STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155026	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/29/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENWOOD VILLAGE SOUTH	295 VILLAGE LANE GREENWOOD, IN 46143

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F000000	This visit was for the Investigation of Complaint IN00154817. Complaint IN00154817- Substantiated. Federal/state deficiencies related to the allegations are cited at F224. Survey dates: August 28 and 29, 2014 Facility number: 000010 Provider number: 155026 AIM number: 100453660 Survey team: Susan Worsham, RN-TC Census bed type SNF: 27: SNF/NF: 70 Residential: 42 Total: 139 Census payor type: Medicare: 10 Medicaid: 43 Other: 86 Total: 139 Sample: 03 This deficiency reflects state findings cited in accordance with 410-IAC 16.2 -	F000000	Preparation and execution of this Plan of Correction in no way constitutes an admission or agreement by Greenwood Village South of the truth of the facts alleged in this statement of deficiencies and Plan of Correction. In fact, Greenwood Village South reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts, and conclusions that form the basis of the deficiency. This Plan of Correction serves as the credible allegation of compliance by September 19, 2014.	

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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	3.1. Quality review completed on September 08, 2014; by Kimberly Perigo, RN.			
F000224 SS=D	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on observation, interview, and record review, the facility failed to ensure that each resident had the right to be free from mistreatment for 1 of 3 residents reviewed for skin tears. (Resident #A) Findings include: Resident #A's arm was observed on August 29, 2014 at 2:00 p.m. LPN # 1 (Resident #A's nurse) unwrapped Resident #A's left forearm to reveal a large skin tear to the left forearm, healing without concern, and with 6 steri strips (sticky strips of a white see thru material	F000224	Corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice:Resident # A's injuries were immediately assessed and the resident was transported to Community Hospital South for evaluation. Physician ordered treatments were initiated.Completion date: 8/09/14The Greenwood Police Department, Mobilex Director of Operations and Regional Vice President and General Manager were immediately notified and met with community leadership during the investigation.Completion date(s):	09/19/2014

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	that is placed over a cut on one side and brought over to the other side of the cut to bring closure to the area) in place from an incident which occurred on 8/10/14. The facility's self reported incident dated 8/10/14 indicated, "[Resident #A's name] sustained bruising to left arm ... X-ray services came to our community to complete X-ray. Upon completion of the X-ray the technician stated to CNA 'she [Resident #A] is bleeding. If her arm isn't fractured it probably is now.' The technician immediately left the building without speaking to licensed personnel. Staff immediately entered resident's [Resident #A's] room to find 4 bleeding skin tears measuring 3 cm X [by] 3 cm; 3 cm X 2 cm; 3 cm X 3 cm; and 5 cm X 3 cm ... Resident stated to administrator 'A man came in here and hurt me and he was a bad man I think he was a Doctor. He grabbed my hand and yanked it.' ...." Resident #A's clinical record was reviewed on 8/29/14 at 10:30 a.m. Diagnoses include, but were not limited to: stroke, dysphasia, hypertension, urinary tract infections, depression, and contractures. Resident #A's emergency room record dated 8/10/14 (no time noted), indicated Resident #A's arm was not broken,		8/09/14-8/27/14Mobilex x-ray technician was immediately prohibited from providing service to any part of our Greenwood Village South continuum of care.Completion date: 8/09/14Procedures were initiated that all Mobilex technician personnel shall be accompanied and attended to by community nursing personnel during x-ray testing. Mobilex technician personnel will confer with licensed personnel upon arrival and prior to departure of the community.Completion date 8/09/14.ADDENDUM:Mobilex personnel have been provided with Greenwood Village South's Abuse Prevention Policy and Procedures. They have agreed to conduct in-service education with all of their personnel that provide services to our community regarding Greenwood Village South's Abuse Prevention Policy and Procedures. They will be providing us with documentation of such by September 30, 2014.How other residents having the potential to be affected by the same alleged deficient practice and what corrective action(s) will be taken:All current residents have the potential to be affected by the alleged deficient practice-no other associated injuries at Greenwood Village South have been identified. Procedures were initiated that all Mobilex technician personnel shall be	

