

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155205	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/08/2015
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NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1225 GREENCROFT DR GOSHEN, IN 46527
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F 000 Bldg. 00	<p>This survey was for the Investigation of Complaint IN00170526 and Complaint IN00170917.</p> <p>Complaint IN00170526 - Substantiated. Federal/State deficiencies related to the allegation are cited at F323.</p> <p>Complaint IN00170917 - Substantiated. No deficiencies related to the allegation are cited.</p> <p>Survey dates: April 7 and 8, 2015</p> <p>Facility number: 000112 Provider number: 155205 AIM number: 100288710</p> <p>Census bed type: SNF: 35 SNF/NF: 146 Total: 181</p> <p>Census payor type: Medicare: 16 Medicaid: 111 Other: 54 Total: 181</p> <p>Sample: 5</p> <p>These deficiencies reflect state findings</p>	F 000	<p>F000 Initial Comments</p> <p>This plan of correction constitutes Greencroft Healthcare's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission or that a deficiency exists, or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. We respectfully request a desk review of this Plan of Correction.</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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F 323 SS=G Bldg. 00	<p>cited in accordance with 410 IAC 16.2-3.1.</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record observations, reviews and interviews, the facility failed to ensure adequate supervision of Resident "C," who was known to have nocturnal (nighttime) wandering. This resulted with Resident "C" entering the room of Resident "D," and moving Resident "D" from the bed, which resulted in Resident "D" sustaining a fall and fracture of the (L) (Left) tibia and fibula. This deficiency affected 1 of 5 residents reviewed for supervision and accidents in a sample of 5.</p> <p>Finding includes:</p> <p>During the Initial Tour, on 04/07/15, between 8:40 a.m. and 9:15 a.m., accompanied by LPN #8, Resident "C" was identified as a "wanderer," who wandered in the facility, primarily during the night. LPN #8 indicated Resident</p>	F 323	<p>F323 Free of Accident Hazards/Supervision/Devices There were no further incidents from Resident C. Resident C continues to ambulate independently throughout the facility. Resident C remains on 15 minute safety checks. The Risk for Elopement Policy was reviewed and updated (Attachment A) All independent residents are able to walk throughout the facility. If staff notices any inappropriate behavior that would endanger other residents or themselves the resident will be redirected. The staff member who redirected will inform the nurse providing care, the NTL and social worker of the resident "behavior" for further monitoring. E-charts of residents who ambulate independently were audited to make sure they do not exhibit any in-appropriate behavior that would endanger</p>	04/24/2015

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	<p>"C" walked independently at a brisk, almost running pace, and required frequent monitoring.</p> <p>The record of Resident "C" was reviewed on 04/07/15 at 10:20 a.m. Resident "C" was admitted to the facility on 06/24/11, with diagnoses including, but not limited to, cognitive deficits, depression, and dementia with behaviors.</p> <p>The most recent Annual MDS (Minimum Data Set) assessment, dated 02/19/15, indicated Resident "C" was severely cognitively impaired, exhibited behaviors of resisting care/assistance, wandering, and required supervision when walking.</p> <p>The record indicated: "03/22/15 2:28 a.m. At 12:30 a.m. this resident was found in resident [Resident "D"] room. Resident [Resident "D"] was laying on the floor and this resident was grabbing her [Resident "D"] hands saying, "let me help you up." Staff quickly intervened and assisted resident [Resident "C"] out of room without difficulty. Within a few minutes resident [Resident "C"] does not remember incident and is in a pleasant mood. Currently put on 1-1 [monitoring]...."</p> <p>Resident "C" was observed throughout the survey, either sleeping in bed or</p>		<p>other residents. Care plans were reviewed and revised as appropriate.</p> <p>All staff members were in-serviced and re-educated (Attachment B) on the potential safety issues associated with residents who ambulate independently throughout the building. The residents are free to walk and rest in common corridors however should a resident show signs of inappropriateness or enter another residents room it is the staff members responsibility to re-direct the and accompany the resident back to their appropriate unit and notify the nurse providing care, the NTL and social worker of the behavior. NTL or designee will continue to audit resident C Point of Care (POC) charting daily to make sure that charting is complete and any behaviors exhibited identified and interventions in place. NTL or designees will monitor POC of any resident identified with inappropriate behavior to make sure charting is complete and interventions in place. Resident C will be reviewed by the behavior team monthly x3 for recommendations. Any resident who exhibits inappropriate behaviors will be reviewed by the behavior team monthly x3 for recommendations. This will be reported to the DON via the community report sheets. The DON or designee will report</p>	

