

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155788	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/02/2014
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NAME OF PROVIDER OR SUPPLIER GREENWOOD MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 N SR 135 GREENWOOD, IN 46142
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F000000	<p>This visit was for the Investigation of Complaint IN00151139.</p> <p>Complaint IN00151139 - Substantiated. Federal/state deficiencies related to the allegation are cited at F323.</p> <p>Survey date: July 2, 2014</p> <p>Facility number: 012564 Provider number: 155788 AIM number: 201018510</p> <p>Survey team: Susan Worsham, RN-TC</p> <p>Census bed type: SNF: 36 SNF/NF: 126 Total: 162</p> <p>Census payor type: Medicare: 43 Medicaid: 96 Other: 23 Total: 162</p> <p>Sample: 03</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC</p>	F000000	<p>July 21, 2014</p> <p>Kim Rhoades, Director Long Term Care Division Indiana State Department of Health 2 North Meridian St Indianapolis, IN 46204</p> <p>Dear Ms Rhoades,</p> <p>On July 9th a complaint survey was conducted at Greenwood Meadows. We respectfully request this document be submitted as the Plan of Correction and be considered for desk review by the staff of your division.</p> <p>If any questions arise regarding this request or attached documents, please feel free to contact me at your earliest convenience.</p> <p>Respectfully submitted,</p> <p>Austin Steele, HFA</p> <p>Cc: Bernie McGuinness, VP of Operations Sue Hornstein, Director of Compliance Martha Herron, Director of Clinical Services File</p>	
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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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F000323 SS=G	<p>16.2-3.1.</p> <p>Quality review completed on July 08, 2014; by Kimberly Perigo, RN.</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure each resident's environment remained free from accidents in that the facility failed to ensure that a Broda chair was sufficiently tilted back as indicated by manufacturer's instructions for 1 of 3 residents reviewed for accidents, which resulted in the resident having tipped over the chair and sustained a subdural hematoma (a collection of blood outside the brain-Web MD). (Resident #C)</p> <p>Findings Include:</p> <p>Resident# C's clinical record was reviewed on 07/02/14 at 12:00 p.m.</p>	F000323	<p>323</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by deficient practice:</p> <ul style="list-style-type: none"> · Resident was evaluated by the therapy and is positioned properly in Broda Chair. <p>How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken:</p> <ul style="list-style-type: none"> · Any residents that have a Broda chair have the potential to be impacted. · All residents with Broda 	07/21/2014
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	<p>Diagnoses included, but were not limited to: history of CHF (congestive heart failure), dementia, failure to thrive, and chronic kidney disease. Resident #C's BIMS (Brief Initial Mental Status) score was a 03, indicating Resident #C was dependent on nursing staff for daily decision making. Current physician orders for Broda indicated use of chair was for resident safety.</p> <p>A nursing note entry indicated, "on 6/15/14 Resident had unwitnessed fall. Resident was found on floor face down with broad chair over resident after fire alarm was clear. Vitals signs taken and skin tear to left side of nose and swelling to left side of head and neck. Resident complained of pain in right shoulder. No active bleeding noted (Resident is on Coumadin therapy). POA [family] contacted and requested Resident #C to be sent to Community South."</p> <p>Nursing notes dated 06/17/14 at 9:40 p.m., indicated Resident #C was re-admitted to facility with Diagnoses including but not limited to: Subdural Hematoma (collection of blood outside the brain). No antiplatelet or anticoagulants or thrombolytics (Coumadin therapy) until given okay by attending physician.</p>		<p>Chairs will be screened by licensed staff to ensure proper chair function and positioning.</p> <ul style="list-style-type: none"> Licensed and certified nursing staff will be educated on but not limited to: proper Broda Chair positioning, Broda Chair function. Staff was educated on 7-14-14 through 7-21-14 by the Director of Nursing or designee. <p>What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> Licensed and certified nursing staff will be educated on but not limited to: proper Broda Chair positioning, Broda Chair function. Staff was educated on 7-14-14 through 7-21-14 by the Director of Nursing or designee. Therapy will train new licensed nursing staff during new hire orientation on but not limited to Broda Chair function, and positioning. Each unit manager or designee will be responsible for round each shift that residents in Broda chair are in proper position per resident plan of care. <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, ie what quality assurance program will be put into place:</p>	

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	<p>Review of facility's interdisciplinary team (IDT) notes dated 6/19/14 at 3:39 p.m., indicated the fall review-follow up from Resident #C's fall indicated Resident #C was in the hall waiting to go to bed and the fire alarm went off. Resident #C was put in her room and door closed per protocol. Resident #C then attempted to get up unassisted causing her to fall out of her chair. During the fall she sustained a subdural hematoma and was sent to the ER (Emergency Room) and admitted. Upon assessment of Resident#C and their environment and interview with staff it was noted that Resident #C was in her Broda chair without the seat dumped, due to the hast of the situation. Root cause of the fall noted to be resident startled by fire alarm and got up unassisted. Staff education provided on the importance of maintaining a tilted position while up in Broda chair. Care plan reviewed and updated.</p> <p>Interview with Resident #C's son on 07/02/2014 at 3:04 p.m., indicated he was informed of the fall, the diagnosis, and has no concerns related to the care that his mother receives at the facility.</p> <p>Observation of and interview with Resident # C on 06/02/2014 at 3:40 p.m., indicated Resident #C was sitting in a</p>		<p>A CQI Tool will be completed as a monitoring tool. This tool will monitor appropriate chair, function, and proper tilt when not at meals or activities. This tool will be completed weekly x4, monthly x6, then on a quarterly basis until continued compliance is maintained for 2 consecutive quarters by the Director of Nursing Services or designee. If a threshold of 95% is not met, the results will be reviewed by the CQI committee and an action plan will be developed. The CQI tool will be overseen by the Director of Nursing, Medical Director, and its members.</p> <p>Date of Completion: 7-21-14</p>		

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	<p>tilted back Broda chair and when approached and her name called, she responded with a "hello." Resident #C did not recall any of the incident when asked and entered into the conversation relating to a totally different subject than what was asked.</p> <p>Interview with ED (Executive Director) on 7/02/14 4:00 p.m., indicated the word "dumping" related to the Broda chair not being tilted back so a resident would not come out of it. He indicated the person involved in the incident was not working today and copies of staff inservices related to the Broda chair were provided by the ED.</p> <p>Review of the manufacturers guidelines for the Broda chair on 07/02/2014 at 4:05 p.m., provided by the ED on 06/02/2014 at 4:00 p.m. indicated on page 2, section 2.5 hazards, under 2.5.2 "Position of Seat Tilt - Danger of Tipping," indicated the manufacturer recommended that the chair's seat be tilted sufficiently to prevent an agitated resident from tipping the chair forward or backward or slumping and sliding in the chair.</p> <p>3.1-45(a)(1)</p>				