STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155783	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/12/2013

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

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F000000	This visit was for Recertification and State Licensure Survey. Survey dates: November 4, 5, 6, 7, 8, & 12, 2013 Facility Number: 002661 Provider Number: 155783 AIM number: 201056540 Survey Team: Shauna Carlson, RN - TC Julie Baumgartner, RN Shelly Miller-Vice, RN Census bed type: SNF: 29 NF: 17 SNF/NF: 10 Residential: 51 Total: 107 Census payor type: Medicare: 29 Medicaid: 10 Other: 68 Total: 107 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.	F000000	Please accept the enclosed information as Greenleaf Health Campus's Plan of Correction for the annual State survey conducted on November 12, 2013.Please contact me if there are any questions.Thank you for your time.Judy Plantinga AdministratorGreenleaf Health Campus.	

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

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

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	Quality review completed on November 18, 2013 by Randy Fry RN.			

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F000226 SS=E	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, 4 of 8 employees failed to identify the Elder Justice Act as an element of reporting abuse and neglect. (Employees #20, #21, #22, and #23) Findings include: On 11/7/13 at 8:30 AM, record reviews were conducted of the following policy and procedures: The Policy/ Procedure titled, "Abuse and Neglect procedural Guidelines," indicating; "...Procedure:... 4.... Implementation and monitoring consists of the following components: ...g. Reporting... v. The Elder Abuse Act...." The Policy/ Procedure titled, "Reporting Crime Pursuant to the Elder Justice Act... Policy. It is [facility's name] policy to notify owners, operators, employees, manager, agents and contractors... of their duty to report reasonable suspicions of crimes to the Secretary and local law enforcement...."	F000226	F-226Employee #20, #21,#22,#23 were all inserviced on the Elder Justice Abuse Act and the abuse policy.No residents have been affected by the deficient practice.All staff have been in-serviced on Elder Justice Abuse Act and the abuse policy by compliance support and the Health Facility Administrator with a pre/post test to ensure understanding.Staff are required to complete this in-service yearly and on hire.Administrator and or there designee will ask 3 randon staff members weeklyx 3 months then monthly x 3 months with results of findings to the Quality Assurance Team and if no issues then remove from Quality Assurance if 100% compliance is meant. If not 100% compliance then re-inservice on an individual basis.	12/06/2013

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	On 11/7/13 at 8:20 AM, interview with the DON (Director of Nursing) in regard to the facility's abuse and neglect policy and procedure indicated the Elder Abuse Justice Act was included into the training of the employees of the facility upon hire and annually there after. On 11/7/13 at 8:40 AM, an interview was conducted with Employee #20 indicating no knowledge of the Elder Justice Abuse Act and could not define what it was or what it included. On 11/7/13 at 9:00 a.m., an interview was conducted with Employee #21 indicating no knowledge of the Elder Justice Abuse Act and could not define what it was or what it included. On 11/7/13 at 9:05 a.m., an interview was conducted with Employee #22 indicating no knowledge of the Elder Justice Abuse Act and could not define what it was or what it included. On 11/7/13 at 9:15 a.m., an interview was conducted with Employee #23 indicating no knowledge of the Elder Justice Abuse Act and could not define what it was or what it included. 3.1-28(a)			

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F000329 SS=D	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. 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.			
	Based on observation, interview and record review, the facility failed to monitor administration of a cardiac medication for 1 of 3 residents observed for medication administration. (Resident #118) Findings include: On 11/7/13 at 7:30 a.m., a record review was conducted of Resident #118's clinical medical record (CMR) indicating diagnosis included but not	F000329	F-329Resident #118 was assessd and no ill effects noted from heart rate not being completed prior to med administration. Employee #30 has been inserviced on this.All residents receiving cardiac medications with parameters will be monitored through audits of medication administration records by ADHS/Unit manager 3x a week for 4 weeks then one time weekly for 3 months. All audits will be dicussed in Quality Assurance Meeting and if audits are 100% compliance then discontinue from Quality	12/06/2013

