

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  09/15/2014
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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 a Recertification and State Licensure Survey.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00156091.</p> <p>Survey dates: September 8, 9, 10, 11, 12, and 15, 2014</p> <p>Facility number: 012564 Provider number: 155788 AIM number: 201018510</p> <p>Survey team: Patti, Allen, LSW-TC Marcy Smith, RN Dottie Plummer, RN Karyn Homan, RN</p> <p>Census bed type: SNF: 25 SNF/NF: 132 Total: 157</p> <p>Census payor type: Medicare: 33 Medicaid: 93 Other: 31 Total: 157</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F000000	<p>October 7, 2014 Kim Rhoades, Director Long Term Care Division Indiana State Department of Health 2 North Meridian St Indianapolis, IN 46204 Dear Ms Rhoades, On September 15th. 2014 a Recertification and State Licensure Survey was conducted at Greenwood Meadows. We respectfully request a face to face IDR for F224, F225, F226 and F441 as the facility disagrees with the scope and severity. Greenwood Meadows then respectfully requests this document be submitted as the Plan of Correction and be considered for desk review by the staff of your division. If any questions arise regarding this request or attached documents, please feel free to contact me at your earliest convenience. Respectfully submitted, Austin Steele, HFA 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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F000224 SS=D	<p>Quality review completed on September 22, 2014; by Kimberly Perigo, RN.</p> <p>483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROP RIATN 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 interview and record review, the facility failed to ensure a resident was free from mistreatment for 1 of 3 residents who met the criteria for review of abuse and mistreatment. (Resident #312)</p> <p>Findings include:</p> <p>The clinical record of Resident #312 was reviewed on 9/11/14 at 11:00 a.m. She was admitted to the facility for rehabilitation on 8/18/14. Diagnoses included, but were not limited to, a fractured hip.</p> <p>During an interview with Resident #312 on 9/10/14 at 8:50 a.m., she indicated on her first night in the facility, she and her roommate did not get very good care. Resident #132 and her roommate reported this to the staff and staff</p>	F000224	<p><b>F 224 PROHIBIT MISTREATMENT/NEGLECT/MI SAPPROPRIATION</b> The facility respectively requests a face-to-face IDR for F224, F225, F226, and F441 as the facility disagrees with the scope and severity of the deficiencies. The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> · Resident #312 no longer resides in this facility <b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b> · All residents have the potential to be affected by the alleged deficient</p>	10/07/2014

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	<p>members followed up on their grievance.</p> <p>Review of a grievance form, dated 8/19/14, provided by the Director of Nursing (DON) on 9/12/14 at 11:30 a.m., indicated, "When talking [with Resident #312] about her first night she stated that CNA [Certified Nursing Assistant] [name of CNA #10] was rude and talked in slang...Action taken: Upon interview with resident CNA [#10] involved was identified as [name of CNA #10]. After review of schedule and time sheet, CNA [#10] was working the assignment that shift. CNA [#10] was educated on facility care values."</p> <p>During the interview on 9/10/14 at 8:50 a.m., Resident #312 indicated about a week after her admission to the facility, during the night, the resident asked for assistance and the CNA (CNA #10) who took care of her the first night told her, "Well, I understand someone is turning me in and I don't know if I want to help her out or not." Resident #312 indicated, she "did not feel intimidated but felt very angry," and didn't think any resident should have to deal with something like that. Resident #312 indicated she reported this interaction with CNA #10 to a nurse, but was not able to remember the name of the nurse.</p>		<p>practice · All residents were interviewed or multiple attempts to be interviewed utilizing the QIS interview to assess signs and/or symptoms of any type of abuse, neglect, mistreatment, or misappropriation of resident property, if any allegations arose, reported to ISDH per policy. · All cognitively impaired residents received a head to toe assessment to look for any signs and/or symptoms of any type of abuse, neglect or mistreatment · Staff was in-serviced by the Director of Nursing Services or designee by 10/07/14 on the Abuse Prohibition, Reporting and Investigation Policy and Procedures revised to include reporting immediately any reportable occurrences · If any allegations of abuse, neglect, mistreatment, or misappropriation of resident property will be reported to the Executive Director immediately and investigated</p> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b> · Staff was in-serviced by the Director of Nursing Services or designee by 10/07/14 on the Abuse Prohibition, Reporting and Investigation Policy and Procedures revised to include reporting immediately any reportable occurrences</p> <p>· ED met with Resident Council with invitation from Resident</p>				

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	<p>On 9/10/14 at 3:00 p.m., the Executive Director (ED) and DON indicated they were not aware of Resident #312's experience with CNA #10 about a week after her admission when she asked for assistance during the night. The ED and DON indicated, at that time, CNA #10 was no longer working at the facility because she had been terminated for unrelated reasons.</p> <p>During an interview with the ED on 9/11/14 at 8:35 a.m., he indicated the facility had done an investigation and had been able to identify the nurse Resident #312 had reported the occurrence to as Licensed Practical (LPN) #3. LPN #3 was disciplined and reminded that all allegations needed to be reported immediately.</p> <p>During an interview with LPN #3 on 9/15/14 at 1:00 p.m., she indicated Resident #312 had come to the nurses station and indicated, the night before she had asked for assistance and CNA #10 provided the assistance, but told the resident (CNA #10), "wasn't supposed to be on this hall" or "wasn't supposed to be in this room." The resident then aborted the conversation and said they (Resident #312 and LPN #3) would talk later, but the resident never came back to talk with LPN #3. LPN #3 indicated she did not</p>		<p>Council President to review Abuse Prohibition, Reporting and Investigation Policy and Procedures and the Elder Justice Act</p> <ul style="list-style-type: none"> <li>· Screening – Business Office Manager/Designee completed an audit of all employee records to ensure complete background/criminal history checks were performed prior to hire</li> <li>· Training –Greenwood Meadows Management Team was in-serviced on Prevention, Identification, Investigation, and Reporting on abuse and the Elder Justice Act</li> <li>· Prevention -- Nursing Management staff will conduct rounds daily to observe for any new resident behaviors, bruises, etc.....Social service staff will investigate any unusual changes in behaviors to identify potential abuse or neglect</li> <li>· Identification -- DNS or designee will review progress notes and facility activity report daily to evaluate for potential 'unreported' occurrences (i.e. bruises of unknown origins, resident altercations/behaviors, abuse allegations, etc)</li> <li>· Investigation – Any allegation of abuse will be thoroughly investigated by adhering to the following process: <ul style="list-style-type: none"> <li>o Staff involved will be suspended pending investigation</li> <li>o Resident involved will be interviewed</li> <li>o Resident who receives care from the staff member alleged to have abused the resident will be</li> </ul> </li> </ul>		

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	<p>take CNA #3's comments as intimidating or threatening, just that she (CNA #3) had been assigned to a different hall that night. She indicated she would have reported CNA #3's comments to the ED immediately if she thought they sounded threatening. LPN #3 indicated she did not pursue further discussion with Resident #312 regarding the incident.</p> <p>On 9/10/14 at 8:35 a.m., the ED provided a policy titled, "Abuse Prohibition, Reporting, and Investigation," dated September, 2012, and indicated it was the policy currently used by the facility. The policy indicated, "It is the policy of [name of facility] to protect residents from abuse including physical abuse, sexual abuse, verbal abuse, mental abuse, neglect, involuntary seclusion and misappropriation of resident property and/or funds... all abuse allegations must be reported to the ED immediately, and the ED will then immediately report all unusual occurrences, which include allegations of abuse, to the Long Term Care Division of the Indiana State Department of Health."</p> <p>The ED indicated, on 9/11/14 at 8:35 a.m., he did not think CNA #10's conversation with Resident #312 about a week after her admission to the facility, was abusive or threatening, but indicated</p>		<p>interviewed using QIS abuse questionnaire. o Social Service will document 3 days of follow-up to ensure psychosocial well being. o Family member of resident who was allegedly abused will be interviewed if applicable o Other staff members will be interviewed to determine knowledge of occurrence. · Reporting - Reporting pending investigation immediately and at the conclusion of the investigation will be reported to the following agencies when applicable: o ISDH o APS o Ombudsman o Licensing/Certification Agency o Local Police · Customer Care Reps will interview residents weekly to ensure proper care and treatment. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <p>·To ensure compliance, the DNS/Designee is responsible for the completion of the Abuse CQI tool weekly times 4 weeks, monthly times 6 months and then until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the Director of Nursing, Executive Director, and Medical Director.</p> <p>·If threshold of 95% is not achieved an action plan will be developed to ensure compliance</p>		