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	however, Resident #A did have a 8-10 cm laceration (cut to the arm)/skin tear to her left forearm, resulting in closure with steri-strips and not sutures or staples due to Resident #A's paper thin skin. Interview with RN #1 on 4/28/14 at 4:15 p.m., indicated the X-Ray technician, needed the X-ray paperwork. The paperwork was it ready and given to him. The technician the went down the hall to Resident #A's room. RN #1 indicated, three times, to the X-ray technician she would be more than happy to help and each time he indicated he did not need any help. CNA #1 also offered to help and the technician again indicated, " 'I just got it.' " After the X-Ray technician was finished and heading toward the door, CNA #1 came to her and stated what he had said. " 'If her arm was not broken before, than it was now.' " RN #1 went running after him, noted that he went in the bathroom, so she waited outside the bathroom door for him. When he came out, he walked right by her. RN #1 asked what he had done to her Resident (#A). The technician asked what type of a doctor would order an X-Ray on her. RN# 1 indicated to the X-Ray tech that Resident #A's arm was bleeding and she asked him if he had done anything to Resident #A. He did not respond. RN#1 then ran back to		accompanied and attended to by community nursing personnel during x-ray testing. Mobilex technician personnel will confer with licensed personnel upon arrival and prior to departure of the community.Completion date 8/09/14What measures will be put into place or systemic changes will be made to ensure that the alleged deficient practice does not recur:An inserivce will be conducted with community staff to review procedures associated with accompanying Mobilex personnel during x-ray testing. Mobilex has been informed of procedural expectations.Completion date: 9/19/14How the corrective action will be monitored to ensure the alleged deficient practice will not recur, i.e. what quality assurance program will be put into place:A weekly audit X six (6) months will be completed to review Mobilex x-ray technician visit documentation. The results of the weekly audit will be discussed during the community's Quality Improvement Meeting.Completion date: 9/27/14	

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	Resident #A's room, assessed her, and then made sure the Administrator, DON, and the police had all been notified; and indicated the Administrator arrived first. Interview with CNA #1 on 4/28/14 at 4:30 p.m., indicated she did not see the X-Ray technician until he was coming out of the Resident #A's room. Who at that time advised CNA #1 he did not know what type of a doctor would order an X-Ray, and if " 'It was not broken, it probably is now' " and that Resident #A's arm was "bleeding pretty badly." CNA #1 asked the X-Ray technician to please wait for the nurse, but he started down the hall to leave. CNA #1 advised RN #1 of the situation and she went running after the X-RAY technician to stop him to ask him what happened. CNA #1 then indicated both she and CNA #2 went in to check on Resident #A, noticed the arm bleeding, and the geri sleeves (skin protector placed over arms for protection) and the derma sleeve (also used for protecting fragile skin) were next to Resident #A. CNA #1 indicated Resident #A asked her, " 'Why would this man hurt me.' " CNA #1 had also heard the RN repeatedly advise, three times, the X-Ray technician that she (RN#1) would be more than willing to help with Resident #A, because she (Resident #A) knows her voice and maybe not be			

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	frightened with the X-Ray and the X-Ray technician stated, "no." Interview with CNA #2 on 8/28/2014 at 4:03 p.m., indicated she was informed by RN #1 that an X-Ray was going to be taken of Resident #A's left forearm. She indicated at 4:40 a.m., the X-Ray technician arrived. She had heard RN #1 advise the X-Ray technician Resident #A's left arm had a contracture and they were not able to straighten her arm out. When the X-Ray technician came out of the Resident #A's room the X-Ray technician indicated Resident #A's arm was bleeding. CNA #2 went into Resident's #A's room and looked at Resident #A's arm and stated, "It looked terrible." CNA #2 indicated it was CNA #1 who told her the X-Ray technician had mentioned if the arm wasn't broken, it was now. CNA #2 indicated when Resident #A was toileted and changed right before X-Ray arrived. Resident #A's Geri and Derma sleeves were on. When CNA #2 came into the room after the X-Ray technician left, both Resident #A's geri-sleeve and derma sleeve were down near her wrist, with a lot of blood around them. The X-Ray technician gave his own statement to his company, who furnished a copy to the facility. There the X-Ray			

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	technician indicated he first asked RN #1 for the paperwork, which she handed him, and then he went to her (Resident #A's) room (note: this room is a to person room, one on each side, head of beds near the wall - North & South). The right arm was bandaged so he checked his phone to see which one needed the X-Ray and it was the left (L) one. Resident #A was moaning and indicating she was in pain. Repeatedly I (the X-Ray) technician told the Resident that I needed to take an X-Ray of their L arm. She (Resident #A) told me to leave and that she hated me. I thought she (Resident #A) was confused. She (Resident #A) was noted to have paper-like thin skin and a retracted left arm. Was wondering what doctor ordered this X-Ray. Staff offered to help, but I told them I would let them know, but did not see how helping could make it any better, plus they were all afraid of radiation. When finished and wrapping up the cord to the machine, she (Resident #A) indicated she was bleeding. I walked over and saw a little blood distal (lower) posterior (back) of her L forearm. The CNA came and told X-Ray technician the staff had to hold Resident #A's arm for bloodwork, and that caused a small bruise. X-Ray indicated they (facility staff) then stated, " 'Well I hope I didn't break her arm doing this.' " What I meant by that was I guess this was a waste of			

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	time putting Resident #A through this and doubted it would be any use to the doctor. Then the nurse came running after me indicating, I indicated Resident #A's arm was broke really bad and I said that I did not think that the arm was broken. I said I hoped I didn't break it doing all those X- Ray's. He (X-Ray tech) indicated that he did not think he caused the laceration, because he was not using any sharp objects. This Federal tags relates to Complaint IN00154817. 3.1-28(a)			