

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155070	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/09/2015
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NAME OF PROVIDER OR SUPPLIER GREEN VALLEY CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3118 GREEN VALLEY RD NEW ALBANY, IN 47150
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00162006.</p> <p>Complaint IN00162006-Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: January 5, 6, 7, 8 and 9, 2015</p> <p>Facility number: 000028 Provider number: 155070 AIM number: 100275370</p> <p>Survey team: Trudy Lytle, RN-TC Jennifer Sartell, RN Gloria Reisert, MSW Josh Emily, RN</p> <p>Census bed type: SNF/NF: 98 Total: 98</p> <p>Census payor type: Medicare: 07 Medicaid: 84 Private: 04 Other: 03 Total: 98</p>	F000000	<p>Allegation of Compliance Please accept the following plan of correction for the annual survey ending on 1/9/2015.</p> <p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provision of the Federal and State Laws. This facility appreciated the time and dedication of the Survey Team; the facility will accept the survey as a tool for our facility to use in continuing to better the quality of care provided to the residents in our community.</p> <p>We respectfully request consideration for a desk review and paper compliance.</p>	

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

TITLE

(X6) DATE

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

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F000280 SS=D	<p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on January 13, 2015, by Janelyn Kulik, RN.</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on record review and interview, the facility failed to update a resident's care plan which addressed a resident and</p>	F000280	1. Resident #85 expired in the facility on 8/12/14 and the resident and family's wishes for Do Not Resuscitate (DNR) was	01/24/2015			

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	<p>family's wishes for Do Not Resuscitate (DNR). This deficient practice affected 1 of 2 residents reviewed for Code Status. (Resident #85)</p> <p>Finding includes:</p> <p>Review of the clinical record for Resident #85 on 1/7/15 at 8:30 a.m., indicated the resident was admitted to the facility on 8/12/14 and had expired in the facility on 9/28/14. Diagnoses included but were not limited to: S/P CVA (Status Post Stroke) and Alzheimer dementia.</p> <p>The family signed the Advanced Directive form at time of admission on 8/11/14 which indicated their wishes were for "No Code DNR".</p> <p>A Care plan dated 8/20/14 indicated the resident was a full code although the resident had a NO Code order since admission.</p> <p>An interview with LPN #1 on 1/7/15 at 10:00 a.m., indicated that the care plan must have been written before the Physician gave the formal order on 8/21/14. When queried, the LPN indicated that the actual code status went into effect when the physician signs the order for a DNR which was 8/21/14.</p>		<p>honored.</p> <p>2. An audit was completed 1/19/2015 by the Medical Records Director of each resident's code status, to ensure the physician order, Advanced Directive form, care plan, monthly physician orders and transfer sheets are complete and accurate with the current code status.</p> <p>3. Licensed nurses were inserviced on 1/19/15-1/20/15 by the Medical Records Director and/or designee. The in-service included but was not limited to: Resident's code status, to ensure the physician order, Advanced Directive form, care plan, monthly physician orders are complete and accurate with the current code status. The Director of Nursing or designee will randomly audit the resident's code status, to ensure the appropriate documentation supporting each resident's code status was clearly marked and available on the medical record, at least five (5) times per week for four (4) weeks and continue weekly for no less than two (2) additional months.</p> <p>4. The results of these audits will be presented to the monthly Performance Improvement Committee. The Performance Improvement Committee will reevaluate the continued need of audits; facility will achieve 95% compliance threshold prior to discontinuing audits. Plan to be updated as indicated.</p>				

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F000329 SS=D	<p>3.1-35(d)(2)(B)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any 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 provide appropriate rationale for an anti-depressant increase for 1 of 5 resident's reviewed for unnecessary medications. (Resident #4)</p> <p>Finding includes: The Clinical Record for Resident #4 was</p>	F000329	<p>1.MD reviewed Resident #4 current medications and provided written justification for maintaining resident on current dose of Prozac</p> <p>2.On 1/20/15, an audit was completed on residents with an increase in anti-depressants over the past 60 days to ensure appropriate rationale is documented to support an</p>	01/24/2015