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	<p>sleeping while seated in chairs in common areas and dozing while seated in the facility's beauty shop.</p> <p>The closed record of Resident "D" was reviewed on 04/07/15 at 11:20 a.m. Resident "D" was admitted to the facility for short term rehabilitation and therapies on 03/15/15, with diagnoses including, but not limited to, acute compression fracture of L1 - L2 (Lumbar vertebrae) and L4 following a fall, a chronic fracture of L5, chronic pain & RA (Rheumatoid Arthritis). The resident had a vertebroplasty (surgery to stabilize spinal fractures) on 03/10/15.</p> <p>The 5 Day- MDS, dated 03/24/15 and following the fall, indicated Resident "D" was cognitively intact and required extensive assistance of 2 or more for transfers and ambulation.</p> <p>The record indicated the following:</p> <p>"03/21/15 10:33 p.m. Resident resting in recliner at bedside chatting with visitor when checked earlier in evening. Alert and interactive. Able to make needs known....Attends therapy as scheduled with goal of return to home. Transfers 1 extensive assist. Ambulates 1 limited assist using walker...."</p>		findings quarterly to QAPI for review and recommendations. Date of Compliance 4/24/2015.				

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	<p>"03/22/15 2:07 a.m....12:30 a.m. Writer heard yelling and found resident laying on (L) side with feet extended outward at side of bed. Call light on. Resident [Resident "C"] standing at foot of bed with arm extended outward saying "let me help you". Resident [Resident "C"] escorted out of room without difficulty. Resident [Resident "D"] had complaints of pain in (L) lower leg. Purple bruising noted on medial [middle] area above (L) ankle. Foot rotated outward. Slight swelling noted. Denied hitting head..."</p> <p>The on call physician and the resident's family were notified and the resident was transferred by EMS (Emergency Medical Service) to the ACF (Acute Care Facility: Hospital) ER (Emergency Room).</p> <p>"03/22/15 3:50 a.m. Son, [name], called from ER. Resident has FX [fracture] in 2 spots in (L) leg. Leg has been splinted and hosp [hospital] sending back NWB [Non-Weight Bearing] and to follow up with [orthopedic group name] on Monday for possible surgical repair consult."</p> <p>"03/22/15 4:05 a.m. Recvd [received] call from [nurse's name] @ [at] [ACF name] ER. Resident has fractured (L) Tib/Fib [Tibula/Fibula]...."</p>			

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	<p>"03/22/15 4:25 a.m. Resident returned from [hospital name] via [by way of] [EMS name]. Air splint on...."</p> <p>"03/24/15 11:19 a.m. Resident LOA [Leave Of Absence] this AM at 0815 [8:15 A.M.] for appointment...Received call from nurse at [Orthopedic group name] that resident was to be direct admitted to [ACF name]..."</p> <p>The ACF "EMERGENCY DEPARTMENT REPORT," dated 03/22/15, indicated: "...EXTREMITIES: The patient has a deformity, Ecchymosis [discoloration: bruising] tenderness left distal calf. Left foot is rotated externally approximately 30 degrees...."</p> <p>"DIAGNOSTIC TESTING: Left ankle X-ray with oblique distal tibia fracture and transverse distal fibula fracture with approximately 20-30 degrees posterior angulation...Post reduction X-ray shows better alignment through now slightly anterior angulated...."</p> <p>"DIAGNOSIS: Distal left tibia fracture. Distal left fibula fracture."</p> <p>Confidential interviews were conducted during the survey, between 04/07/15 and 04/08/15, with nursing staff, family members, and residents. During the</p>			

