

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155743	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/16/2015
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NAME OF PROVIDER OR SUPPLIER  GREEN-HILL MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 501 N LINCOLN AVE FOWLER, IN 47944
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F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaints IN00183921 and IN00184045. This visit resulted in a Partially Extended Survey-Immediate Jeopardy.</p> <p>Complaint IN00183921-Substantiated. No deficiencies related to the allegations were cited.</p> <p>Complaint IN00184045- Substantiated. Federal/State deficiencies related to the allegation were cited at F204, F250, and F224.</p> <p>Unrelated deficiencies were cited.</p> <p>Survey date: October 14, 2015 Extended dates: October 15 and 16, 2015</p> <p>Facility number: 000288 Provider number: 155743 AIM number: 100287380</p> <p>Census bed type: SNF/NF: 34 Total: 34</p> <p>Census Payor type: Medicare: 3 Medicaid: 22</p>	F 0000	The creation and submission of this plan of correction does not constitute an admission by this provider or any conclusion set forth in the statement of deficiency or any violation of regulation. Provider desires that the 2567 planof correction be considered the letter of credible compliance on or after 11-06-2015. James D. Sizemore, HFA Administrator	

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 0204 SS=D Bldg. 00	<p>Other: 9 Total: 34</p> <p>Sample: 7 Extended sample: 4</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 26143, on October 22, 2015.</p> <p>483.12(a)(7) PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHRG A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.</p> <p>In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency the State LTC ombudsman, residents of the facility, and the legal representatives of the residents or other responsible parties, as well as the plan for the transfer and adequate relocation of the</p>				

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	<p>residents, as required at §483.75(r). Based on record review and interview, the facility failed to provide sufficient preparation and orientation to a resident who was discharged from the facility, which resulted in a resident being discharged without proper notification and approval of the Legal Guardian, ensuring the resident had outside assistance from home health care, and ensuring discharge instructions were explained to the resident's Legal Guardian, for 1 of 7 residents reviewed for transfer/discharges, in a total sample of 7 and extended sample of 4. (Resident #C)</p> <p>Finding includes:</p> <p>During a telephone interview on 10/14/15 at 9 a.m., Adult Protective Services (APS) indicated Resident #C had been transferred from the facility to the Guardian's apartment without the approval from the Guardian. Resident #C had no home healthcare services set up and was not receiving care from anyone.</p> <p>Resident #C's record was reviewed on 10/14/15 at 2:55 p.m. The resident's diagnoses included, but were not limited to, schizophrenia, intellectual disability, and diabetes mellitus. The resident was</p>	F 0204	<p><b><u>Please note provider desires to IDR F204 please see uploaded documents</u></b> <b><u>PLEASE SEE ATTACHED ADDENDUM F204 483.12(a) (7)Preparation for Safe/Orderly Transfer/Discharge</u></b> A facility must provide sufficient preparation and orientation to Residents to ensure safe and orderly transfer or discharge from the facility. In the case of facility closure, the individual who is the Administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency the State LTC Ombudsman, Residents of the facility, and the legal representatives of the Resident or other responsible parties, as well as the plan for the transfer and adequate relocation of the Residents, as required at 483.75(r)</p> <p><b>1. What corrective actions will be accomplished for those Residents found to have been affected by the deficient practice?</b> Resident #C was discharged from the facility on 09/28/2015. Resident # C remains discharged at this time, and to the knowledge of the facility, remains in the care of his family.</p> <p><b>1. How other Residents having the potential to be affected by the same deficient practice will be identified and what</b></p>	11/06/2015			

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	<p>admitted into the facility on 09/25/15 from home.</p> <p>A Court Document, dated 02/23/13, titled, "Order Appointing Guardian Over Person of Incapacitated Person", and signed by the Circuit Court Judge, indicated, "...Indiana Code have been satisfied, and (Guardian's Name) is entitled to be guardian of the person...and is so appointed without any limitations as to her duties, responsibilities, or powers... (Resident Name) by reason of his incapacity is unable to care for his person and is therefore adjudicated to be an incapacitated person, and the appointment of a guardian over his person is necessary..."</p> <p>A care plan, dated 09/25/15 indicated the resident required long term care placement due to needing 24 hour supervision and the resident's family was unable to meet the needs of the resident. The interventions included, "Discharge plan will (sic) reviewed and updated as needed, Encourage resident to continue to live in the nursing home due to the need for 24 hour supervision for health and safety, safe mobility and transfers, assistance with ongoing health issues, and assistance with personal care and all other daily living tasks, Provide one-to-one services as needed to assist</p>		<p><b>corrective action(s) will be taken?</b></p> <p>Everyresident that discharges from the facility has the potential to be affected bythe same deficient practice. The facility conducted staff education (includingadministrative staff) regarding ensuring residents are discharged from thefacility in a safe and orderly manner. The education included informationregarding providing preparation to ensure that the plan for safe and adequatedischarges/transfers/relocations is accomplished according to facilitypolicies, ensuring that the residents have outside assistance appropriate totheir care needs, and family/responsible parties/legal representatives areadequately notified</p> <p><b>1. What measures will be put into place or whatsystemic changes will be made to ensure that the deficient practice does notrecur.</b></p> <p>Thefacility staff has been instructed to notify the Regional Director and or theRegional Nurse Consultant prior to any future discharge of a resident. Prior to the discharge, The Regional Directorand or the Regional Nurse Consultant will go over the steps with the staff toensure the discharge is being conducted in a safe and orderly manner, thatoutside assistance (if required) are set up and, that</p>	

