STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155026	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENWOOD VILLAGE SOUTH	295 VILLAGE LANE GREENWOOD, IN46143

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F0000	This visit was for the Investigation of Complaint IN00096244. This visit was in conjunction with the Post Survey Revisit to the Investigation of Complaint IN00094734 completed on 08-18-11. Complaint IN00096244 - Substantiated. State deficiency related to the allegation is cited at F9999. Survey dates: October 7 & 11, 2011 Facility number: 000010 Provider number: 155026 AIM number: 100453660 Survey Team: Mary Jane G. Fischer RN Census Bed Type: SNF: 16 SNF/NF: 82 Residential: 199 Total: 297 Census Payor Type: Medicare: 14 Medicaid: 33 Other: 250 Total: 297	F0000	The creation and submission of this plan of correction does not consitute an admission of any conclusion set forth in the statement of deficiencies or any violation of regulations.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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

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	Sample: 6 Supplemental sample: 11 Greenwood Village South was found to be in compliance with 42 CFR Part 483 Subpart B in regard to Complaint IN00096244. This state finding is cited in accordance with 410 IAC 16.2. Quality review 10/13/11 by Suzanne Williams, RN			
F9999	ADMINISTRATION AND MANAGEMENT The Administrator is responsible for the overall management of the facility but shall not function as a departmental supervisor, for example, director of nursing or food service supervisor, during the same hours. The responsibilities of the administrator shall include, but are not limited to, the following: Immediately informing the division by telephone followed by written notice within twenty-four (24) hours, of unusual occurrences that directly threaten the welfare, safety, or health of the resident or residents ...	F9999	All resident rooms affected were treated professionally for bed bugs. Families were notified by Administrator or designee. Social Service Director monitored residents for psychosocial well being. The Administrator will report all unusual occurrences to ISDH within 24 hours of such incident. All residents have the potential to be affected by this action. The Administrator will report all unusual occurrences to ISDH within 24 hours of such incident. The policy and procedure for reporting unusual occurrences has been updated to reflect if incident is questionable, Administrator will contact ISDH for advisement. Administrator will	11/10/2011

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	This state rule was not met as evidenced by: Based on record review and interview, the facility failed to notify the State Agency of an unusual occurrence, in that when the facility was alerted of the infestation of bed bugs, the Administrative staff failed to notify the State Agency of the occurrence, resident involvement and the extent of the infestation. This deficient practice affected 2 of 3 nursing units and 2 of 6 sampled and 11 of 11 supplemental sampled residents. [Residents "D", "E", "G", "H", "I", "J", "K", "L", "M", "N", "O", "P" and "Q"]. Findings include: During interview on 10-11-11 at 5:15 a.m., Licensed Practical Nurse employee #6 indicated, "Yes we did have bed bugs. I saw them. We had a lot of them on this Unit [Dogwood] but I heard the other Units had them too. [Name of resident "E"] had them twice. Once [name of employee #8] moved [resident's pillow] and they just scattered." During interview on 10-11-11 at 5:25 a.m., Certified Nurses Aide employee #8 indicated, "I had bites on me from taking care of the residents. I talked with [name		follow current ISDH reportable incident guidelines. Administrator will report all unusual occurrences to ISDH within 24 hours of such incident. All unusual occurrences will be reported at monthly QA along with any actions taken including reporting incidents to ISDH.	

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	of licensed practical nurse #4] and she told me I was crazy. I know what I saw and I didn't want to take them [in reference to the bed bugs] home to my family. I saw the bites on residents." When interviewed if when the pillow of a resident was moved had she seen any bed bugs, the Certified Nurses aide responded "yes they went everywhere." During interview on 10-11-11 at 5:35 a.m., Certified Nurses Aide employee #9 indicated "I didn't see any but I heard about it. The bugs were here on Dogwood and the other Units." During interview on 10-11-11 at 5:45 a.m., Certified Nurses Aide employee #7 indicated, "Yes they had bed bugs on this Unit [Sycamore - Memory Care], I didn't see any but I heard about it." During interview on 10-11-11 at 5:50 a.m., Licensed Nurse employee #10 indicated, "Yes there was a problem a little over a month ago, but nothing recently." During interview on 10-11-11 at 10:45 a.m., the housekeeper employee #11 indicated, "Yes they found the bed bugs on this Unit [Dogwood], but I don't know where it all started. It gave me the creeps. You know that old saying 'sleep tight and			

