility failed to ensure residents who received an anti-psychotic medication were monitored for side effects for 2 of 5 residents reviewed for unnecessary medication use. (Resident #172, Resident #66).</p> <p>Findings include:</p> <p>1. The clinical record was reviewed for Resident #172 on 4/9/2015 at 10:00 a.m. Diagnoses included, but were not limited to psychosis and dementia with behavioral disturbance.</p> <p>The annual Minimum Data Set (MDS) assessment dated 2/5/2015, assessed Resident #172 as taking an anti-psychotic medication the last 7 out of 7 days.</p> <p>Physician's order dated 3/1/2015, indicated Resident #172's medications</p>	F 329	<p>1.) The medication regimen for resident #172 and resident #66 has been reviewed by the licensed pharmacist. As a result recommendations were made to the physician. The plan of care for resident #172 and resident #66 has been reviewed and updated to reflect the use of antipsychotic medications. 2.) All residents that are prescribed psychoactive medications have the potential to be affected. The plan of care for all residents that are prescribed psychoactive medications will be reviewed to ensure accuracy and that appropriate interventions are in place. The pharmacist will continue to review residents' drug regimen monthly and report any irregularities to the DON and Administrator through the written monthly report. Any irregularities will be reviewed with the physician/NP monthly. 3.) A drug specific information sheet will be placed in the MARs as an alert to</p>	05/13/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155100	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/13/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER GARDEN VILLA - BEDFORD	STREET ADDRESS, CITY, STATE, ZIP CODE 2111 NORTON LN BEDFORD, IN 47421
--	--

(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>included but, were not limited to: haloperidol tablet (an anti-psychotic used to treat schizophrenia, acute psychosis, and for tics and vocal utterances of Tourette's syndrome) 1 milligram three times a day for dementia with behavioral disturbances. Original start date of 6/19/2014. Olanzapine tablet (an anti-psychotic used to treat mental disorders, such as schizophrenia or bipolar disorders) 2.5 milligrams every day at 3:00 p.m., with an original start date of 4/16/2014, and olanzapine tablet 5 milligrams every night at bedtime for psychosis, with an original start date of 4/4/2014.</p> <p>On 4/9/2015 at 2:30 p.m., Registered Nurse #4 (RN #4) provided Resident 172's current and undated care plan. No care plan had been initiated for the use of anti-psychotic medications for Resident #172.</p> <p>On 4/9/2015 at 11:10 a.m., an interview with RN #4 indicated Resident #172 did not have a care plan for the use of anti-psychotic medications.</p> <p>The Wolters Kluwer Nursing 2015 Drug Handbook, 35th edition, copyright 2015, Black Box Warning for haloperidol include: "Elderly patients with dementia-related psychosis treated with</p>		<p>nursing that a resident is taking a black box drug. An entry will be added to the MARs to monitor the residents for adverse reactions. Education will be completed with all nurses regarding this process (Exhibit #2). A review of the care plan and MARs of residents taking psychoactive medications will be completed by the DON and/or designee three times weekly for four weeks to ensure that the resident is being monitored for adverse reactions to the medication and that the care plan is appropriate (Exhibit #1). If the reviews are 100% compliant they will be reduced to weekly for two months. 4.) Results of the above reviews will be presented at the monthly QA meeting, when results show 100% compliance for 90 days consecutively the monthly reviews will be changed to as needed.</p>	

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 04/13/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GARDEN VILLA - BEDFORD	STREET ADDRESS, CITY, STATE, ZIP CODE 2111 NORTON LN BEDFORD, IN 47421
--	--

(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>atypical or conventional anti-psychotics are at increased risk for death.</p> <p>Anti-psychotics aren't approved for the treatment of dementia-related psychosisAlert: Watch for signs and symptoms of neuroleptic malignant syndrome (extrapyramidal effects, hyperthermia, autonomic disturbance), which is rare but commonly fatal."</p> <p>2. The clinical record was reviewed for Resident #66's on 4/9/2015 at 1:00 p.m. Diagnoses included, but were not limited to Alzheimer's disease, anxiety and dementia.</p> <p>The annual Minimum Data Set (MDS) assessment dated 2/1/2015, assessed Resident #66 as taking an anti-psychotic the last 7 out of 7 days.</p> <p>Physician's order dated 3/1/2015, indicated Resident #66 medications included but, were not limited to: Risperdal tablet (an anti-psychotic medication used to treat schizophrenia and bipolar disorder) 0.25 milligram every morning with an original start date of 3/25/2014, and Risperdal 0.25 milligrams, 1/2 tablet (0.125 mg) at bedtime with an original start date of 3/25/2014, for dementia with behaviors and alprazolam tablet (an anti-anxiety used to treat anxiety disorders, panic</p>			