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	<p>with adjustment issues if the resident desires to discharge but this goal was unobtainable.</p> <p>The Social Service Admission Note, dated 09/25/15, indicated the resident's (Guardian) could no longer provide care for the resident, the resident's appearance was unkept, cognitive status was alert and impaired, and the resident walked independently with a walker. The Discharge planning indicated the resident lived with the Guardian, who could no longer provide care to the resident and long term placement was needed</p> <p>The Admission Resident Assessment, dated 09/25/15 at 1 p.m., indicated the resident required assistance of one for transfers, ambulation, hygiene, and toileting.</p> <p>The Nurses' Progress Notes indicated:</p> <p>09/26/15 at 10 a.m.- "...requires ii (2) assist transfers et (and) i (1) assist c/ (with) ADL's."</p> <p>09/28/15 at 8:30 a.m.- "Res (resident) arguementive (sic) c(with)/ writer this a.m. re: (about) meds (medication)...grabbed my arm and started to twist it I pulled away then he grabbed the med card et tried to take</p>		<p>appropriate notifications and planninghas been accomplished prior to the discharge of the resident.</p> <p><b>1.Howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place and</b></p> <p>Thefacility will initiate the use of a tracking form on an ongoing basis for a minimum of six months. Residents thatare being discharged from the facility will be reviewed. The tracking form willbe "checked-off" indicating that all steps have been completed to ensure thateach resident discharged was completed in a safe and orderly manner, andappropriate notifications and planning accomplished. Should concerns be noted,immediate corrective action will occur. Results of these reviews, any noted concerns, and any corrective actionswill be discussed during the facility's QA meetings and the plan adjusted asindicated.</p> <p><b>1.By what date the systemic changeswill be completed</b> 11-06-2015.</p>				

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	<p>them away from me...grabbed the med card away before he could take it. He did agree to take medication. Behavior sheet done."</p> <p>09/28/15 at 3:20 p.m.- "CNA's x 2 attempting to give (Name) a shower when he began yelling out very loudly-stated leave me alone- Res has a prosthetic leg and began to beat the CNA with it- 2 RN's- writer and ADM (Administrator) (Name) present by this time...once in his room began yelling out get of here this is my room. Gave (Name) Haldol (anti-psychotic) IM (intramuscularly) after he agreed to that. Place call to (Physician's Name) received new orders to send to home c/ meds et Home Health Care."</p> <p>09/28/15 6:40 p.m., late entry for 09/28/15 at 4:15 p.m.- "Writer @ facility requested to assist c/ this agitated res. Res in his rm (room) @ the time, calming after becoming agitated with shower...res initially agreed c/ shower et things were 'going well' then res 'just switched' got angry et agitated...res allowed 1 nurse to attend to needs...Res demanding to be allowed to go home et even during periods when he was not angry et talking rationally stating he wants to go home, does not need to be here...HFA (Healthcare facility Administrator) made</p>			

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	<p>phone call to (Guardian) 0/ (no) answer. Call made to res Aunt. Aunt in agreement c/ res orders...to discharge home c. home health."</p> <p>Social Service Progress Notes, dated 09/28/15 (no time documented), indicated "Spoke with resident's (Guardian) in regard to resident's behaviors. (Guardian) has asked that resident be transported back to her home and in her care. Transportation arranged...Home Health Services (Name) were initiated."</p> <p>A Physician's Order, dated 09/28/15 at 4 p.m., indicated to discharge the resident to home with medications and home health care.</p> <p>Home Discharge Instructions, dated 09/28/15, indicated the resident was discharged from the facility to home, the discharge medications were listed, and the form was signed by the nurse. The form lacked a signature the instructions had been provided to the Guardian. The Notice of Transfer or Discharge, dated 09/28/15, indicated the transfer or discharge was necessary to meet the resident's welfare and the resident's needs could not be met in the facility.</p> <p>During an interview on 10/14/15 at 3:50</p>			

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	<p>p.m., the RN Corporate Consultant indicated she was unsure who received the discharge instructions but the written instructions were sent with the resident.</p> <p>During an interview on 10/16/15 at 12:25 p.m., LPN #3 indicated she had given the discharge instructions to the resident and the driver of the transport van. She indicated she had not attempted to reach the Legal Guardian to give her the discharge instructions. She indicated the resident had not been in the facility that long and the Legal Guardian had brought him in.</p> <p>During an interview on 10/14/15 at 3:15 p.m., the Social Service Director indicated the Administrator informed her the resident's family had requested the resident be discharged to home, so she telephoned the resident's Guardian and told her what time the resident would be transferred. The Social Service Director indicated her understanding was the Guardian wanted the resident discharged to home. She indicated the Ombudsman had not been notified. The Social Service Director indicated the resident had been referred to a home health agency (Name provided).</p> <p>During a telephone interview on 10/14/15 at 4:30 p.m., the Supervisor at the home</p>			

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	<p>health agency indicated they were notified on 09/28/15 of the resident in need of home health care. She indicated she had informed the Administrator the resident would need prior approval before they could accept him for care due to the skilled services needed and it would take a few days to get the approval. The Supervisor indicated he would refer the resident to another agency. The Supervisor indicated the home health services called the facility again on 09/30/15 and informed the Administrator they were unable to accept the resident and offered to assist in finding home health care for the resident and the Administrator declined the offer for assistance. She indicated the Administrator had not informed her the resident had already been discharged from the facility.</p> <p>During an interview on 10/14/15 at 3:50 p.m., the Administrator indicated he had attempted to contact the resident's Guardian and was unable to. He indicated he had spoken to the resident's Aunt and she was understanding of the situation and said to send the resident home. The Administrator indicated he had not documented the conversation. The Administrator indicated it was his understanding the resident's Aunt was relaying the information to the resident's</p>			

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	<p>Guardian. The Administrator indicated he did not know what time he called the resident's Aunt. He indicated the first time he called the Aunt she gave the approval to discharge the resident to home.</p> <p>During an interview on 10/14/15 at 3:50 p.m., the Social Service Director indicated she had spoke with the resident's Guardian and gave her the time the transportation would arrive to discharge the resident to home and she said she would be waiting.</p> <p>During a telephone interview on 10/14/15 at 6:08 p.m., the resident's Aunt indicated the resident's Guardian had no phone and her (Aunt) number was the number they had to call, so they would not have spoken to the Guardian. She indicated the only way the Guardian would have been able to approve the discharge from the facility was for her to drive to the Guardian's house, 27 miles away, and tell her the resident was being discharged home. The Aunt indicated the facility did not give her an option and told her they were sending the resident home. The Aunt indicated the facility had not given the resident time to adjust to the facility and the resident's Guardian was elderly and in bad health. She indicated the resident resents the Guardian and because</p>			