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F000225 SS=D	<p>he would not want any of his staff saying those things to a resident. The ED indicated he did not report this incident to the state when it occurred, because he was unaware the conversation had taken place and LPN #3 did not report the conversation to him (the ED), because LPN #3 did not think CNA #10's remarks to the resident regarding that she was supposed to be on a different hall, were abusive or intimidating.</p> <p>On 9/15 at 2:30 p.m., the DON indicated LPN #3 should have told a supervisor about Resident #312's concerns regarding CNA #10's remarks, even though she didn't think they were abusive or intimidating.</p> <p>3.1-28(a)</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p>						

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	<p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record review, the facility failed to ensure they followed their policy and procedure to prevent mistreatment of a resident, for 1 of 3 residents who met the criteria for review of abuse and mistreatment. (Resident #312)</p> <p>Findings include:</p> <p>The clinical record of Resident #312 was reviewed on 9/11/14 at 11:00 a.m. She was admitted to the facility for rehabilitation on 8/18/14. Diagnoses</p>	F000225	<p><b>F225 INVESTIGATION/REPORT ALLEGATIONS/INDIVIDUALS</b></p> <p>The facility respectively requests a face-to-face IDR for F224, F225, F226, and F441 as the facility disagrees with the scope and severity of the deficiencies.</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or</p>	10/07/2014

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	<p>included, but were not limited to, a fractured hip.</p> <p>During an interview with Resident #312 on 9/10/14 at 8:50 a.m., she indicated on her first night in the facility, she and her roommate did not get very good care. Resident #132 and her roommate reported this to the staff and staff members followed up on their grievance.</p> <p>Review of a grievance form, dated 8/19/14, provided by the Director of Nursing (DON) on 9/12/14 at 11:30 a.m., indicated, "When talking [with Resident #312] about her first night she stated that CNA [Certified Nursing Assistant] [name of CNA #10] was rude and talked in slang...Action taken: Upon interview with resident CNA [#10] involved was identified as [name of CNA #10], After review of schedule and time sheet, CNA [#10] was working the assignment that shift. CNA [#10] was educated on facility care values."</p> <p>During the interview on 9/10/14 at 8:50 a.m., Resident #312 indicated about a week after her admission to the facility, during the night, the resident asked for assistance and the CNA (CNA #10) who took care of her the first night told her, "Well, I understand someone is turning me in and I don't know if I want to help</p>		<p>misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violations is verified appropriate corrective action must be taken.</p> <p><b>What corrective action(s) will</b></p>		

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	<p>her out or not.' " Resident #312 indicated, she "did not feel intimidated but felt very angry," and didn't think any resident should have to deal with something like that. Resident #312 indicated she reported this interaction with CNA #10 to a nurse, but was not able to remember the name of the nurse.</p> <p>On 9/10/14 at 3:00 p.m., the Executive Director (ED) and DON indicated they were not aware of Resident #312's experience with CNA #10 about a week after her admission when she asked for assistance during the night. The ED and DON indicated, at that time, CNA #10 was no longer working at the facility because she had been terminated for unrelated reasons.</p> <p>During an interview with the ED on 9/11/14 at 8:35 a.m., he indicated the facility had done an investigation and had been able to identify the nurse Resident #312 had reported the occurrence to as Licensed Practical (LPN) #3. LPN #3 was disciplined and reminded that all allegations needed to be reported immediately.</p> <p>During an interview with LPN #3 on 9/15/14 at 1:00 p.m., she indicated Resident #312 had come to the nurses station and indicated, the night before she</p>		<p><b>be accomplished for those residents found to have been affected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>· Resident #312 no longer resides in this facility</li> </ul> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>· All residents have the potential to be affected by the alleged deficient practice</li> <li>· All residents were interviewed or multiple attempts to be interviewed utilizing the QIS interview to assess signs and/or symptoms of any type of abuse, neglect, mistreatment, or misappropriation of resident property, if any allegations arose, reported to ISDH per policy.</li> <li>· All cognitively impaired residents received a head to toe assessment to look for any signs and/or symptoms of any type of abuse, neglect or mistreatment</li> <li>· Staff in-serviced by the Director of Nursing Services or designee by 10/07/14 on the Abuse Prohibition, Reporting and Investigation Policy and Procedures revised to include reporting immediately any reportable occurrences</li> <li>· If any allegations of abuse, neglect, mistreatment, or misappropriation of resident property will be reported to the Executive Director immediately and investigated</li> </ul>		

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	<p>had asked for assistance and CNA #10 provided the assistance, but told the resident (CNA #10), "wasn't supposed to be on this hall" or "wasn't supposed to be in this room." The resident then aborted the conversation and said they (Resident #312 and LPN #3) would talk later, but the resident never came back to talk with LPN #3. LPN #3 indicated she did not take CNA #3's comments as intimidating or threatening, just that she (CNA #3) had been assigned to a different hall that night. She indicated she would have reported CNA #3's comments to the ED immediately if she thought they sounded threatening. LPN #3 indicated she did not pursue further discussion with Resident #312 regarding the incident.</p> <p>On 9/10/14 at 8:35 a.m., the ED provided a policy titled, "Abuse Prohibition, Reporting, and Investigation," dated September, 2012, and indicated it was the policy currently used by the facility. The policy indicated, "It is the policy of [name of facility] to protect residents from abuse including physical abuse, sexual abuse, verbal abuse, mental abuse, neglect, involuntary seclusion and misappropriation of resident property and/or funds... all abuse allegations must be reported to the ED immediately, and the ED will then immediately report all unusual occurrences, which include</p>		<p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b></p> <ul style="list-style-type: none"> <li>· Staff was in-serviced by the Director of Nursing Services or designee by 10/07/14 on the Abuse Prohibition, Reporting and Investigation Policy and Procedures revised to include reporting immediately any reportable occurrences</li> <li>· ED met with Resident Council with invitation from Resident Council President to review Abuse Prohibition, Reporting and Investigation Policy and Procedures and the Elder Justice Act</li> <li>· Screening – Business Office Manager/Designee completed an audit of all employee records to ensure complete background/criminal history checks were performed prior to hire</li> <li>· Training –Greenwood Meadows Management Team was in-serviced on Prevention, Identification, Investigation, and Reporting on abuse and the Elder Justice Act</li> <li>· Prevention -- Nursing Management staff will conduct rounds daily to observe for any new resident behaviors, bruises, etc.....Social service staff will investigate any unusual changes in behaviors to identify potential abuse or neglect</li> </ul>	

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	<p>allegations of abuse, to the Long Term Care Division of the Indiana State Department of Health."</p> <p>The ED indicated, on 9/11/14 at 8:35 a.m., he did not think CNA #10's conversation with Resident #312 about a week after her admission to the facility, was abusive or threatening, but indicated he would not want any of his staff saying those things to a resident. The ED indicated he did not report this incident to the state when it occurred because he was unaware the conversation had taken place, and LPN #3 did not report the conversation to him (the ED), because LPN #3 did not think CNA #10's remarks to the resident, regarding that she was supposed to be on a different hall, were abusive or intimidating.</p> <p>On 9/15 at 2:30 p.m., the DON indicated LPN #3 should have told a supervisor about Resident #312's concerns regarding CNA #10's remarks, even though she didn't think they were abusive or intimidating.</p> <p>3.1-28(c)</p>		<ul style="list-style-type: none"> <li>- Identification -- DNS or designee will review progress notes and facility activity report daily to evaluate for potential 'unreported' occurrences (i.e. bruises of unknown origins, resident altercations/behaviors, abuse allegations, etc)</li> <li>- Investigation – Any allegation of abuse will be thoroughly investigated by adhering to the following process: <ul style="list-style-type: none"> <li>o Staff involved will be suspended pending investigation</li> <li>o Resident involved will be interviewed</li> <li>o Resident who receives care from the staff member alleged to have abused the resident will be interviewed using QIS abuse questionnaire.</li> <li>o Social Service will document 3 days of follow-up to ensure psychosocial well being.</li> <li>o Family member of resident who was allegedly abused will be interviewed if applicable</li> <li>o Other staff members will be interviewed to determine knowledge of occurrence.</li> </ul> </li> <li>- Reporting - Reporting pending investigation immediately and at the conclusion of the investigation will be reported to the following agencies when applicable: <ul style="list-style-type: none"> <li>o ISDH</li> <li>o APS</li> <li>o Ombudsman</li> <li>o Licensing/Certification Agency</li> <li>o Local Police</li> </ul> </li> </ul>		

