STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155783	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/26/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENLEAF HEALTH CAMPUS	1201 E BEARDSLEY ELKHART, IN 46514

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	This visit was for the Investigation of Complaint IN00153771. Complaint IN00153771 - Substantiated. Federal/state deficiency related to the allegations are cited at F284. Survey dates: August 25-26, 2014 Facility number: 002661 Provider number: 155783 AIM number: 201056540 Survey team: Honey Kuhn, RN Census bed type: SNF: 41 SNF/NF: 9 Residential: 49 Total: 99 Census payor type: Medicare: 25 Medicaid: 6 Other: 68 Total: 99 Sample: 3 This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.	F000000	Please accept the enclosed information as Greenleaf Health Campus's Plan of Correction for the complaint survey conducted on August 25 and 26, 2014. Please contact me if there are any questions. Thank you Judy Plantinga Health Facility Administrator Greenleaf Health Campus.	

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155783	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/26/2014
NAME OF PROVIDER OR SUPPLIER GREENLEAF HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 E BEARDSLEY ELKHART, IN 46514	

(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
	Quality Review completed on August 27, 2014, by Brenda Meredith, R.N.			
F000284 SS=D	483.20(l)(3) ANTICIPATE DISCHARGE: POST-DISCHARGE PLAN When the facility anticipates discharge a resident must have a discharge summary that includes a post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment. Based on record review and interviews, the facility failed to follow the corporate policy & procedure for discharge to ensure ordered medications were sent home with 1 of 3 residents reviewed for discharge planning in a sample of 3. (Resident "C") Findings include: The closed record of Resident "C" was reviewed on 08/25/14 at 11:50 a.m. Resident "C" was admitted to the facility, on 11/03/13, with diagnoses including, but not limited to, muscle weakness, dysphagia (difficult swallowing) , and (L) (left) hemiparesis (loss of mobility)	F000284	1. Resident C had no reported ill effects to the facility. No other residents were affected by the practice. 2. All other discharges to home have been checked since survey and no other residents affected. 3. DHS and/or her designee have re-educated the nurses to the discharge procedure of private pay residents and handling of their medications. IDT now initiates the post discharge instructions during the morning Clinical meeting to ensure all areas are completed prior to discharge. DHS/Designee will audit discharges weekly as they occur until 100% complance is achieved with procedure. 4. The findings will be brought to Quality Assurance Committee	09/05/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155783	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 08/26/2014
NAME OF PROVIDER OR SUPPLIER GREENLEAF HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 E BEARDSLEY ELKHART, IN 46514	

(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
	secondary to a CVA (Cerebrovascular Accident: stroke). Resident "C" was discharged home to care of family on 06/05/2014. Review of the record indicated Resident "C's" payor source as "Private Pay." Review of the "NURSES'S NOTES" indicated, "06/05/14 11:00 a.m. Resident discharged home c [with] Dtr[daughter]. All instructions for medications given to Dtr & res [resident] as well as 3 day supply of meds. Refills called into [Pharmacy name]. Left facility in w/c [wheelchair]. Transpo [transportation] per [by] Dtr car." Review of the form, titled, "POST-DISCHARGE PLAN OF CARE," indicated Home Health Care with Physical Therapy, Occupational Therapy, as well as private duty 24* [hour] nursing staff, would be providing care for the resident. The front page of the form included the appropriate contact information in regard to the Home Health Care agency and the local Ombudsman. The back side of the form, which included, but was not limited to, areas to provide discharge information on Dietary/Nutritional needs, Activities, Medications, and Treatments, was blank. This included an area for signature by the Caregiver providing the information,		meetings monthly x 3 months and if no findings will consider system in place and if not then further education will be conducted.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155783	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/26/2014
NAME OF PROVIDER OR SUPPLIER GREENLEAF HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 E BEARDSLEY ELKHART, IN 46514	

(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
	which was also blank. A form, titled, "[Corporate Name]," dated 06/05/14, was included with the discharge information. The form included an area for "Medications", where eight medications and vitamin supplements were listed by name, route, frequency, and number of pills the resident was to take. A column indicated, "Number sent with resident" indicated numbers ranging from 1 to 5 for the medications sent with the resident. The form was signed by the responsible party for the resident and the "Signature/title of nurse completing form" was blank. The DNS (Director of Nursing Services) was interviewed on 08/26/14 at 8:58 a.m. and indicated Resident "C" was discharged home by the nursing staff on 06/05/14 with 3 days of medication. The DNS indicated the facility policy & procedure reflected the resident should have been discharged with all medications procured on behalf of the resident since the resident/payor source paid for all medications. The DNS indicated being made aware of the discrepancy following discharge of the resident and after notification from the family. Upon investigation by the DNS, it was determined the remainder of the medications had been returned to the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155783	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/26/2014
NAME OF PROVIDER OR SUPPLIER GREENLEAF HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 E BEARDSLEY ELKHART, IN 46514	

(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
	pharmacy. The DNS indicated the pharmacy returned the medications to the facility, for the family to pick up, on 06/11/14, which was 7 days following the discharge of Resident "C". Review of an undated facility policy and procedure, titled, "[Corporate Name]...GUIDELINES FOR LOA [Leave of Absence]/DISCHARGE INSTRUCTIONS", and provided by the DNS on 08/25/14 at 8:50 a.m., indicated: "...Discharge Instructions: ...5. All Medications (bubble packs, liquids, narcotics, etc.) should be sent with the resident/responsible party if they are Medicaid or Private Pay as their payor source paid for these and they belong to them." This Federal tag relates to Complaint IN00153771. 3.1-36(a)(3)			