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	<p>of this the Guardian was living in a shelter. She indicated the facility had not spoken to the Guardian about the discharge and the facility just said they were transferring him. The Aunt indicated she had not given the facility permission to discharge the resident.</p> <p>A facility policy, dated 01/15, received from the RN Corporate Consultant as current, titled, "Transfer/Discharge", indicated, "...When a transfer or discharge of a resident is proposed, whether intrafacility or interfacility, provision for continuity of care shall be provided by the facility...Prior to any interfacility...relocation, the facility shall prepare a relocation plan to prepare the resident for relocation and to provide continuity of care...The facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility..."</p> <p>This Federal Tag relates to Complaint IN00184045.</p> <p>3.1-12(a)(21)</p>			

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F 0224 SS=J Bldg. 00	<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.</p> <p>Based on record review and interview, the facility failed to ensure a resident with an intellectual disability, who required supervision and assistance with activity of daily living (ADL's) was free from neglect, related to discharging the resident from the facility to the community with no discharge planning, no home health service, no Social Service interventions for mental health therapy, and without the permission from the Legal Guardian. This resulted in the resident being left at home unsupervised and with no assistance with ADL's and health care services, for 1 of 3 residents reviewed for discharge/transfers and discharge planning. (Resident #C)</p> <p>The Immediate Jeopardy began on</p>	F 0224	<p><b><u>Please note provider desires to IDR F224 please see uploaded documents</u></b> <b><u>PLEASE REFER TO ATTACHED ADDENDUM F 224</u></b> <b><u>483.13(C)Prohibit</u></b> <b><u>Mistreatment/Neglect/Misappropiation</u></b> Thefacility must develop and implement written policies and procedures thatprohibit mistreatment, neglect, and abuse of Residents and misappropriation ofResident property <b>1.Whatcorrective actions will be accomplished for those Residents found to have beenaffected by the deficient practice?</b> Resident#C was discharged from the facility on 09/28/2015. Resident # C remains discharged at this time, and to theknowledge of the facility, remains in the care of his family.</p>	11/06/2015

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	<p>09/28/15 when the facility discharged a resident with an intellectual disability home without permission from the Legal Guardian, leaving the resident with no supervision or ADL assistance.</p> <p>The Administrator, Director of Nursing (DoN), and the Regional Director were notified of the Immediate Jeopardy at 3:15 p.m. on 10/15/15. The immediate jeopardy was removed on 10/16/15, but noncompliance remained at the lower scope and severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy.</p> <p>Finding includes:</p> <p>During a telephone interview on 10/14/15 at 9 a.m., Adult Protective Services (APS) indicated Resident #C had been transferred from the facility to the Guardian's apartment without the approval from the Guardian. Resident #C had no home healthcare services set up and was not receiving care from anyone. APS indicated the Guardian was no longer living at the apartment due to the resident's behaviors and the Guardian goes to the apartment one time a day to check on the resident.</p> <p>Resident #C's record was reviewed on 10/14/15 at 2:55 p.m. The resident's</p>		<p><b>1.Howother Residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken?</b></p> <p>Everyresident that discharges from the facility has the potential to be affected bythe same deficient practice. The facility conducted staff education (includingadministrative staff) regarding ensuring residents are discharged from thefacility in a safe and orderly manner. The education included informationregarding providing preparation to ensure that the plan for safe and adequatedischarges/transfers/relocations is accomplished according to facilitypolicies. The education included information regarding ensuring that theresidents are free from neglect by having outside assistance appropriate totheir care needs arranged, and family/responsible parties/legal representativesare adequately notified.</p> <p><b>1.Whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur.</b></p> <p>Thefacility staff has been instructed to notify the Regional Director and or theRegional Nurse Consultant prior to any future discharge of a resident. Prior to the discharge, The Regional Directorand or the</p>		

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NAME OF PROVIDER OR SUPPLIER  GREEN-HILL MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 501 N LINCOLN AVE FOWLER, IN 47944		
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	<p>diagnoses included, but were not limited to, schizophrenia, individual intellectual disability, and diabetes mellitus. The resident was admitted into the facility on 09/25/15 from home.</p> <p>A Court Document, dated 02/23/13, titled, "Order Appointing Guardian Over Person of Incapacitated Person", and signed by the Circuit Court Judge, indicated, "...incapable of handling his person because of his multiple medical issues including, schizophrenia, Diabetes Type II requiring amputation of the right leg below the knee and of the hallux and metatarsal on the left foot...and is hereby found to be an incapacitated person under Indiana law...Indiana Code have been satisfied, and (Guardian's Name) is entitled to be guardian of the person...and is so appointed without any limitations as to her duties, responsibilities, or powers... (Resident Name) by reason of his incapacity is unable to care for his person and is therefore adjudicated to be an incapacitated person, and the appointment of a guardian over his person is necessary..."</p> <p>The Pre-Admission Screening, dated 09/23/15, indicated the resident's diagnoses were, residual schizophrenia, "mild mental retardation", diabetes, hypertension, amputation of the left leg</p>		<p>Regional Nurse Consultant will ensure the discharging resident is freefrom neglect by going over the steps with the staff to ensure the discharge isbeing conducted in a safe and orderly manner, that outside assistance (ifrequired) are set up and, that appropriate notifications and planning has beenaccomplished prior to the discharge of the resident.</p> <p><b>1.Howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place and</b></p> <p>Thefacility will initiate the use of a tracking form on an ongoing basis for a minimum of six months. Residents thatare being discharged from the facility will be reviewed. The tracking form willbe "checked-off" indicating that all steps have been completed to ensure that eachresident discharged was completed in a safe and orderly manner, and appropriatenotifications and planning accomplished. Should concerns be noted, immediatecorrective action will occur. Results ofthese reviews, any noted concerns, and any corrective actions will be discussedduring the facility's QA meetings and the plan adjusted as indicated.</p> <p><b>1.By what date the systemic changeswill be completed</b> 11-06-2015</p>		