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F000226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 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 interview and record review, the facility failed to ensure implementation of their policy and procedure to prevent mistreatment of a resident, for 1 of 3 residents who met the criteria for review of abuse and mistreatment. (Resident #312)	F000226	· Customer Care Reps will interview residents to ensure proper care and treatment.  <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b> ·To ensure compliance, the DNS/Designee is responsible for the completion of the Abuse CQI tool weekly times 4 weeks, monthly times 6 months and then until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the Director of Nursing, Executive Director, and Medical Director. ·If threshold of 95% is not achieved an action plan will be developed to ensure compliance  <b>F 226 DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC POLICIES</b>  The facility respectively requests a face-to-face IDR for F224, F225, F226, and F441 as the facility disagrees with the scope and severity of the deficiencies.	10/07/2014	

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	<p>Findings include:</p> <p>The clinical record of Resident #312 was reviewed on 9/11/14 at 11:00 a.m. She was admitted to the facility for rehabilitation on 8/18/14. Diagnoses included, but were not limited to, a fractured hip.</p> <p>During an interview with Resident #312 on 9/10/14 at 8:50 a.m., she indicated on her first night in the facility, she and her roommate did not get very good care. Resident #132 and her roommate reported this to the staff and staff members followed up on their grievance.</p> <p>Review of a grievance form, dated 8/19/14, provided by the Director of Nursing (DON) on 9/12/14 at 11:30 a.m., indicated, "When talking [with Resident #312] about her first night she stated that CNA [Certified Nursing Assistant] [name of CNA #10] was rude and talked in slang...Action taken: Upon interview with resident CNA [#10] involved was identified as [name of CNA #10], After review of schedule and time sheet, CNA [#10] was working the assignment that shift. CNA [#10] was educated on facility care values."</p> <p>During the interview on 9/10/14 at 8:50</p>		<p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>· Resident #312 no longer resides in this facility</li> </ul> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>· All residents have the potential to be affected by the alleged deficient practice</li> <li>· All residents were interviewed or multiple attempts to be interviewed utilizing the QIS interview to assess signs and/or symptoms of any type of abuse, neglect, mistreatment, or misappropriation of resident property, if any allegations arose, reported to ISDH per policy.</li> <li>· All cognitively impaired residents received a head to toe assessment to look for any signs and/or symptoms of any type of abuse, neglect or mistreatment</li> <li>· Staff was in-serviced by the Director of Nursing Services or designee by 10/07/14 on the Abuse Prohibition, Reporting and</li> </ul>				

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	<p>a.m., Resident #312 indicated about a week after her admission to the facility, during the night, the resident asked for assistance and the CNA (CNA #10) who took care of her the first night told her, " 'Well, I understand someone is turning me in and I don't know if I want to help her out or not.' " Resident #312 indicated, she "did not feel intimidated but felt very angry," and didn't think any resident should have to deal with something like that. Resident #312 indicated she reported this interaction with CNA #10 to a nurse, but was not able to remember the name of the nurse.</p> <p>On 9/10/14 at 3:00 p.m., the Executive Director (ED) and DON indicated they were not aware of Resident #312's experience with CNA #10 about a week after her admission when she asked for assistance during the night. The ED and DON indicated, at that time, CNA #10 was no longer working at the facility because she had been terminated for unrelated reasons.</p> <p>During an interview with the ED on 9/11/14 at 8:35 a.m., he indicated the facility had done an investigation and had been able to identify the nurse Resident #312 had reported the occurrence to as Licensed Practical (LPN) #3. LPN #3 was disciplined and reminded that all</p>		<p>Investigation Policy and Procedures revised to include reporting immediately any reportable occurrences</p> <ul style="list-style-type: none"> <li>· If any allegations of abuse, neglect, mistreatment, or misappropriation of resident property will be reported to the Executive Director immediately and investigated</li> </ul> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b></p> <ul style="list-style-type: none"> <li>· Staff was in-serviced by the Director of Nursing Services or designee by 10/07/14 on the Abuse Prohibition, Reporting and Investigation Policy and Procedures revised to include reporting immediately any reportable occurrences</li> <li>· ED met with Resident Council with invitation from Resident Council President to review Abuse Prohibition, Reporting and Investigation Policy and Procedures and the Elder Justice Act</li> <li>· Screening – Business Office Manager/Designee completed an audit of all employee records to ensure complete background/criminal history checks were performed prior to hire</li> <li>· Training –Greenwood Meadows Management Team was in-serviced on Prevention, Identification, Investigation, and</li> </ul>	

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	<p>allegations needed to be reported immediately.</p> <p>During an interview with LPN #3 on 9/15/14 at 1:00 p.m., she indicated Resident #312 had come to the nurses station and indicated, the night before she had asked for assistance and CNA #10 provided the assistance, but told the resident (CNA #10), "wasn't supposed to be on this hall" or "wasn't supposed to be in this room." The resident then aborted the conversation and said they (Resident #312 and LPN #3) would talk later, but the resident never came back to talk with LPN #3. LPN #3 indicated she did not take CNA #3's comments as intimidating or threatening, just that she (CNA #3) had been assigned to a different hall that night. She indicated she would have reported CNA #3's comments to the ED immediately if she thought they sounded threatening. LPN #3 indicated she did not pursue further discussion with Resident #312 regarding the incident.</p> <p>On 9/10/14 at 8:35 a.m., the ED provided a policy titled, "Abuse Prohibition, Reporting, and Investigation," dated September, 2012, and indicated it was the policy currently used by the facility. The policy indicated, "It is the policy of [name of facility] to protect residents from abuse including physical abuse,</p>		<p>Reporting on abuse and the Elder Justice Act</p> <ul style="list-style-type: none"> <li>· Prevention -- Nursing Management staff will conduct rounds daily to observe for any new resident behaviors, bruises, etc.....Social service staff will investigate any unusual changes in behaviors to identify potential abuse or neglect</li> <li>· Identification -- DNS or designee will review progress notes and facility activity report daily to evaluate for potential 'unreported' occurrences (i.e. bruises of unknown origins, resident altercations/behaviors, abuse allegations, etc)</li> <li>· Investigation – Any allegation of abuse will be thoroughly investigated by adhering to the following process: <ul style="list-style-type: none"> <li>o Staff involved will be suspended pending investigation</li> <li>o Resident involved will be interviewed</li> <li>o Resident who receives care from the staff member alleged to have abused the resident will be interviewed using QIS abuse questionnaire.</li> <li>o Social Service will document 3 days of follow-up to ensure psychosocial well being.</li> <li>o Family member of resident who was allegedly abused will be interviewed if applicable</li> <li>o Other staff members will be interviewed to determine knowledge of occurrence.</li> </ul> </li> <li>· Reporting - Reporting pending investigation immediately</li> </ul>				

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	<p>sexual abuse, verbal abuse, mental abuse, neglect, involuntary seclusion and misappropriation of resident property and/or funds... all abuse allegations must be reported to the ED immediately, and the ED will then immediately report all unusual occurrences, which include allegations of abuse, to the Long Term Care Division of the Indiana State Department of Health."</p> <p>The ED indicated, on 9/11/14 at 8:35 a.m., he did not think CNA #10's conversation with Resident #312 about a week after her admission to the facility, was abusive or threatening, but indicated he would not want any of his staff saying those things to a resident. The ED indicated he did not report this incident to the state when it occurred because he was unaware the conversation had taken place, and LPN #3 did not report the conversation to him (the ED), because LPN #3 did not think CNA #10's remarks to the resident, regarding that she was supposed to be on a different hall, were abusive or intimidating.</p> <p>On 9/15 at 2:30 p.m., the DON indicated LPN #3 should have told a supervisor about Resident #312's concerns regarding CNA #10's remarks, even though she didn't think they were abusive or intimidating.</p>		<p>and at the conclusion of the investigation will be reported to the following agencies when applicable:</p> <ul style="list-style-type: none"> <li>o ISDH</li> <li>o APS</li> <li>o Ombudsman</li> <li>o Licensing/Certification Agency</li> <li>o Local Police</li> </ul> <p>· Customer Care Reps will interview residents to ensure proper care and treatment.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <p>·To ensure compliance, the DNS/Designee is responsible for the completion of the Abuse CQI tool weekly times 4 weeks, monthly times 6 months and then until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the Director of Nursing, Executive Director, and Medical Director.</p> <p>·If threshold of 95% is not achieved an action plan will be developed to ensure compliance</p>		