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	<p>interviews, 2 of 3 nursing staff indicated Resident "C" was on hourly monitoring prior to the incident and 3 of 3 nursing staff indicated Resident "C" remained on 15 minute checks since 03/22/15, following the 1:1 monitoring. Interviews indicated Resident "C" had not had physical contact with residents prior to the 03/22/15 incident and no further physical contact with other residents since. Interviews indicated Resident "C" continues to wander, primarily at night, and is redirected and/or followed to prevent wandering into other residents rooms. The resident continues, at times, to ambulate to the Gables Unit, which is connected to the North Unit and South Unit by a long hallway, approximately 100 steps, which turns and is not visible from the North Unit and South Unit.</p> <p>During an interview on 04/08/15 at 11:42 a.m., LPN #5 indicated Resident "C" was observed asleep while sitting in the hallway near the South Unit nurses station on 03/22/15, during the night shift. LPN #5 continued with assigned duties and then observed Resident "C" seated on the love seat near the North Unit nurses station and appeared to be dozing. The units are located next to each other along a continuous hallway. LPN #5 indicated she left the area to check on another resident and when she returned to</p>			

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	<p>the nurses station, Resident "C" was gone, and at the same time, she received a phone call from a Gables Unit staff member that Resident "C" had wandered to the Gables Unit. LPN #5 indicated Resident "C" was seated next to a staff member at the Gables Unit nurses station and indicated the entire episode, from last observation until seeing the resident on the Gables Unit was less than 15 minutes. LPN #5 indicated Resident "C" is quick and moves at a brisk pace. LPN #5 indicated Resident "C" continues to wander and is followed per staff and redirected as needed.</p> <p>Resident "D" was interviewed and the record was reviewed, in her current ECF (Extended Care Facility: nursing home), on 04/08/15 at 8:55 a.m. Resident "D" was transferred to the current ECF, on 03/30/15, following surgery on her left ankle. Resident "D" was seated in a wheelchair with both legs elevated and had an occlusive (unable to see through) wrap on her left lower leg. Resident "D" remained alert and oriented as corroborated by her most recent 5 day MDS, dated 04/03/15. The MDS further indicated Resident "D" required extensive assistance of 2 or more for mobility, transfers, hygiene, and toileting. The resident was non-ambulatory. A review of current Physician Orders</p>			

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	<p>indicated, on 04/01/15, Resident "D" now required a Hoyer lift, a mechanical device to assist in transfers, to her chair and was to be NWB on her (L) leg.</p> <p>The records indicated Resident "D" had surgical procedures: "03/24/15 External fixation of left distal tibia and fibula shaft fracture." "04/01/15 ORIF [Open Reduction Internal Fixation] (L) tibia and fibula fracture."</p> <p>During the interview, Resident "D" related the sequence of events in regards related to her fall. Resident "D" indicated she was sound asleep when she was awakened by someone pulling on her. Resident "D" indicated she initially thought it was a CNA and told the person she did not need to get up to the bathroom, and clearly stated to the person, "I didn't ring my buzzer." Resident "D" indicated the person was, "pulling on me, yanking on me, ...I don't have to get up." Resident "D" indicated the person (Resident "C") told her she needed to get up, at which time Resident "D" began screaming, "let me alone," and the "next thing I knew, I was on the floor." Resident "D" indicated she continued to scream to the person "you broke my leg" at which time nursing staff entered the room. Resident "D" indicated</p>			

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	<p>prior to the incident she was ambulating with minimal assistance and was anticipating a discharge home with family within the following week. Resident "D" indicated she has had 2 surgeries as a result of the incident and is fearful she will no longer be able to walk.</p> <p>Resident "F," room mate of Resident "D" at the time of the incident, was interviewed on 04/08/15 at 2:05 p.m. Resident "F" indicated she clearly recalled the incident and correctly noted the day it occurred. Resident "F" indicated she was lying in her bed, awake, on 03/22/15, with the privacy curtain drawn between her & the room mate. Resident "F" heard a commotion at approximately 12:00 a.m. The resident indicated it sounded as if someone was rummaging around and as she thought it was a CNA, and did not turn on her call light. Resident "F" indicated she heard a conversation indicating her room mate (Resident "D") did not want to go to the bathroom and indicated the person (Resident "C") had awoken Resident "D," which was followed by screaming and yelling by her room mate, Resident "D," and she had been dropped on the floor, yelling, "You broke my leg," at which time Resident "F" activated her call light and staff arrived almost simultaneously. Resident "F" indicated Resident "C" had</p>			

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	not wandered into her room since. This Federal tag relates to Complaint IN00170526. 3.1-45(a)(2)				