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NAME OF PROVIDER OR SUPPLIER  GREEN-HILL MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 501 N LINCOLN AVE FOWLER, IN 47944
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	<p>and a history of seizures. The resident was living with the Guardian, who was elderly and was unable to handle the resident's Activity of Daily Living (ADL's) and was overwhelmed by the resident's care. The screen indicated the resident had no reported fears, but could display anxiety when in new situations or meeting new people and would adjust to changes with time for the transition and the resident was stable when on the prescribed medications consistently and he eats appropriately but was unable to care for those things himself. The screening indicated the resident was noncompliant with medication and diet and the resident was unable to care for his own ADL's. The resident's ability to participate in ADL care had declined and he required meals to be set up and assistance with toileting and hygiene. The screen indicated the resident and the Guardian's relationship was strained and his behaviors were directed toward the Guardian and the resident was not considered a danger to self or others, but was at risk due to inconsistent self-administration of medications. The screen indicated the resident had a right leg amputation and could only walk for short distances. The Screening indicated the Physician recommended a long-term nursing facility due to home care was not safe or feasible regarding the resident's</p>			

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	<p>health and safety.</p> <p>A care plan, dated 09/24/15 (sic, should be 09/25/15), indicated the resident had diagnoses of MR (mental retardation) and schizophrenia and may exhibit agitation, physical aggression, verbal aggression, and playing with feces. The interventions included psychiatric care, psychiatric medications as ordered, ensure all needs are met, encourage activities of interest, and assist resident in problem solving any issues.</p> <p>A care plan, dated 09/25/15 indicated the resident required long term care placement due to needing 24 hour supervision and the resident's family was unable to meet the needs of the resident. The interventions included, "Discharge plan will (sic) reviewed and updated as needed, Encourage resident to continue to live in the nursing home due to the need for 24 hour supervision for health and safety, safe mobility and transfers, assistance with ongoing health issues, and assistance with personal care and all other daily living tasks, Provide one-to-one services as needed to assist with adjustment issues if the resident desires to discharge but this goal was unobtainable.</p> <p>A care plan, dated 09/25/15, indicated,</p>				

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NAME OF PROVIDER OR SUPPLIER  GREEN-HILL MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 501 N LINCOLN AVE FOWLER, IN 47944
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	<p>Adjustment to new environment. The interventions included, provide frequent visits to ensure that resident was not exhibiting any signs or symptoms of depression and provide activities of choice and interest.</p> <p>The Social Service Admission Note, dated 09/25/15, indicated the resident's (Guardian) could no longer provide care for the resident, the resident's appearance was unkept, cognitive status was alert and impaired, and the resident walked independently with a walker. The Discharge planning indicated the resident lived with the Guardian, who could no longer provide care to the resident and long term placement was needed</p> <p>The Admission Resident Assessment, dated 09/25/15 at 1 p.m., indicated the resident required assistance of one for transfers, ambulation, hygiene, and toileting.</p> <p>The Nurses' Progress Notes indicated:</p> <p>09/26/15 at 10 a.m.- "...requires ii (2) assist transfers et (and) i (1) assist c/ (with) ADL's."</p> <p>09/28/15 at 8:30 a.m.- "Res (resident) arguementive (sic) c(with)/ writer this a.m. re: (about) meds</p>			

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NAME OF PROVIDER OR SUPPLIER  GREEN-HILL MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 501 N LINCOLN AVE FOWLER, IN 47944		
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	<p>(medication)...grabbed my arm and started to twist it I pulled away then he grabbed the med card et tried to take them away from me...grabbed the med card away before he could take it. He did agree to take medication. Behavior sheet done."</p> <p>09/28/15 at 3:20 p.m.- "CNA's x 2 attempting to give (Name) a shower when he began yelling out very loudly-stated leave me alone- Res has a prosthetic leg and began to beat the CNA with it- 2 RN's- writer and ADM (Administrator) (Name) present by this time...once in his room began yelling out get of here this is my room. Gave (Name) Haldol (anti-psychotic) IM (intramuscularly) after he agreed to that. Place call to (Physician's Name) received new orders to send to home c/ meds et Home Health Care."</p> <p>09/28/15 at 4:10 p.m.- "Has agreed to smoke cigarette c/ supervision away from nrsg (nursing) home population. Calmed down went to his rm (room). No further agitation @ this time...w/c (wheelchair) van to p/u (pick up) at 6:30 p.m."</p> <p>09/28/15 6:40 p.m., late entry for 09/28/15 at 4:15 p.m.- "Writer @ facility requested to assist c/ this agitated res. Res in his rm (room) @ the time, calming</p>				

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	<p>after becoming agitated with shower...res initially agreed c/ shower et things were 'going well' then res 'just switched' got angry et agitated...res allowed 1 nurse to attend to needs...Res demanding to be allowed to go home et even during periods when he was not angry et talking rationally stating he wants to go home, does not need to be here...HFA (Healthcare facility Administrator) made phone call to (Guardian) 0/ (no) answer. Call made to res Aunt. Aunt in agreement c/ res orders...to discharge home c. home health."</p> <p>Social Service Progress Notes, indicated:</p> <p>09/27/15 (no time documented), "Resident became aggressive c/ CNA when CNA tried to clean resident up after BM (bowel movement). Resident also became aggressive when CNA tried to get cigarettes and matches back from resident after several interventions resident calmed."</p> <p>09/28/15 (no time documented), "Resident was punching and kicking doors, yelling at CNA. Resident was smearing/playing in feces. While CNA was giving care, resident attempting to smear feces on staff, hitting kicking and trying to hit staff c/ prosthetic leg. Will start referral process for inpatient mental</p>			

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NAME OF PROVIDER OR SUPPLIER  GREEN-HILL MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 501 N LINCOLN AVE FOWLER, IN 47944
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	<p>health services."</p> <p>09/28/15 (no time documented), "Spoke with resident's (Guardian) in regard to resident's behaviors. (Guardian) has asked that resident be transported back to her home and in her care. Transportation arranged...Home Health Services (Name) were initiated."</p> <p>A Physician's Order, dated 09/28/15 at 4 p.m., indicated to discharge the resident to home with medications and home health care.</p> <p>Home Discharge Instructions, dated 09/28/15, indicated the resident was discharged from the facility to home, the discharge medications were listed, and the form was signed by the nurse. The form lacked a signature the instructions had been provided to the Guardian. The Notice of Transfer or Discharge, dated 09/28/15, indicated the transfer or discharge was necessary to meet the resident's welfare and the resident's needs could not be met in the facility.</p> <p>During an interview on 10/14/15 at 3:50 p.m., the RN Corporate Consultant indicated she was unsure who received the discharge instructions but the written instructions were sent with the resident.</p>			