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	don't let the bed bugs bite,' well they found them during the night shift !" During interview on 10-11-11 at 1:10 p.m., Licensed Nurse employee #12 indicated, "I saw one - it was a little bitty one. At first I wasn't sure what it was." An interview on 10-11-11 at 8:00 a.m. with the Administrator and the Director of Nurses indicated the following in regard to the concerns of bed bugs in the facility: "Yes we did have bed bugs it was around the first of July [2011]. Initially on the Dogwood Unit and it started with 2 residents [Residents "O" and "P"]. We contacted [name of local company] and also got a bed bug sniffing dog brought in. The dog 'alerted [sat down]' to the room the two residents had been in. At that time 3 rooms were treated. They used a heated treatment to 140 degrees for less than 24 hours. We also did staff education regarding the precautions to take after working here and returning home. Then we had another case of bed bugs in another neighborhood [Sycamore Memory Care Unit]. The dog was brought in and 'alerted' to the rooms involved. The dog also 'alerted' to a room on the Redbud [Rehabilitation] unit. I personally saw the bed bugs. We had to call [name of local area company] them back a second time			

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	around August 9th [2011] to treat 8 additional rooms." On 10-11-11 at 9:30 a.m., the Administrator provided a listing of resident names and room numbers of rooms treated for infestation during the first occurrence on 06-29-11. This listing included and involved residents "D", "O", "P" and "Q". The listing also included the names and room numbers of the residents' rooms that were treated for infestation during the second occurrence on 08-09-11. These resident rooms included and involved residents "E", "G", "H", "I", "J", "K", "L", "M", and "N." A notation at the bottom of this listing indicated a specific room on the Dogwood Unit which had to be treated for a second time on 08-11-11. During random chart review on 10-11-11 at 12:45 p.m., nurses notes indicated the following: Resident "E" 07-28-11 1:30 p.m. Res. [resident] c/o [complained of] bites, checked res. and every where [resident] has been, not res. 1st complaint. Nothing seen - no bite marks only red area res. right axillary that [resident] was scratching, unable to see bite mark there. 08-02-11 4:00 p.m. [Name of resident's			

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	physician] here. N/O [new order] received ... for bites." Resident "N" 07-28-11 at 9:00 p.m. "skin assessment completed per precaution, bugs found in room. No bug bites found. 08-03-11 at 11:00 p.m. "res. [resident] was taken to Dogwood Unit so room could be exterminated at 7:00 p.m." Resident "O" 06-30-11 at 2:00 p.m. "skin assessment done. Res. has rask <sic> like area note after shower on [arrow down] back portion of scalp/neck and shoulders. Two bites on right foot just above ankle. Red spot on arm and shoulder a few stratches note <sic> to right shoulder. Res. c/o [complained of] itching. Call then fax to MD [Medical Doctor] about itching. 06-30-11 10:15 p.m. N/O [new order] received for benadryl 25 mg [milligrams] by mouth every 8 hours PRN [as needed] for itching d/t [due to] bites from bugs found on scalp, neck and shoulders and right foot." Resident "H" 07-31-11 9:00 a.m. Bugs reported in room by staff - maintenance notified. Res. removed from room. Full skin assessment provided. No redness, bite marks or c/o itching/scratching noted. 07-31-11 11:00 a.m. Nurse on unit called this nurse on call d/t bugs found in resident's room. Advised nurse on unit to			

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	do full body and skin assessment. Skin assessment done and no irritations or skin issues noted. 08-01-11 [no time documented] Res. has red raised dots on right temple. res. scratched at arms and abdomen no noticeable marks there. 08-01-11 [no time documented] Res. had red bumps on face appears to be a bug bite. MD notified 1:1 Lotrimin cream ordered two times a day PRN." Resident "K" 07-28-11 "Skin assessment completed as precautionary measure to check for bug bites d/t bugs found in roommates side of room. no bites found." The infestation affected 4 rooms on the Dogwood Unit, 4 rooms on the Sycamore [Memory Care unit] and 1 room on the Redbud [Rehabilitation Unit]. During further interview on 10-11-11 at 12:10 p.m., the Director of Nurses indicated "We tried to investigate and narrow it down but never found the source. I called the local [name of county] Health Department and they told me it was not anything to report. I didn't call the State Agency." This State Finding relates to complaint IN00096244. 3.1-13(g)			

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