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F000241 SS=D	<p>3.1-28(a)</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, interview, and record review, the facility failed to maintain the dignity of a randomly observed resident who received glucose testing in the middle of the facility hallway. (Resident #67)</p> <p>Findings include:</p> <p>The clinical record of Resident #67 was reviewed on 9/9/14 at 4:45 p.m. Diagnoses included, but were not limited to, diabetes.</p> <p>A review of the recapitulation of physician's orders dated 9/1/14 - 9/30/14, indicated Resident #67 was to have blood glucose monitoring before meals and at bedtime.</p> <p>On 9/9/14 at 4:28 p.m., Resident #67 was observed sitting on the seat of a walker next to a medication cart in the hallway. Registered Nurse (RN) #2 was observed</p>	F000241	<p><b>F241 DIGNITY AND RESPECT OF INDIVIDUALITY</b> It is the practice of this facility to promote care for residents in a manner and an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> · Resident #67 will have blood glucose testing performed in their room and will be informed of the results in privacy <b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b> · All residents who receive blood glucose monitoring have the potential to be affected by the alleged deficient practice · Clinical Education Coordinaor or designee will utilize</p>	10/07/2014
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	<p>wiping the finger of the resident with a small white pad, then obtained a drop of blood on a strip in a meter. RN #2 looked at the meter and then informed the resident of the results. Two other residents and a visitor were were located within 2 to 3 feet of the medication cart.</p> <p>During an interview with RN #2 on 9/9/14 at 4:30 p.m., RN #2 indicated a blood glucose test had just been performed on Resident #67.</p> <p>During an interview with the Director of Nursing (DON) on 9/15/14 at 11:30 a.m., the DON indicated glucose testing should be performed in the resident's room and not in the hallway.</p> <p>On 9/11/14 at 12:30 p.m., the Executive Director provided a Nursing Policy and Procedure Skills Validation for Glucose Meter Cleaning and Testing dated 7/2011, and indicated the policy was the one currently used by the facility. The procedure steps for obtaining blood sugar results indicated, "...12. Proceed to the resident room with cleaned meter, testing equipment and supplies. 13. Verify resident...17. Cleanse resident's finger tip...27. Exit room...."</p> <p>3.1-3(t)</p>		<p>Glucose Meter Cleaning and Testing tool during blood glucose monitoring to evaluate dignity and privacy practices to ensure that residents have blood glucose monitoring performed in their room and that they are informed of their blood glucose results in privacy</p> <ul style="list-style-type: none"> <li>· Corrections will be made accordingly based on observation</li> <li>· Staff has been in-serviced by 10/07/14 by Director of Nursing Services or designee on blood glucose monitoring, and resident rights including dignity and privacy to ensure that <ul style="list-style-type: none"> <li>o All residents have blood glucose testing performed in their room</li> <li>o All residents will be informed of their blood glucose results in privacy</li> </ul> </li> </ul> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b></p> <ul style="list-style-type: none"> <li>· Clinical Education Coordinator or designee will utilize Glucose Meter Cleaning and Testing tool during blood glucose monitoring to evaluate dignity and privacy practices to ensure that residents have blood glucose monitoring performed in their room and that they are informed of their blood glucose results in privacy</li> <li>· Corrections will be made accordingly based on observation</li> <li>· Staff was in-serviced by</li> </ul>				

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F000279 SS=E	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 the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to		10/07/14 by Director of Nursing Services or designee on blood glucose monitoring, and resident rights including dignity and privacy to ensure that o All residents have blood glucose testing performed in their room o All residents will be informed of their blood glucose results in privacy  <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b> ·Dignity and Privacy CQI tool will be completed weekly times 4 weeks, monthly times 6 months and then until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the Director of Nursing, Executive Director, and Medical Director. ·If threshold of 95% is not achieved an action plan will be developed to ensure compliance		

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	<p>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 record review and interview, the facility failed to ensure care plans were developed for residents with diabetes, bruising and antipsychotic medications for 3 of 40 residents reviewed for development of care plans. (Residents #232, #308, and #202)</p> <p>Findings include:</p> <p>1. The clinical record of Resident #232 was reviewed on 9/11/14 at 4:20 p.m. Diagnoses for the resident included, but were not limited to, diabetes mellitus and chronic kidney disease.</p> <p>Diabetes is a chronic disease in which the body does not have enough insulin to enable it to absorb glucose from the blood into the cells. Complications include, but are not limited to, kidney failure, heart disease, stroke, and blindness.</p>	F000279	<p><b>F 279 DEVELOP COMPREHENSIVE CARE PLANS</b></p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>· Resident #232 has a care plan for diabetes</li> <li>· Resident #308 no longer resides in this facility</li> <li>· Resident #202 has a care plan in place for delusional disorder and use of antipsychotic medication</li> </ul> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>· All residents who have the diagnosis of diabetes, delusional disorder, who take antipsychotic</li> </ul>	10/07/2014

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	<p>A recapitulated order for August, 2014, with an original order date of 4/4/14, indicated Resident #232 was receiving injections of insulin 2 - 4 times per day, depending on the results of her blood glucose monitoring tests performed by the nurses.</p> <p>A care plan for Resident #232 being at risk for complications of diabetes was not found. On 9/12/14 at 10:47 a.m., the Director of Nursing indicated the resident should have had a diabetes care plan, but one had not been developed.</p> <p>2. The clinical record of Resident #202 was reviewed on 9/12/14 at 9:10 a.m. Diagnoses included, but were not limited to, delusional disorder.</p> <p>A Quarterly Minimum Data Set (MDS) assessment completed 8/29/14, assessed Resident #202 as having a Brief Interview for Mental Status (BIMS) of 5, indicating the resident was moderately to severely cognitively impaired. The resident was assessed as having anxiety and depression.</p> <p>A review of the recapitulation of physician's orders dated 9/1/14 - 9/30/14, indicated Resident #202 was prescribed olanzapine (an antipsychotic medication used to treat a psychiatric disorder) 5 mg</p>		<p>medications, or have alterations in skin integrity that reside in this facility have the potential to be affected by the alleged deficient practice</p> <ul style="list-style-type: none"> <li>· The MDS Coordinator/designee reviewed all clinical records to identify residents who have the diagnosis of diabetes, delusional disorder, or who take antipsychotic medications to ensure careplans were developed for these issues.</li> <li>· The Interdisciplinary Team will review all physician's orders, facility activity report, new admissions and re-admissions, and residents with significant changes in the clinical meeting utilizing the IDT admission/readmission review form to identify residents who have the diagnosis of diabetes, delusional disorder, who take antipsychotic medications, to ensure appropriate care plan is developed daily Monday-Friday and Weekend Supervisor/designee will review on Saturday and Sunday</li> <li>· Alterations in skin integrity will have a new skin event to ensure plan of care followed and observe for any changes</li> <li>· Licensed nurses have been in-serviced by 10/07/14 by the Director of Nursing Services or designee on admission and temporary care plans</li> </ul> <p><b>What measures will be put into place or what systemic</b></p>	