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 04/13/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GARDEN VILLA - BEDFORD	STREET ADDRESS, CITY, STATE, ZIP CODE 2111 NORTON LN BEDFORD, IN 47421
--	--

(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>disorders, and anxiety) 0.25 milligrams, 1 tablet at bedtime and 2 tablets before showers.</p> <p>On 4/9/2015 at 2:00 p.m., License Practical Nurse #1 (LPN #1) provided the current and undated care plan for Resident #66. No care plan had been initiated for the use of anti-psychotic medications for Resident #66.</p> <p>On 4/09/2015 at 1:36 p.m., an interview with LPN #1 indicated she doesn't know how they monitor for side effects on anti-psychotics and anti-anxiety medications. She indicated the staff is familiar with the resident so it would be noticeable if the resident acted differently and they would chart findings in the nurses notes.</p> <p>On 4/10/2015 at 9:10 a.m., the Assistant Director of Nursing (ADON) indicated the facility does not have a policy for care plans. They are usually developed within 7 days but that varies at times.</p> <p>The Wolters Kluwer Nursing 2015 Drug Handbook, 35th edition, copyright 2015, Black Box Warning for Risperdal include: " Elderly patients with dementia-related psychosis treated with anti-psychotics are at increased risk for death. Drug isn't approved to treat</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155100	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/13/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER GARDEN VILLA - BEDFORD	STREET ADDRESS, CITY, STATE, ZIP CODE 2111 NORTON LN BEDFORD, IN 47421
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371 SS=D Bldg. 00	<p>elderly patients with dementia-related psychosisAlert: Watch for evidence of neuroleptic malignant syndrome (extrapyramidal effects, hyperthermia, autonomic disturbance), which is rare but can be fatal."</p> <p>3.1-48(a)(3)</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, interview, and record review, the facility failed to ensure staff used proper handwashing while serving trays in the Main dining room in that the staff was observed not to wash their hands as indicated by facility policy, Center for Disease Control, and Retail Food Establishment Sanitation Requirements. (CNA #1, CNA #2)</p> <p>Findings include:</p> <p>1). On 4/6/15 at 12:31 p.m., CNA #1 was observed to handwash for 10 seconds and to stand in line to get trays. She got out of line and handwashed for 4 seconds. CNA #1 was observed to get in the</p>	F 371	<p>1.) Hand washing education (Exhibit #8) and hand washing skills check off (Exhibit #9) will be completed with all facility staff. 2.) All residents have the potential to be affected. To ensure the same deficient practice does not occur all staff will be educated regarding hand washing (Exhibit #8) and complete a hand washing skills check off (Exhibit #9). 3.) Random hand washing audits (Exhibit #10) will be completed three times weekly for 4 weeks by DON and/or designee for all meals (breakfast, lunch and dinner) including on weekends. If 100% compliant, random audits will decrease to weekly for two months for all meals (breakfast, lunch and dinner) including on</p>	05/13/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155100		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 04/13/2015	
NAME OF PROVIDER OR SUPPLIER GARDEN VILLA - BEDFORD				STREET ADDRESS, CITY, STATE, ZIP CODE 2111 NORTON LN BEDFORD, IN 47421			
(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>serving line to get trays for Unit 4's dining room. CNA #1 left the serving line and walked over to the 400 hall's nursing station with RN #1. CNA #1 was observed to push Resident #219 down the 400 hall in a wheelchair. No handwashing was observed at that time. CNA #1 indicated, should hand wash for 30 seconds, after every tray, and whenever you touch someone. She also indicated, "I count Mississippi. That's what I was taught in Georgia."</p> <p>2). CNA #2 was observed to deliver a tray to the 400 hall dining room, walk over by the sink, took off her glasses and looked at them. CNA #2 was observed to put her glasses back on and walk over to the serving line. No hand washing was observed. CNA #2 was observed to take a tray to the 400 dining room. CNA #2 walked over to the sink in the main dining room, hand washed for 15 seconds, got another tray, and took it to the 400 hall dining room. CNA #2 left the dining room and walked down the front 300 hallway.</p> <p>On 4/6/15 at 1:06 p.m., CNA #2 indicated she should hand wash before and after each serve, before and after you put gloves on, before and after care, and giving a shower. Wash for 20 seconds which includes rinsing and rubbing.</p>		<p>weekends. If not 100% compliant, education will be immediate and audits will increase as needed. 4.) 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 to as needed.</p>				