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	<p>The Facility Discharge Summary, dated 09/28/15, indicated the resident was belligerent and aggressive with the staff, the resident demanded to return home, the family was contacted and the family agreed to the discharge.</p> <p>During an interview on 10/14/15 at 3:15 p.m., the Social Service Director indicated the resident only had behaviors one day and the Administrator had ordered her to contact inpatient mental health facilities. The Social Service Director indicated she had notified two different mental health facilities and both said they would not admit the resident due to his payor status. The Social Service Director indicated the Administrator informed her the resident's family had requested the resident be discharged to home, so she telephoned the resident's Guardian and told her what time the resident would be transferred. The Social Service Director indicated her understanding was the Guardian wanted the resident discharged to home. She indicated the Ombudsman had not been notified. The Social Service Director indicated she had faxed the information to the in-patient facilities, but did not have copies of the fax or the fax acknowledgement from the facilities. She indicated she had not documented the referral information. The Social</p>			

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NAME OF PROVIDER OR SUPPLIER  GREEN-HILL MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 501 N LINCOLN AVE FOWLER, IN 47944
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	<p>Service Director indicated when the resident was admitted the Guardian had informed her she had no telephone and the facility would need to call the resident's Aunt and the Aunt would get a hold of her. The Social Service Director indicated the resident had been referred to a home health agency (Name provided).</p> <p>During an interview with the Social Service Director, 10/14/15 at 3:50 p.m., she indicated when she calls for a referral for in-patient therapy, she talks to whoever answers the phone and she was unsure who she spoke with for the referrals for in-patient therapy.</p> <p>During a telephone interview on 10/14/15 at 4:30 p.m., the Supervisor at the home health agency indicated they were notified on 09/28/15 of the resident in need of home health care. She indicated she had informed the Administrator the resident would need prior approval before they could accept him for care due to the skilled services needed and it would take a few days to get the approval. The Supervisor indicated he would refer the resident to another agency. The Supervisor indicated the home health services called the facility again on 09/30/15 and informed the Administrator they were unable to accept</p>			

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NAME OF PROVIDER OR SUPPLIER  GREEN-HILL MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 501 N LINCOLN AVE FOWLER, IN 47944
--	--

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	<p>the resident and offered to assist in finding home health care for the resident and the Administrator declined the offer for assistance. She indicated the Administrator had not informed her the resident had already been discharged from the facility.</p> <p>During a telephone interview on 10/14/15 at 4:40 p.m., the Care Coordinator at In-Patient facility #1 indicated they had received a call about a referral and had asked the facility to fax the information to them and they had not received a fax from the facility. The Care Coordinator indicated if the paper work had been faxed they would have followed up with the facility and documented the follow up, and there was no documentation to indicated the facility faxed information.</p> <p>During a telephone interview on 10/15/15 at 8:50 a.m., the Assessment Department at In-Patient facility #2 indicated the facility had not received a referral for the resident. She indicated the In-Patient facility normally does not take patients from a long term nursing facility. She indicated had a referral been called, they would have talked to the resident, and there was no documentation to indicate they had spoken with the resident.</p> <p>During an interview on 10/14/15 at 3:50</p>			

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	<p>p.m., the Administrator indicated he had attempted to contact the resident's Guardian and was unable to. He indicated he had spoken to the resident's Aunt and she was understanding of the situation and said to send the resident home. The Administrator indicated he had not documented the conversation. The Administrator indicated it was his understanding the resident's Aunt was relaying the information to the resident's Guardian. The Administrator indicated he did not know what time he called the resident's Aunt. He indicated the first time he called the Aunt she gave the approval to discharge the resident to home.</p> <p>During an interview on 10/14/15 at 3:50 p.m., the Social Service Director indicated she had spoke with the resident's Guardian and gave her the time the transportation would arrive to discharge the resident to home and she said she would be waiting.</p> <p>During a telephone interview on 10/14/15 at 6:08 p.m., the resident's Aunt indicated the resident's Guardian had no phone and her (Aunt) number was the number they had to call, so they would not have spoken to the Guardian. She indicated the only way the Guardian would have been able to approve the discharge from the</p>			

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	<p>facility was for her to drive to the Guardian's house, 27 miles away, and tell her the resident was being discharged home. The Aunt indicated the facility did not give her an option and told her they were sending the resident home. The Aunt indicated the facility had not given the resident time to adjust to the facility and the resident's Guardian was elderly and in bad health. She indicated the resident resents the Guardian and because of this the Guardian was living in a shelter. She indicated the facility had not spoken to the Guardian about the discharge and the facility just said they were transferring him. The Aunt indicated she had not given the facility permission to discharge the resident.</p> <p>A facility policy, dated 01/15, received from the RN Corporate Consultant as current, titled, "Transfer/Discharge", indicated, "...When a transfer or discharge of a resident is proposed, whether intrafacility or interfacility, provision for continuity of care shall be provided by the facility...Prior to any interfacility...relocation, the facility shall prepare a relocation plan to prepare the resident for relocation and to provide continuity of care...The facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the</p>			

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	<p>facility..."</p> <p>A facility policy, dated 10/14, titled, "Abuse Prohibition, Reporting and Investigation", received from the Administrator as current, indicated, "...Neglect-Failure to provide goods and services necessary to avoid physical harm, mental and/or physical anguish or mental illness..."</p> <p>The immediate jeopardy that began on 09/28/15 was removed on 10/16/15 when the facility in-serviced administrative staff, nursing, and social services on Post Discharge Plan of Care, documentation of all efforts, and what efforts should be taken if the facility was unable to meet the resident's needs. The Administration will be responsible to notify the Regional Director and/or Nurse Consultant of all prospective discharges prior to the discharge from the facility and review all steps of the discharge planning. Continued compliance with the safe and appropriate discharge and transfer of each resident of the facility will be reported to the Quality Assurance Committee during monthly meetings. Staff were interviewed and were knowledgeable on what they were to do when a resident was being transferred, but the noncompliance remained at a lower scope and severity level of no actual harm with potential for</p>				

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F 0225 SS=D Bldg. 00	<p>more than minimal harm that was not immediate jeopardy because the facility had no further discharges to ensure policy and procedures had been followed.</p> <p>This Federal Tag relates to Complaint IN00184045.</p> <p>3.1-27(a)(3)</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> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or</p>			