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	<p>once a day. The start date for the olanzapine was 5/22/14.</p> <p>A review of the careplans indicated Resident #202 lacked a plan of care to address delusional disorder and lacked a plan of care to address the use of an antipsychotic medication.</p> <p>During an interview with the Director of Nursing (DoN) on 9/12/14 at 3:20 p.m., the DoN indicated Resident #202 did not have a current plan of care to address the use of the antipsychotic medication olanzapine. The DoN indicated a plan of care should have been in place and would be developed.</p> <p>3. On 9/10/14 at 10:17 a.m., Resident #308 was observed sitting in her wheelchair, in her room. Resident #308 had one large green and yellow discolored area on the top and outside of her right forearm. The discolored area started just below her elbow and extended down to her wrist. The area appeared to be a healing bruise.</p> <p>On 9/10/14 at 10:17 a.m., Resident #308 indicated, the area on her arm was a bruise. The bruise had first appeared when she broke her elbow earlier that month.</p>		<p><b>changes you will make to ensure that the deficient practice does not recur?</b></p> <ul style="list-style-type: none"> <li>· The Interdisciplinary Team will review all physician's orders, facility activity report, new admissions and re-admissions, and residents with significant changes in the clinical meeting utilizing the IDT admission/readmission review form to identify residents who have the diagnosis of diabetes, delusional disorder, or who take antipsychotic medications to ensure appropriate care plan is developed daily Monday-Friday and Weekend</li> <li>· Supervisor/designee will review on Saturday and Sunday</li> <li>· Alterations in skin integrity will have a new skin event to ensure plan of care followed and observe for any changes</li> <li>· Licensed nurses have been in-serviced by 10/07/14 by the Director of Nursing Services or designee on admission and temporary care plans</li> <li>· All residents found without appropriate care plans for diabetes, delusional disorder, antipsychotic medications will have appropriate care plans put in place</li> </ul> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <ul style="list-style-type: none"> <li>· A Care Plan Updating CQI tool will be completed weekly times 4</li> </ul>				

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	<p>Resident #308's clinical record was reviewed on 9/11/14 at 11:00 a.m.</p> <p>Diagnoses included, but were not limited to, humerus fracture (broken upper bone of the arm) and anemia (low blood count levels).</p> <p>Hospital physician's progress note dated 8/5/2014, indicated Resident #308 had broken her right humerus two weeks prior to her hospital visit.</p> <p>No care plan for the discolored area was found in Resident #308's chart.</p> <p>On 9/15/14 at 11:15 a.m., the Director of Nursing (DON) indicated, the facility was unable to locate a care plan referring to the discolored area on Resident #308's right forearm. They are unaware of where the discolored area came from nor why it was not documented. Resident #308 has dementia. The DON was unsure if the Resident #308 would be able to tell her where the bruise came from.</p> <p>On 9/15/14 at 11:15 a.m., the DON provided the Skin Management Program, dated 9/2014, and indicated the policy was the one currently being used by the facility. The policy indicated, "... Resident will have a skin assessment completed no less than weekly by the licensed nurse in an effort to assess</p>		<p>weeks, monthly times 6 months and then until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the Director of Nursing, Executive Director, and Medical Director.</p> <p>-If threshold of 95% is not achieved an action plan will be developed to ensure compliance.</p>	

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F000282 SS=D	<p>overall skin condition, skin integrity, and skin impairment.... 5. The licensed nurse is responsible for assessing any and all skin alterations as reported by the direct caregivers on the shift reported, following the same protocol above...."</p> <p>The policy indicated the procedure was, "... 1. A head to toe assessment will be completed by a licensed nurse upon admission/re-admission and documented on the 'nursing admission assessment.' ... all alterations in skin integrity will be documented in EMR [electronic medical record] -- New Skin Alteration event... the care plan will be initiated to include specific alterations in skin integrity.... 3. Weekly skin assessments will be completed on all residents as follows: ... all alterations in skin integrity will be documented in EMR ... The care plan will be initiated/revised addressing any new areas...."</p> <p>3.1-35(a)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on interview and record review, the facility failed to ensure care plans</p>	F000282	<b>F 282 SERVICES BY QUALIFIED PERSONS/PER</b>	10/07/2014			

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	<p>were followed for 2 of 5 residents reviewed for unnecessary medications in that blood sugar monitoring, sliding scale insulin, and labs were not performed, as indicated by physicians' orders. (Residents #308 and #232)</p> <p>Findings include:</p> <p>1. The clinical record of Resident #232 was reviewed on 9/11/14 at 4:20 p.m. Diagnoses for the resident included, but were not limited to, diabetes mellitus and chronic kidney disease.</p> <p>Diabetes is a chronic disease in which the body does not have enough insulin to enable it to absorb glucose from the blood into the cells. Complications include, but are not limited to, kidney failure, heart disease, stroke, and blindness.</p> <p>A recapitulated physician's order for June, 2014, with an original order date of 4/10/14, indicated Resident #232 was to receive a finger stick blood test 3 times per day before meals, to measure how much sugar was in her blood.</p> <p>A recapitulated physician's order for June, 2014, and July, 2014, with original order dates of 4/10/14, indicated Resident #232 was supposed to receive Humalog</p>		<p><b>CARE PLAN</b> The services provided or arranged by the facility must be provided by qualified person in accordance with each resident's written plan of care. <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> · Resident #308 no longer resides in this facility · Resident #232 will have blood glucose monitoring and sliding scale insulin administered per physician's order <b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <p>·All residents that reside in the facility have the potential to be affected by the alleged deficient practice</p> <p>·The Assistant Director of Nursing Services/designee completed an audit of all lab orders and placed lab tracking book to ensure that labs are drawn per physician's order</p> <p>·The Assistant Director of Nursing will audit all labs daily Monday-Friday and weekend supervisor/designee on Saturday and Sunday using the lab tracking log to ensure that labs are drawn per physician's orders</p> <p>·Licensed nurses have been in-serviced by Director of Nursing Services or designee by 10/07/14 on lab tracking, blood glucose monitoring, medication</p>		

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	<p>insulin 3 times per day according to the following sliding scale:</p> <p>Blood sugar 201-250 2 units of insulin Blood sugar 251 - 300 4 units of insulin Blood sugar 301 - 350 6 units of insulin Blood sugar 351 - 400 8 units of insulin. Notify physician if blood sugar less than 70 or over 400.</p> <p>A Blood Glucose Monitoring Tool for June, 2014, indicated the following: 6/4 at 5:00 p.m. no test done. 6/5 at 5:00 p.m. no test done. 6/8 at 5:00 p.m. blood sugar = 246 No sliding scale insulin given. Should have received 2 units. 6/11 at 7:00 a.m. blood sugar = 64 There was no documentation in the record which indicated the physician was notified. 6/12 at 5:00 p.m. no test done. 6/16 at 11:00 a.m. and 5:00 p.m. no tests done. 6/19 at 5:00 p.m. no test done. 6/20 at 11:00 a.m. blood sugar = 390 no sliding scale insulin given. Should have received 8 units. 6/21 at 7:00 a.m. blood sugar = 59 There was no documentation in the record which indicated the physician was notified. 6/21 at 11:00 a.m. no test done. 6/23 at 11:00 a.m. no test done.</p>		<p>administration including administration of sliding scale insulin per physician's orders and physician notification of blood sugars outside of the call parameters</p> <p>·MAR/TAR audits will be completed and reviewed by Director of Nursing Service/designee to ensure that blood glucose monitoring, sliding scale insulin, physician notification are done per physician orders</p> <p>·The Interdisciplinary Team will review all physicians orders, in clinical meeting to ensure that services are provided according to physician's orders Monday-Friday and weekend supervisor/designee on Saturday and Sunday</p> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b> · The Assistant Director of Nursing Services/designee completed an audit of all lab orders and placed lab tracking book to ensure that labs are drawn per physician's order · The Assistant Director of Nursing will audit all labs daily Monday-Friday and weekend supervisor/designee on Saturday and Sunday using the lab tracking log to ensure that labs are drawn per physician's orders · Licensed nurses have been in-serviced by Director of Nursing Services or designee by 10/07/14 on lab tracking, blood glucose</p>		