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	<p>reviewed on 1/6/15 at 8:10 a.m. Diagnoses included, but were not limited to congestive heart failure, atrial fibrillation and depression.</p> <p>The Minimum Data Set quarterly assessment for Resident #4, dated 11/3/14, indicated the following: Feeling bad about yourself-or that you were a failure or have let yourself or you family down; 7-11 days. It also indicated no behaviors.</p> <p>The physician order, dated 1/9/14 at 2 p.m., indicated the following: Discontinue Prozac 10 mg [milligrams] daily. Prozac 5 mg orally daily.</p> <p>The physician order, dated 9/12/14 at 4 p.m., indicated the following: Discontinue Prozac 5 mg daily. Prozac 10 mg by mouth daily related to depression.</p> <p>The physician order, dated 10/8/14 at 8 p.m., indicated the following: Increase [up arrow] Prozac to 40 mg P.O. [by mouth] q [every] day due to failed GDR [gradual dose reduction].</p> <p>Review of the document titled Behavior/Intervention Monthly Flow Sheet indicated Resident #4 exhibited no behaviors for June, July and August,</p>		<p>anti-depressant increase. No concerns were noted.</p> <p>3. On 1/22/15 & 1/23/15, Staff were inserviced by the Staff Development Coordinator on the behavior management program with specific emphasis on documentation of resident mood and behavior and non-pharmacological interventions, as well as ensuring supportive documented rationale for an anti-depressant increase. The Director of Nursing or designee will audit physician orders for changes in antidepressants to ensure documentation supports rationale for an anti-depressant increase, at least five (5) times per week for four (4) weeks and continue no less than two (2) additional months.</p> <p>4. The results of these audits will be presented to the monthly Performance Improvement Committee. The Performance Improvement Committee will reevaluate the continued need of audits; facility will achieve 95% compliance threshold prior to discontinuing audits. Plan to be updated as indicated.</p>				

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	<p>2014.</p> <p>Review of the September, 2014 Behavior/Intervention Monthly Flow Sheet indicated Resident #4 had depression 8/30 days. The flow sheet lacked any documentation as to what the depression signs/symptoms were.</p> <p>Review of the October, 2014 Behavior/Intervention Monthly Flow Sheet indicated Resident #4 had depression/crying 5/31 days.</p> <p>Review of the September and October 2014 progress notes lacked documentation of physician and/or nursing assessment regarding causative factors related to Resident #4's behavior change.</p> <p>During an interview with the DON on 1/7/15 at 2 p.m., she indicated the family told them she had always been on 40 mg of Prozac while at home so we let the doctor know and he increased it.</p> <p>During an interview with the Social Services Director on 1/9/15 at 11:20 a.m., she indicated, considering the circumstances of the resident being on that amount at home and the family requesting the increase, she didn't think the increase was too much. She also</p>						

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	indicated if those circumstances were not involved, then yes, the increase would be too much. 3.1-48(a)(1)						
F000514 SS=D	483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview, the facility failed to ensure monthly	F000514	1. Resident #85 expired in the facility on 8/12/14 and the resident and family's wishes for	01/24/2015			

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	<p>physician orders and transfer sheet are complete and accurate with the correct code status. This deficient practice affected 1 of 2 residents reviewed for code status. (Resident #85)</p> <p>Finding included:</p> <p>Review of the clinical record for Resident #85 on 1/7/15 at 8:30 a.m., indicated the resident was admitted to the facility on 8/12/14 and had expired in the facility on 9/28/14. Diagnoses included but were not limited to: S/P (Status Post) CVA (Stroke) and Alzheimer dementia.</p> <p>On 8/11/14, the family signed the Advanced Directive form which indicated the wishes were for "Do Not Resuscitate (DNR)".</p> <p>The September 2014 Monthly Physician Orders failed to note a check mark next to the box for DNR and the physician then subsequently signed these orders on 9/17/14 without notation for Code Status.</p> <p>The Transfer form to the hospital dated 9/18/14 was also observed to be marked as the resident being a Full Code despite the family's request.</p> <p>On 1/7/15 at 2:30 p.m., LPN #1 indicated that it was the nurse who was doing the</p>		<p>Do Not Resuscitate (DNR) was honored. 2. An audit was completed 1/19/2015 by the Medical Records Director of each resident's code status, to ensure the physician order, Advanced Directive form, care plan, monthly physician orders and transfer sheets are complete and accurate with the current code status. 3. Licensed nurses were inserviced on 1/19/15-1/20/15 by the Medical Records Director and/or designee. The in-service included but was not limited to: Resident's code status, to ensure the physician order, Advanced Directive form, care plan, monthly physician orders are complete and accurate with the current code status. The Director of Nursing or designee will randomly audit the resident's code status, to ensure the appropriate documentation supporting each resident's code status was clearly marked and available on the medical record, at least five (5) times per week for four (4) weeks and continue weekly for no less than two (2) additional months. 4. The results of these audits will be presented to the monthly Performance Improvement Committee. The Performance Improvement Committee will reevaluate the continued need of audits; facility will achieve 95% compliance threshold prior to discontinuing audits. Plan to be updated as indicated.</p>				

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	<p>monthly Physician re-writes responsibility to make sure all information on the next month's re--write was correct. She also indicated she could not say why she had marked Full Code instead of DNR on the resident's transfer sheet to the hospital.</p> <p>3.1-50(a) 3.1-50(b)</p>			