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	limited to, "...CHF (Congested Heart Failure)...." Physician order dated 11/1/2013 on the Physicians Order Sheet (POS) to administer, "...Metoprolol [cardiac/heart medication] 75 mg [milligram] BID [twice a day] po [by mouth]; hold if HR [heart rate] less than 55...." On 11/7/13 at 7:32 a.m., an observation was conducted of Employee #30 administering the medication, Metoprolol to Resident #118 On 11/7/13 at 7:33 a.m., interview with Employee #30 indicated, "... I'd have to look on the oxygen saturation monitor... I think we took them... well, I'm not sure... I really can't remember what it was... she's been on it for a long time...." On 11/7/13 at 7:32 a.m., interview with Employee #30 indicated no knowledge of the actual heart rate of Resident #118 prior to administration of the cardiac medication. On 11/7/13 at 7:45 a.m., interview with Employee #30 indicated it was the procedure of the facility to ensure assessments were conducted and be knowledgeable of the parameters of cardiac medication administration.		Assurance review and if not re-inservice.All licensed staff inserviced by pharmacist and or her designee. In-servicing will be done yearly and as needed.	

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	3.1-48(a)(3)			

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F000514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE 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 document continued resident response and effectiveness of interventions for falls for 16 of 72 hours for one of three residents reviewed for falls. (Resident #101) Findings include: On 11/7/13 at 9:40 A.M., record review of a History and Physical, dated 10/2/13, for Resident #101 indicated the following diagnosis: DM (diabetes mellitus), hypertension, chronic congestive heart failure, dementia, hypothyroidism, urinary incontinence, GERD (gastroesophageal reflux disease), ground-level fall with right femoral neck fracture with postop delirium	F000514	F-514Resident #101 was assessed and had no ill effects from deficient practice.No other residents were affected by this deficient practice. During clinical morning meeting all fall circumstance forms will be audited by medical records and or ADHS/Unit manager. Any areas not addressed will have licensed nurse called back in and educated on this. This will be monitored 5 days a week x 3 months then weekly x 3 months with audit results to Quality Assurance committee monthly and when 100% compliance obtained then taken off Quality Assurance or if needed more in-servicing. All licensed staff will be in-serviced on the importance of accurate completed assessments.	12/06/2013

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	(9/26/13), left hip fracture ORIF (open reduction and internal fixation) (9/2013). On 10/17/13 at 11:50 A.M., Resident #101 fell. On 11/7/13 at 1:33 P.M., record review of "Fall circumstance, assessment and intervention" form for Resident #101, dated 10/17/2013, indicated missing documentation for 10/20/13, 10 to 6 AM shift and 10/20/13, 2 to 10 PM shift post fall. On 11/7/13 at 1:45 P.M., interview with DON (Director of Nursing) indicated expectations are to assess and document the assessment of the resident for 72 hours post fall. On 11/7/13 at 2 P.M., record review of "Falls management program guidelines" policy, provided by the DON, indicated "Procedure: 8. Nursing staff will monitor and document continued resident response and effectiveness of interventions for 72 hours." (01/06 Revised 3/08) 3.1-50(a)(1)			

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F009999	3.1-14 PERSONNEL (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. This state rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure that a physical examination was completed on one of ten employees sampled, (employee #3). This deficiency has the potential to affect 56 out of 56 residents. Findings include: On 11/8/13 at 3:30 P.M., review of the employee files indicated that Employee #3 did not have a physical examination prior to employment. On 11/8/13 at 3:45 P.M., interview with the AIT (Administrator In Training) indicated that Employee #3 did not have a physical examination prior to employment.	F009999	F-9999Employee # 3 was sent out to have a physical completed. 56 out 56 had no ill effects from the deficient practice.All Employee files have been audited to ensure all have physicals on file with none noted missing. All hiring staff have been in-serviced on the procedure for hiring and the need for pre-employment physical. Human Resources will track all new hires to ensure pre-employment is completed before start of employment. Administrator will audit new hire for completion of physicals before start weekly x 4 then monthly x3 months and if 100% compliance then removed from QA	12/06/2013

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