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	<p>6/24 at 11:00 a.m. no test done.</p> <p>6/25 at 4:00 p.m. blood sugar = 208 4 units of insulin given, should have received 2 units.</p> <p>6/26 at 7:00 a.m. blood sugar = 65 There was no documentation in the record which indicated the physician was notified.</p> <p>6/26 at 5:00 p.m. no test done.</p> <p>6/30 at 7:00 a.m. blood sugar = 61 There was no documentation in the record which indicated the physician was notified.</p> <p>6/30 at 4:00 p.m. no test done.</p> <p>A Blood Glucose Monitoring Tool for July, 2014, indicated the following:</p> <p>7/1 - 7/8, 7/10, 7/11, 7/16, 7/29, and 7/30 at 5:00 p.m. no tests done.</p> <p>7/9 at 4:00 p.m. blood sugar = 351 4 units of insulin given, should have been 8 units.</p> <p>7/14 at 5:00 p.m. blood sugar = 221 no sliding scale insulin given. should have received 2 units.</p> <p>7/19 at 11:00 a.m. blood sugar = 235 no sliding scale insulin given. Should have received 2 units.</p> <p>7/20 at 11:00 a.m. blood sugar = 266 no sliding scale insulin given. Should have received 4 units.</p> <p>7/28 at 11:00 a.m. no test done.</p>		<p>monitoring, medication administration including administration of sliding scale insulin per physician's orders and physician notification of blood sugars outside of the call parameters · · MAR/TAR audits will be completed daily, 7 days a week, and reviewed by Director of Nursing Service/ designee to ensure that blood glucose monitoring, sliding scale insulin, physician notification are done per physician orders- A second nurse will verify correct insulin dose per physician's order prior to administration. Both nurses will co-sign the Blood Glucose monitoring sheet· The Interdisciplinary Team will review all physicians orders, in clinical meeting to ensure that services are provided according to physician's orders Monday-Friday and weekend supervisor/designee on Saturday and Sunday <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <p>·To ensure compliance, the DNS/Designee will complete the Blood Glucose Monitoring and Labs/Diagnostic CQI tool weekly times 4 weeks, monthly times 6 months and then until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen</p>				

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	<p>A physician's order dated 8/9/14 indicated the above sliding scale originally dated 4/10/14 and added: Blood sugar 401 - 450 give 10 units of insulin Blood sugar 451 - 500 give 12 units of insulin Call physician if blood sugar less than 70 or over 500.</p> <p>A Blood Glucose Monitoring Tool for August, 2014, indicated the following:</p> <p>8/3 at 4:00 p.m. blood sugar = 358 6 units of insulin given. Should have received 8 units. 8/15 at 11:00 a.m. no test done. 8/17 at 4:00 p.m. blood sugar = 54, There was no documentation in the record which indicated the physician was notified. 8/18 at 11:00 a.m. no test done. 8/28 at 4:00 p.m. blood sugar = 290 No insulin was given.</p> <p>During an interview on 9/12/14 at 10:12 a.m., the Nurse Consultant and the Director of Nursing indicated it was the policy of the facility for the nurses to follow physician's orders regarding blood glucose monitoring and sliding scale insulin.</p> <p>During an interview on 9/15/14 at 2:00</p>		<p>by the Director of Nursing, Executive Director, and Medical Director. ·If threshold of 95% is not achieved an action plan will be developed to ensure compliance</p>				

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	<p>p.m., the Director or Nursing was asked for further information regarding the missing glucose monitoring blood tests, the wrong dose or lack of sliding scale insulin being administered, and the lack of documentation regarding physician notification of blood sugars outside the call parameters. She did not provide any further information by the end of survey on 9/15/14 at 6:30 p.m.</p> <p>2. Resident #308's clinical record was reviewed on 9/11/14 at 11:00 a.m. Diagnoses included, but were not limited to, anemia (low amount of red blood cells in the body), diabetes (inability of the body to produce enough insulin causing irregular blood sugars), and hypertension (high blood pressure).</p> <p>Physician admission orders dated 8/6/14, indicated, "CBC [complete blood count] [lab test to determine level of blood cells in the body] /BMP [basic metabolic panel] [lab test to determine levels of electrolytes in the body] QMon [every Monday] x's 4 weeks [for four weeks]."</p> <p>Physician order dated 8/7/14, indicated, "... 13. CBC/BMP q 4 weeks [every 4 weeks] --D/C [discontinue]."</p> <p>On 9/11/14 at 4:30 p.m., the Assistant Director of Nursing (ADON) indicated,</p>			

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	<p>the physician's order to discontinue the CBC and BMP written on 8/7/14 was referring to the admission CBC and BMP order written on 8/6/14 and not inclusive of the CBC and BMP to be completed every four weeks. The order to discontinue the CBCs and BMPs was written incorrectly.</p> <p>Physician signed recapulated orders for September 2014, indicated, "CBC/BMP Q [every] week x4 [4 times] then D/C [discontinue]." Recapulated physician's order indicated the lab order was originated on 8/25/14.</p> <p>Physician order dated 9/5/14, indicated an one time CBC and BMP to be drawn.</p> <p>The only CBC and BMP lab result found after 8/25/14, was on 9/5/14, the one time ordered lab.</p> <p>On 9/15/14 at 3:51 p.m., the director of nursing (DON) indicated, the CBC and BMP order that was on the September 2014 recapulated orders was a transcription error. The nurse who transcribed the orders was unsure of where the date 8/25/14 came from. The facility does not have a policy referring to transcribing orders.</p> <p>3.1-35(g)(2)</p>			

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F000329 SS=E	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>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 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 record review and interview, the facility failed to ensure blood sugars were consistently monitored for a resident receiving both scheduled and sliding scale insulin, for 1 of 5 residents reviewed for unnecessary medications. (Resident #232)</p> <p>Findings include:</p> <p>The clinical record of Resident #232 was</p>	F000329	<p><b>F329 DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</b></p> <p>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</p>	10/10/2014	

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	<p>reviewed on 9/11/14 at 4:20 p.m. Diagnoses for the resident included, but were not limited to, diabetes mellitus and chronic kidney disease.</p> <p>Diabetes is a chronic disease in which the body does not have enough insulin to enable glucose to be absorbed from the blood into the cells. Complications include, but are not limited to, kidney failure, heart disease, stroke, and blindness.</p> <p>Recapitulated physician's orders for June, 2014, and July, 2014, with original order dates of 5/17/14, indicated Resident #232 was to receive scheduled doses of Levemir insulin, 16 units in the morning and 14 units in the evening. Levemir is a long acting insulin.</p> <p>Recapitulated physician's orders for June, 2014, and July, 2014, with original order dates of 4/4/14, indicated the resident was to have a finger stick blood test three times per day before meals to measure her blood sugar. In addition, the orders indicated the resident was supposed to receive Humalog insulin (a short acting insulin) injections 3 times per day, depending on the results of the blood test, according to the following sliding scale:</p> <p>Blood sugar 201 - 250 2 units of insulin</p>		<p>discontinued; or any combinations of the reasons above <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> · Resident #232 will have blood glucose monitoring and sliding scale insulin administered per physician's order and physician will be notified of blood sugars outside the call parameter <b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b> · All residents that receive blood glucose monitoring have the potential to be affected by the alleged deficient practice · Licensed nurses will be in-serviced by Director of Nursing Services or designee by 10/06/14 on blood glucose monitoring, medication administration including administration of sliding scale insulin per physician's orders and physician notification of blood sugars outside of the call parameters · MAR/TAR audits will be completed and reviewed by Director of Nursing Service/ designee daily to ensure that blood glucose monitoring, sliding scale insulin, physician notification are done per physician orders · The Interdisciplinary Team will review all physicians orders, in clinical meeting to ensure that services are provided according to</p>	

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	<p>Blood sugar 251 - 300 4 units of insulin Blood sugar 301 - 350 6 units of insulin Blood sugar 351 - 400 8 units of insulin. Notify physician if blood sugar less than 70 or over 400.</p> <p>A Blood Glucose Monitoring Tool for June, 2014, indicated the following: 6/4 at 5:00 p.m. no test done. 6/5 at 5:00 p.m. no test done. 6/8 at 5:00 p.m. blood sugar = 246 No sliding scale insulin given. Should have received 2 units. 6/11 at 7:00 a.m. blood sugar = 64 There was no documentation in the record which indicated the physician was notified. 6/12 at 5:00 p.m. no test done. 6/16 at 11:00 a.m. and 5:00 p.m. no tests done. 6/19 at 5:00 p.m. no test done. 6/20 at 11:00 a.m. blood sugar = 390 no sliding scale insulin given. Should have received 8 units. 6/21 at 7:00 a.m. blood sugar = 59 There was no documentation in the record which indicated the physician had been notified. 6/21 at 11:00 a.m. no test done. 6/23 at 11:00 a.m. no test done. 6/24 at 11:00 a.m. no test done. 6/25 at 4:00 p.m. blood sugar = 208 4 units of insulin given, should have received 2 units.</p>		<p>physician's orders Monday-Friday and weekend supervisor/designee on Saturday and Sunday <b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b> · Licensed nurses have been in-serviced by Director of Nursing Services or designee by 10/07/14 on blood glucose monitoring, medication administration including administration of sliding scale insulin per physician's orders and physician notification of blood sugars outside of the call parameters · MAR/TAR audits will be completed daily, 7 days a week, and reviewed by Director of Nursing Service/ designee to ensure that blood glucose monitoring, sliding scale insulin, physician notification are done per physician orders -A second nurse will verify correct insulin dose per physician's order prior to administration. Both nurses will co-sign the Blood Glucose monitoring sheet· The Interdisciplinary Team will review all physicians orders, in clinical meeting to ensure that services are provided according to physician's orders Monday-Friday and weekend supervisor/designee on Saturday and Sunday <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality</b></p>		