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 04/13/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GARDEN VILLA - BEDFORD	STREET ADDRESS, CITY, STATE, ZIP CODE 2111 NORTON LN BEDFORD, IN 47421
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441 SS=D Bldg. 00	<p>Review of 410 IAC 7-24 dated November 13, 2004, indicated, ... 410 IAC 7-24-128 Hand cleaning ...vigorously rubbing together the surface of their lathered hands and arms for at least twenty seconds, ... 410 IAC 7-24-129 When to wash hands, Sec. 129. (a) Food employees shall clean their hands and exposed portions of their arms as specified under section 128 ... immediately before engaging in food preparation, ...(1) After touching bare human body parts, ...(11) After engaging in other activities that contaminate the hands. ..."</p> <p>The Administrator provided policy "Handwashing/Hand Hygiene" undated, and indicated the policy was the one currently used by the facility. The policy indicated, "...1. Appropriate 20 second handwashing, ..."</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155100	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/13/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER GARDEN VILLA - BEDFORD	STREET ADDRESS, CITY, STATE, ZIP CODE 2111 NORTON LN BEDFORD, IN 47421
--	--

(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>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 infection control practices were followed related to hand washing during patient care as indicated by the facility policy and Center for Disease Control for 1 of 1 randomly observed resident during Stage</p>	F 441	1.) Hand washing education (Exhibit #8) and hand washing skills check off (Exhibit #9) will be completed with all facility staff. 2.) All residents have the potential to be affected. To ensure the same deficient practice does not occur all staff will be educated regarding hand washing (Exhibit	05/13/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155100	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/13/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER GARDEN VILLA - BEDFORD	STREET ADDRESS, CITY, STATE, ZIP CODE 2111 NORTON LN BEDFORD, IN 47421
--	--

(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>2. (Resident #218) (Physical Therapist (PT) #1, Registered Nurse (RN) #3)</p> <p>Findings include:</p> <p>On 4/8/15 at 2:35 p.m., PT #1 was observed to put on gloves, assist Resident #218 into bed, and placed Resident #218 on the bedpan. No handwashing was observed. PT #1 the removed dirty linen from Resident #218's recliner chair and bed. PT #1 placed the dirty linen in a large plastic bag and removed the gloves. No hand washing was observed. PT #1 was observed to put on gloves and assisted Resident #218 off the bedpan with the assistance from RN #3. PT #1 cleansed Resident #218's perineal area (genital area), removed gloves, and repositioned Resident #218 in the bed. PT #1 placed the call light on the bed rail. No handwashing was observed. PT #1 and RN #3 were observed to pull Resident #218 up in the bed. PT #1 was observed to handwash for 12 seconds.</p> <p>On 4/13/15 at 10:00 a.m., Physical Therapist (PT) #1 indicated, she should handwash upon entering a resident's room, after anytime she dealt with a patient, when removing her gloves and before she exited the room. She should wash her hands between different task if bodily fluids were involve. "I should</p>		<p>#8) and complete a hand washing skills check off (Exhibit #9). 3.)Random hand washing audits (Exhibit #10) will be completed three times weekly for 4 weeks by DON and/or designee for all meals (breakfast, lunch and dinner) including on weekends. If 100% compliant, random audits will decrease to weekly for two months for all meals (breakfast, lunch and dinner) including on weekends. If not 100% compliant, education will be immediate and audits will increase as needed. 4.) 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 to as needed.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155100	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/13/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER GARDEN VILLA - BEDFORD	STREET ADDRESS, CITY, STATE, ZIP CODE 2111 NORTON LN BEDFORD, IN 47421
--	--

(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>handwash at least 20 seconds."</p> <p>Center for Disease Control at www.cdc.gov/handwashing http://www.cdc.gov/handwashing, dated December 16, 2013 indicated, "When should you wash your hands? ... Before and after caring for someone who is sick ...After using the toilet ... After touching garbage, ...How should you wash your hands? ...Scrub your hands for at least 20 seconds. ..."</p> <p>The Administrator provided policy "Handwashing/Hand Hygiene," undated, and indicated the policy was the one currently used by the facility. The policy indicated, "...1. Appropriate 20 second handwashing, ... b. After contact with blood, body fluids, secretions, ... c. After handling items potentially contaminated with blood, body fluids, or secretions; ... 3. The use of gloves does not replace handwashing. ..."</p> <p>3.1-18(l)</p>			