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NAME OF PROVIDER OR SUPPLIER  GREEN-HILL MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 501 N LINCOLN AVE FOWLER, IN 47944
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	<p>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 record review and interview, the facility failed to investigate an injury of unknown origin, related to a laceration above the right eyebrow, for 1 resident reviewed for injuries in a total extended sample of 4. (Resident #K)</p> <p>Finding includes:</p> <p>Resident #K's record was reviewed on 10/15/15 at 9:15 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus and organic psychosis.</p>	F 0225	<p><b>PLEASE SEE ATTACHED ADDENDUM F225 483.13(c)(1)(ii)-(iii), (c)(2)-(4) Investigate/Report Allegations/Individuals</b></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 or 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</p>	11/06/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155743	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/16/2015
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	<p>A Nurses' Note, dated 09/25/15 at 5 a.m., indicated, "...Resident has a head injury, bleeding from (R) (right) eyebrow and left arm. refused assessment...911 called...resident transferred via cot...for evaluation of head injury..."</p> <p>A hospital Emergency Department note, indicated, "...report falling out of his bed and having 'something to drink last night'...Per RN...Pt (patient) was combative and aggressive with ECF (extended care facility) staff. According to EMS (emergency management system) patient answered all questions appropriately, until getting in the truck he became to act confused...closed head injury without concussion..."</p> <p>During an interview on 10/15/15 at 9:45 a.m., the DoN (Director of Nursing) indicated she was unaware of the head injury.</p> <p>During an interview on 10/15/15 at 10:20 a.m., the DoN indicated she was unable to find an investigation of the laceration.</p> <p>During an interview on 10/15/15 at 1 p.m., the Administrator indicated all injuries of unknown origin were investigated for a cause.</p> <p>3.1-28(d)</p>		<p>aide or other facility staff to theState nurse aide Registry of licensing authorities. Thefacility must ensure that all alleged violations involving mistreatment,neglect, or abuse, including injuries of unknown source and misappropriation ofResident property are reported immediately the Administrator of the facilityand to other officials in accordance with State law through establishedprocedures (including to the State survey and certification agency). The facilitymust have evidence that all alleged violations are thoroughly investigated, andmust prevent further potential abuse while the investigation is in progress. Therresults of all investigations must be reported to the Administrator or his/herdesignated representative and to other official in accordance with State law(including to the State survey and certification agency) within 5 working daysof the incident, and if the alleged violation is verified appropriatecorrective actions must be taken.</p> <p><b>1.Whatcorrective actions will be accomplished for those Residents found to have beenaffected by the deficient practice?</b></p> <p>Resident#K was transferred to the hospital on 10-01-2015 and at this time remains atthe hospital. An investigation has been completed regarding the injury</p>		

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			<p>of unknown origin.</p> <p><b>1. How other Residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</b></p> <p>Each resident was assessed by the Director of Nursing or Designee to ensure that no other resident has an injury of unknown source. There were no other residents identified with injury of unknown origin.</p> <p><b>1. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</b></p> <p>The facility will conduct re-education and an in-service for the staff. The content will include information pertaining to adequate completion of an "incident/accident" report, investigation of injury of unknown source, and proper notification of administrator and or his designated representative of any injury of unknown source. Any report or identified injury of unknown source will be thoroughly investigated by the Director of Nursing and or Designee. The Administrator will ensure that any injury of unknown source is properly investigated and further reported (if warranted) in accordance with State law.</p> <p><b>1. How the corrective action(s) will be monitored to ensure the</b></p>	

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F 0226 SS=D Bldg. 00	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 record review and interview, the facility failed to follow their abuse policy, related to reporting an injury and investigating an injury of unknown origin, related to a laceration above the right eye brow, for 1 resident reviewed	F 0226	<b>deficient practicewill not recur, i.e., what quality assurance program will be put into place and</b> All reports of, or identified injury of unknown source will be tracked using the tracking log, should a concern be noted, immediate corrective action will occur. The documentation regarding the investigation of the injury of unknown source will be maintained by the Director of Nursing and or the Administrator or Designee. The tracking will be completed on an ongoing basis for a minimum of 6 months. The results of these reviews, any concerns noted, and any corrective actions will be discussed during the facility's QA meetings and the plan adjusted if indicated. <b>5.) By what date the systemic changes will be completed 11-06-2015</b>  <b><u>F 226 483.13(c)</u></b> <b><u>Develop/Implement abuse/neglect, etc. policies</u></b> The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of Residents and	11/06/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155743	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/16/2015
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	<p>for injuries in an extended sample of 4. (Resident #K)</p> <p>Finding includes:</p> <p>Resident #K's record was reviewed on 10/15/15 at 9:15 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus and organic psychosis.</p> <p>A Nurses' Note, dated 09/25/15 at 5 a.m., indicated, "...Resident has a head injury, bleeding from (R) (right) eyebrow and left arm. refused assessment...911 called...resident transferred via cot...for evaluation of head injury..."</p> <p>A hospital Emergency Department note, indicated, "...closed head injury without concussion..."</p> <p>During an interview on 10/15/15 at 9:45 a.m., the DoN (Director of Nursing) indicated she was unaware of the head injury.</p> <p>During an interview on 10/15/15 at 10:20 a.m., the DoN indicated she was unable to find an investigation of the laceration.</p> <p>During an interview on 10/15/15 at 1 p.m., the Administrator indicated all injuries of unknown origin were</p>		<p>misappropriation of Resident property.</p> <p><b>1. What corrective actions will be accomplished for those Residents found to have been affected by the deficient practice?</b></p> <p>Resident #K was transferred to the hospital on 10-01-2015 and at this time remains at the hospital. The incident has been reported and an investigation has been completed regarding the injury of unknown origin.</p> <p><b>1. How other Residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</b></p> <p>Each resident was assessed by the Director of Nursing or Designee to ensure that no other resident has an injury of unknown source. There were no other residents identified with injury of unknown source.</p> <p><b>1. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</b></p> <p>To ensure the deficient practice does not recur, the facility will conduct re-education and an in-service for the staff, including the administrative staff.</p>	