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	<p>6/26 at 7:00 a.m. blood sugar = 65 There was no documentation in the record which indicated the physician was notified.</p> <p>6/26 at 5:00 p.m. no test done.</p> <p>6/30 at 7:00 a.m. blood sugar = 61 There was no documentation in the record which indicated the physician was notified.</p> <p>6/30 at 4:00 p.m. no test done.</p> <p>A Blood Glucose Monitoring Tool for July, 2014, indicated the following:</p> <p>7/1 - 7/8, 7/10, 7/11, 7/16, 7/29, and 7/30 at 5:00 p.m. no tests done.</p> <p>7/9 at 4:00 p.m. blood sugar = 351 4 units of insulin given, should have received 8 units.</p> <p>7/14 at 5:00 p.m. blood sugar = 221 no sliding scale insulin given. Should have received 2 units.</p> <p>7/19 at 11:00 a.m. blood sugar = 235 no sliding scale insulin given. Should have received 2 units.</p> <p>7/20 at 11:00 a.m. blood sugar = 266 no sliding scale insulin given. Should have received 4 units.</p> <p>7/28 at 11:00 a.m. no test done.</p> <p>A physician's order dated 8/9/14 indicated the above sliding scale originally dated 4/10/14 and added: Blood sugar 401 - 450 give 10 units of</p>		<p><b>assurance program will be put into place?</b></p> <ul style="list-style-type: none"> <li>·Blood Glucose Monitoring CQI will be utilized weekly times 4 weeks, monthly times 6 months and then until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the Director of Nursing, Executive Director, and Medical Director.</li> <li>·If threshold of 95% is not achieved an action plan will be developed to ensure compliance</li> </ul>	

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	<p>insulin Blood sugar 451 - 500 give 12 units of insulin Call physician if blood sugar less than 70 or over 500.</p> <p>A Blood Glucose Monitoring Tool for August, 2014, indicated the following:</p> <p>8/3 at 4:00 p.m. blood sugar = 358 6 units of insulin given. Should have received 8 units. 8/15 at 11:00 a.m. no test done. 8/17 at 4:00 p.m. blood sugar = 54 There was no documentation in the record which indicated the physician was notified. 8/18 at 11:00 a.m. no test done. 8/28 at 4:00 p.m. blood sugar = 290 No insulin was given.</p> <p>During an interview on 9/12/14 at 10:12 a.m., the Nurse Consultant and the Director of Nursing indicated it was the policy of the facility for the nurses to follow physician's orders regarding blood glucose monitoring and sliding scale insulin.</p> <p>During an interview on 9/15/14 at 2:00 p.m., the Director of Nursing was asked for further information regarding the missing glucose monitoring blood tests, the wrong dose or lack of sliding scale</p>				

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F000387 SS=D	<p>insulin being administered, and the lack of documentation regarding physician notification of blood sugars outside the call parameters. She did not provide any further information by the end of survey on 9/15/14 at 6:30 p.m.</p> <p>3.1-48(a)(3)</p> <p>483.40(c)(1)-(2) FREQUENCY &amp; TIMELINESS OF PHYSICIAN VISIT</p> <p>The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.</p> <p>A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.</p> <p>Based on interview and record review, the facility failed to ensure a resident was seen by a physician every 60 days for 1 of 40 residents reviewed. (Resident #148)</p> <p>Findings include:</p> <p>The clinical record of Resident #148 was reviewed on 9/15/14 at 1:45 p.m.</p> <p>Diagnoses included, but were not limited to, cerebral vascular accident (CVA/stroke).</p>	F000387	<p>387</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by deficient practice:</b></p> <p>Resident #148 had a physician's visit on 9-15-14 and will receive a physician's visit at least once every 60 days thereafter.</p> <p><b>How will other residents having the potential to be affected by</b></p>	10/07/2014

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	<p>A Quarterly Minimum Data Set (MDS) assessment completed 8/13/14, assessed Resident #148 as having a Brief Interview for Mental Status (BIMS) of 15, indicating the resident was cognitively intact. The resident was assessed as requiring extensive assistance of 2 staff for toileting and personal hygiene and extensive assistance of 1 staff for transfers and dressing.</p> <p>A review of the physician's progress notes indicated Resident #148 was seen by the physician on 7/4/13. The next physician visit was 114 days later on 10/26/13 and then again on 11/13/13. The next physician visit was 101 days later on 2/22/14. The last recorded physician visit was on 7/6/14, 134 days after the previous visit.</p> <p>During an interview with the Director of Nursing (DON) and the Corporate Nurse Consultant on 9/15/14 at 4:00 p.m., the DON indicated physician visits were tracked by Licensed Practical Nurse (LPN) #1 and should be completed every 60 days.</p> <p>During an interview with LPN #1 on 9/15/14 at 4:13 p.m., LPN #1 indicated the last physician visit for Resident #148 was completed on 7/6/14. LPN #1</p>		<p><b>the same deficient practice be identified and what corrective action(s) will be taken:</b></p> <ul style="list-style-type: none"> <li>· All residents have the potential to be affected by the alleged deficient practice</li> <li>· Medical records coordinator has done an audit of all residents MD visits to ensure in compliance</li> <li>· A physician visit schedule log is kept by the medical records coordinator to track physician's visits</li> <li>· All physician's were provided a copy of the Physician Services Policy by the Medical Records Coordinator by 10-7-14</li> <li>· Physician's will be notified 2 weeks prior to next upcoming visit via fax by the Medical Records Coordinator</li> <li>· All physician visits out of compliance will be referred to the Medical Director for review</li> </ul> <p><b>What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur:</b></p> <ul style="list-style-type: none"> <li>· Medical records coordinator has done an audit of all residents MD visits to ensure in compliance</li> <li>· A physician visit schedule log is kept by the medical records coordinator to track physician's visits</li> <li>· All physician's were provided a copy of the Physician</li> </ul>				

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F000441 SS=D	<p>indicated the physician had been called to remind of the need to complete a visit but the call was not documented and LPN #1 could not remember when the call had been made. LPN #1 indicated Resident #148 was the only resident in the facility under the care of this physician.</p> <p>3.1-22(d)1</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 development and transmission of disease and infection.</p>		<p>Services Policy by the Medical Records Coordinator by 10-7-14</p> <ul style="list-style-type: none"> <li>Physician's will be notified 2 weeks prior to next upcoming visit via fax by the Medical Records Coordinator</li> <li>All physician visits out of compliance will be referred to the Medical Director for review</li> </ul> <p><b>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:</b></p> <ul style="list-style-type: none"> <li>A Physician Services CQI tool, will be utilized weekly times 4 weeks, monthly times 6 months and then until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the Director of Nursing, Executive Director, and Medical Director.</li> <li>If threshold of 95% is not achieved an action plan will be developed to ensure compliance.</li> </ul>	

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	<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 maintain contact isolation to minimize or prevent the spread of vancomycin resistant enterococcus (VRE, a bacteria resistant to the antibiotic vancomycin) and Clostridium difficile (c-diff, a bacterial infection resistant to antibiotics and characterized by diarrhea) infection</p>	F000441	<p><b>F441 INFECTION CONTROL, PREVENT SPREAD, LINENS</b></p> <p>The facility respectfully requests a face-to-face IDR for F224, F225, F226, and F441 as the facility disagrees with the scope and severity of the deficiencies.</p> <p>The facility must establish and maintain an Infection Control</p>	10/07/2014