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	<p>investigated for a cause.</p> <p>A facility policy, dated 10/14, titled, "Abuse Prohibition, Reporting and Investigation", received from the Administrator as current, indicated, "...This facility will ensure that all alleged violations...including injuries of unknown source..are reported immediately to the administrator of the facility..."</p> <p>A facility policy, dated 01/15, titled, "Unusual Occurrences", received from the Administrator as current, indicated, "...The facility shall ensure all alleged violations involving...injuries of unknown source...are reported immediately to the Administrator...A complete investigation of the said unusual occurrence shall be conducted by the Administrator..."</p> <p>3.1-28(a)</p>		<p>The content will include information pertaining to adequate completion of an "incident/accident" report, investigation of injury of unknown source, and proper notification of administrator and or his designated representative of any injury of unknown source, and following facility abuse policies related to reporting an injury and investigating an injury of unknown source. Any report or identified injury of unknown source will be thoroughly investigated by the Director of Nursing/Administrator and or Designee. The Administrator will ensure that any injury of unknown source is properly investigated and further reported (if warranted) in accordance with State law.</p> <p><b>1. 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 and</b></p> <p>All reports of or identified injury of unknown source will be tracked using the tracking log, should a concern be noted, immediate corrective action will occur. The documentation regarding the investigation of the injury of unknown source will be maintained by the Director of Nursing and or the Administrator or Designee. The tracking will be completed on an ongoing basis</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155743	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/16/2015
NAME OF PROVIDER OR SUPPLIER  GREEN-HILL MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 501 N LINCOLN AVE FOWLER, IN 47944		
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F 0250 SS=D Bldg. 00	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on record review and interview, the facility failed to provide medically related Social Services for a resident with a mental health disorder and behaviors, related to no discharge planning with obtaining in or out patient mental health services for 1 of 7 residents reviewed for transfer/discharges in a total sample of 7 and extended sample of 4. (Resident #C)</p> <p>Finding includes:</p> <p>Resident #C's record was reviewed on 10/14/15 at 2:55 p.m. The resident's diagnoses included, but were not limited to, schizophrenia, intellectual disability, and diabetes mellitus. The resident was admitted into the facility on 09/25/15 from home.</p>	F 0250	<p>for a minimum of 6 months. The results of these reviews, any concerns noted, and any corrective actions will be discussed during the facility's QA meetings and the plan adjusted if indicated.</p> <p><b>5.) By what date the systemic changes will be completed</b> 11-06-2015</p> <p><b><u>Please note provider desires to IDR F224 please see uploaded documents F250 483.15(g)(1) Provision of Medically Related Social Services</u></b></p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each Resident</p> <p><b>1. What corrective actions will be accomplished for those Residents found to have been affected by the deficient practice?</b> Resident #C was discharged from the facility on 09/28/2015. Resident # C remains discharged at this time, and to the knowledge of the facility, remains in the care of his</p>	11/06/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155743	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/16/2015
NAME OF PROVIDER OR SUPPLIER  GREEN-HILL MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 501 N LINCOLN AVE FOWLER, IN 47944		
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	<p>A Court Document, dated 02/23/13, titled, "Order Appointing Guardian Over Person of Incapacitated Person", and signed by the Circuit Court Judge, indicated, "...Indiana Code have been satisfied, and (Guardian's Name) is entitled to be guardian of the person...and is so appointed without any limitations as to her duties, responsibilities, or powers... (Resident Name) by reason of his incapacity is unable to care for his person and is therefore adjudicated to be an incapacitated person, and the appointment of a guardian over his person is necessary..."</p> <p>The Pre-Admission Screening, dated 09/23/15, indicated the resident's diagnoses were, residual schizophrenia, "mild mental retardation", diabetes, hypertension, amputation of the left leg and a history of seizures. The resident was living with the Guardian, who was elderly and was unable to handle the resident's Activity of Daily Living (ADL's) and was overwhelmed by the resident's care. The screen indicated the resident had no reported fears, but could display anxiety when in new situations or meeting new people and would adjust to changes with time for the transition and the resident was stable when on the prescribed medications consistently and</p>		<p>family.</p> <p><b>1.Howother Residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken?</b></p> <p>Everyresident that discharges from the facility has the potential to be affected bythe same deficient practice. The facility conducted staff education (includingadministrative staff) regarding ensuring residents are discharged from thefacility in a safe and orderly manner. The education included informationregarding providing preparation to ensure that the plan for safe and adequatedischarges/transfers/relocations is accomplished according to facilitypolicies, ensuring that the residents have outside assistance, any othermedically related social services appropriate to their care needs, andfamily/responsible parties/legal representatives are adequately notified.</p> <p><b>1. What measures will be put into place or whatsystemic changes will be made to ensure that the deficient practice does notrecur.</b></p> <p>Thefacility staff has been instructed to notify the Regional Director and or theRegional</p>		

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	<p>he eats appropriately but was unable to care for those things himself. The screening indicated the resident was noncompliant with medication and diet and the resident was unable to care for his own ADL's. The resident's ability to participate in ADL care had declined and he required meals to be set up and assistance with toileting and hygiene. The screen indicated the resident and the Guardian's relationship was strained and his behaviors were directed toward the Guardian and the resident was not considered a danger to self or others, but was at risk due to inconsistent self-administration of medications. The screen indicated the resident had a right leg amputation and could only walk for short distances. The Screening indicated the Physician recommended a long-term nursing facility due to home care was not safe or feasible regarding the resident's health and safety.</p> <p>A care plan, dated 09/24/15 (sic, should be 09/25/15), indicated the resident had diagnoses of MR (mental retardation) and schizophrenia and may exhibit agitation, physical aggression, verbal aggression, and playing with feces. The interventions included psychiatric care, psychiatric medications as ordered, ensure all needs are met, encourage activities of interest, and assist resident in problem solving any</p>		<p>Nurse Consultant prior to any future discharge of a resident. Prior to the discharge, The Regional Director and or the Regional Nurse Consultant will go over the steps with the staff to ensure the discharge is being conducted in a safe and orderly manner, that outside assistance (if required) are set up and, any other medically related social services are provided and, that appropriate notifications and planning has been accomplished prior to the discharge of the resident.</p> <p><b>1. 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 and</b></p> <p>The facility will initiate the use of a tracking form on an ongoing basis for a minimum of six months. Residents that are being discharged from the facility will be reviewed. The tracking form will be "checked-off" indicating that all steps have been completed to ensure that each resident discharged was completed in a safe and orderly manner, and appropriate notifications and planning accomplished. Should concerns be noted, immediate corrective action will occur. Results of these reviews, any noted concerns, and any corrective actions will be discussed during the facility's QA</p>	