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	<p>by cohabitating a resident with an active VRE and c-diff infection with a resident who did not have an active or colonized (non-active) VRE or c-diff infection. (Resident #29 and Resident #33)</p> <p>Findings include:</p> <p>The clinical record of Resident #29 was reviewed on 9/9/14 at 3:13 p.m. Diagnoses included, but were not limited to, urinary tract infection caused by VRE and c-diff infection.</p> <p>A Quarterly Minimum Data Set (MDS) assessment completed 8/6/14 assessed Resident #29 as having a Brief Interview for Mental Status (BIMS) of 2, indicating the resident was severely cognitively impaired. Resident #29 was assessed as requiring extensive assistance of 2 staff members for bed mobility and transfers and extensive assistance of 1 staff member for dressing, eating, toileting, and personal hygiene.</p> <p>A review of the recapitulation of physician's orders dated 9/1/14 - 9/30/14, indicated Resident #29 was placed into contact isolation on 8/18/14, after the facility received urine culture results which indicated the resident had the bacteria VRE present in the urine.</p>		<p>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-</p> <p>(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</p>		

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	<p>A care plan dated 8/19/14, indicated Resident #29 had "...a need for isolation related to active infectious disease: ESBL (Extended spectrum B-lactamase producing Enterobacteriaceae [a multi-drug resistant bacteria]), hx [history] of c-diff, VRE in urine...."</p> <p>Interventions included, but were not limited to, contact isolation and practicing good handwashing.</p> <p>During an observation of Resident #29 with Licensed Practical Nurse (LPN) #3 on 9/10/14 at 12:30 p.m., Resident #33 independently propelled into the room in a wheelchair. No staff were in attendance with the resident. Resident #29 was in contact isolation for VRE and c-diff infections and was sitting up in a reclining chair in the middle of the room. Resident #33 wheeled past the sign alerting staff and visitors to check with nursing staff prior to entering the room, past the bin containing personal protective equipment, past the bathroom, and stopped as the wheelchair came into contact with the chair of Resident #29. Resident #33 proceeded to push the reclining chair toward the bed of Resident #29 allowing Resident #33 to pass by the chair. The over the bed table of Resident #29 was in the middle of the room and Resident #33 moved the table out of the way to allow Resident #33 to</p>		<p>infection</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>· Resident #29 had a private room on 09/12/14.</li> <li>· Resident #33 was moved to a new room on 09/12/14.</li> </ul> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>· All residents who reside in this facility have the potential to be affected by the alleged deficient practice</li> <li>· The Director of Nursing or designee will review all residents who require isolation per facility policy and all residents with Clostridium Difficile and/or VRE will be placed in a private room if available, if private room not available, place in room with resident that is infected or colonized with the same organism. If neither is available resident will be placed in a semi private room with a low-risk roommate</li> <li>· The Interdisciplinary Team will review physician orders and facility activity report in clinical meeting to identify residents with signs and symptoms requiring isolation, positive lab results, diagnosed infections to ensure proper infection control practices are initiated and maintained</li> </ul>				

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	<p>go to the far side of the room. Resident #33 turned the wheelchair around and came into the middle of the room to ask if Resident #29 was married. LPN #3 answered the resident and Resident #33 returned to the far side of the room. A bedside commode was in the middle of the room between the two beds and was touching the privacy curtain between the beds. LPN #3 indicated the commode was used by Resident #29 due to the c-diff infection. LPN #3 indicated Resident #29 would occasionally alert staff to the need to use the bathroom and the staff utilized the commode for the resident.</p> <p>During an interview with the Executive Director (ED) and the Director of Nursing (DON) on 9/10/14 at 3:20 p.m., the ED indicated Resident #29 and Resident #33 had been roommates prior to the implementation of contact isolation for Resident #29 and the facility did not have another similar payor type bed available in which to move either resident. The DON indicated Resident #29 had been having diarrhea but had not had a bowel movement in 24 hours. The DON indicated Resident #33 was considered a low risk resident for contracting the infection from the other resident. The ED and the DON indicated Resident #33 was severely cognitively</p>		<ul style="list-style-type: none"> <li>· Staff has been in-serviced by the Director of Nursing Services and/or designee by 10/07/14 on Infection Control Policies and Procedures including transmission based precaution guidelines, Clostridium Difficile, and multidrug resistant organism policies</li> <li><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b></li> <li>· The Interdisciplinary Team will review physician orders and facility activity report in clinical meeting to identify residents with signs and symptoms requiring isolation, positive lab results, diagnosed infections to ensure proper infection control practices are initiated and maintained</li> <li>· The Director of Nursing or designee will review all residents who require isolation per facility policy and all residents with Clostridium Difficile and/or VRE will be placed in a private room if available, if private room not available, place in room with resident that is infected or colonized with the same organism. If neither is available resident will be placed in a semi private room with a low-risk roommate</li> <li>· Staff has been in-serviced by the Director of Nursing Services and/or designee by 10/07/14 on Infection Control Policies and Procedures including</li> </ul>				

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	<p>impaired and would not remember to utilize proper handwashing after touching items belonging to Resident #29 or when entering or exiting the room. The ED and the DON acknowledged Resident #33 and any visitors for the resident would need to pass through the isolated portion of the room to in order to reach the bed and room of Resident #33.</p> <p>During an observation of Resident #29 on 9/11/14 at 11:00 a.m., Resident #33 was observed asleep in the bed in the room with Resident #29.</p> <p>During an interview with LPN #4 on 9/11/14 at 11:00 a.m., LPN #4 indicated Resident #29 continued to have loose stools as recently as the evening of 9/10/14.</p> <p>The clinical record of Resident #33 was reviewed on 9/12/14 at 4:15 p.m. Diagnoses included, but were not limited to, dementia and oxygen dependent chronic obstructive pulmonary disease (COPD).</p> <p>A Significant Change MDS assessment completed 8/7/14, assessed Resident #33 with a BIMS of 4 indicating severe cognitive impairment. Resident #33 was assessed as requiring extensive assistance of 1 staff member for toileting, dressing,</p>		<p>transmission based precaution guidelines, Clostridium Difficile, and multidrug resistant organism policies</p> <ul style="list-style-type: none"> <li>Director of Nursing or designee will conduct daily rounds to ensure infection control practices are being followed.</li> </ul> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <ul style="list-style-type: none"> <li>Infection Control Review CQI tool will be utilized weekly times 4 weeks, monthly times 6 months and then until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the Director of Nursing, Executive Director, and Medical Director.</li> <li>If threshold of 95% is not achieved an action plan will be developed to ensure compliance.</li> </ul>	

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  09/15/2014	
NAME OF PROVIDER OR SUPPLIER  GREENWOOD MEADOWS				STREET ADDRESS, CITY, STATE, ZIP CODE 1200 N SR 135 GREENWOOD, IN 46142			
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	<p>and personal hygiene.</p> <p>On 9/10/14 at 11:15 a.m., the DON provided the Clostridium Difficile (CDI, C.diff)Policy dated 4/2014, and the Transmission-Based Precaution Guidelines also dated 4/2014, and indicated the policies were the ones currently used by the facility. The Clostridium Difficile policy indicated, "...4. CONTACT PRECAUTIONS... c. Resident Placement - Infected residents should be placed in a private room or cohorted...." The Transmission-Based Guidelines indicated, "...Cohort: refers to the practice of grouping residents infected or colonized with the same infectious agent together to confine their care and prevent contact with susceptible residents...<u>CONTACT PRECAUTION:</u> ...Resident Placement...Private room should be utilized if possible...."</p> <p>"How can Clostridium difficile Infection Be Prevented in Hospitals and Other Healthcare Settings," (last updated 3/6/12) was retrieved on 9/11/14 at 9:30 a.m., from the Centers of Disease Control (CDC) website. The guidance indicated, "... Use Contact Precautions: for patients with known or suspected <i>Clostridium difficile</i> infection: Place these residents in private rooms. If private rooms are not available, these patients can be placed in rooms (cohorted) with other patients with <i>Clostridium difficile</i> infection. Use</p>						

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	gloves when entering patients' rooms...continue these precautions until diarrhea ceases...." Another article titled, "Management of Multi-Drug Resistant Organisms in Healthcare Settings," was retrieved on 9/11/14 at 9:45 a.m., from the CDC website. The article indicated, on page 45, "...V.B.7.a.1 Place MDRO (MultiDrug Resistant Organism) Patients in single patient rooms...Cohort patients with the same MDRO...."  3.1-18(b)2				