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NAME OF PROVIDER OR SUPPLIER  GREEN-HILL MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 501 N LINCOLN AVE FOWLER, IN 47944			
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	<p>issues.</p> <p>A care plan, dated 09/25/15 indicated the resident required long term care placement due to needing 24 hour supervision and the resident's family was unable to meet the needs of the resident. The interventions included, "Discharge plan will (sic) reviewed and updated as needed, Encourage resident to continue to live in the nursing home due to the need for 24 hour supervision for health and safety, safe mobility and transfers, assistance with ongoing health issues, and assistance with personal care and all other daily living tasks, Provide one-to-one services as needed to assist with adjustment issues if the resident desires to discharge but this goal was unobtainable.</p> <p>A care plan, dated 09/25/15, indicated, Adjustment to new environment. The interventions included, provide frequent visits to ensure that resident was not exhibiting any signs or symptoms of depression and provide activities of choice and interest.</p> <p>The Social Service Admission Note, dated 09/25/15, indicated the resident's (Guardian) could no longer provide care for the resident, the resident's appearance was unkept, cognitive status was alert</p>		<p>meetings and the plan adjusted as indicated.</p> <p><b>1.By what date the systemic changes will be completed</b></p> <p>11-06-2015.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155743	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  10/16/2015
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NAME OF PROVIDER OR SUPPLIER  GREEN-HILL MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 501 N LINCOLN AVE FOWLER, IN 47944
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	<p>and impaired, and the resident walked independently with a walker. The Discharge planning indicated the resident lived with the Guardian, who could no longer provide care to the resident and long term placement was needed</p> <p>The Nurses' Progress Notes indicated:</p> <p>09/28/15 at 8:30 a.m.- "Res (resident) arguementive (sic) c(with)/ writer this a.m. re: (about) meds (medication)...grabbed my arm and started to twist it I pulled away then he grabbed the med card et tried to take them away from me...grabbed the med card away before he could take it. He did agree to take medication. Behavior sheet done."</p> <p>09/28/15 at 3:20 p.m.- "CNA's x 2 attempting to give (Name) a shower when he began yelling out very loudly-stated leave me alone- Res has a prosthetic leg and began to beat the CNA with it- 2 RN's- writer and ADM (Administrator) (Name) present by this time...once in his room began yelling out get of here this is my room. Gave (Name) Haldol (anti-psychotic) IM (intramuscularly) after he agreed to that. Place call to (Physician's Name) received new orders to send to home c/ meds et Home Health Care."</p>			

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	<p>09/28/15 at 4:10 p.m.- "Has agreed to smoke cigarette c/ supervision away from nrsg (nursing) home population. Calmed down went to his rm (room). No further agitation @ this time...w/c (wheelchair) van to p/u (pick up) at 6:30 p.m."</p> <p>09/28/15 6:40 p.m., late entry for 09/28/15 at 4:15 p.m.- "Writer @ facility requested to assist c/ this agitated res. Res in his rm @ the time, calming after becoming agitated with shower...res initially agreed c/ shower et things were 'going well' then res 'just switched' got angry et agitated...res allowed 1 nurse to attend to needs...Res demanding to be allowed to go home et even during periods when he was not angry et talking rationally stating he wants to go home, does not need to be here...HFA (Healthcare facility Administrator) made phone call to (Guardian) 0/ (no) answer. Call made to res Aunt. Aunt in agreement c/ res orders...to discharge home c. home health."</p> <p>Social Service Progress Notes, indicated:</p> <p>09/27/15 (no time documented), "Resident became aggressive c/ CNA when CNA tried to clean resident up after BM (bowel movement). Resident also became aggressive when CNA tried to</p>			

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NAME OF PROVIDER OR SUPPLIER  GREEN-HILL MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 501 N LINCOLN AVE FOWLER, IN 47944
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	<p>get cigarettes and matches back from resident after several interventions resident calmed."</p> <p>09/28/15 (no time documented), "Resident was punching and kicking doors, yelling at CNA. Resident was smearing/playing in feces. While CNA was giving care, resident attempting to smear feces on staff, hitting kicking and trying to hit staff c/ prosthetic leg. Will start referral process for inpatient mental health services."</p> <p>09/28/15 (no time documented), "Spoke with resident's (Guardian) in regard to resident's behaviors. (Guardian) has asked that resident be transported back to her home and in her care. Transportation arranged...Home Health Services (Name) were initiated."</p> <p>A Physician's Order, dated 09/28/15 at 4 p.m., indicated to discharge the resident to home with medications and home health care.</p> <p>Home Discharge Instructions, dated 09/28/15, indicated the resident was discharged from the facility to home, the discharge medications were listed, and the form was signed by the nurse. The form lacked a signature the instructions had been provided to the Guardian. The</p>			
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	<p>Notice of Transfer or Discharge, dated 09/28/15, indicated the transfer or discharge was necessary to meet the resident's welfare and the resident's needs could not be met in the facility.</p> <p>During an interview on 10/14/15 at 3:50 p.m., the RN Corporate Consultant indicated she was unsure who received the discharge instructions but the written instructions were sent with the resident.</p> <p>The Facility Discharge Summary, dated 09/28/15, indicated the resident was belligerent and aggressive with the staff, the resident demanded to return home, the family was contacted and the family agreed to the discharge.</p> <p>During an interview on 10/14/15 at 3:15 p.m., the Social Service Director indicated the resident only had behaviors one day and the Administrator had ordered her to contact inpatient mental health facilities. The Social Service Director indicated she had notified two different mental health facilities and both said they would not admit the resident due to his payor status. The Social Service Director indicated the Administrator informed her the resident's family had requested the resident be discharged to home, so she telephoned the resident's Guardian and told her what</p>			

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	<p>time the resident would be transferred. The Social Service Director indicated her understanding was the Guardian wanted the resident discharged to home. She indicated the Ombudsman had not been notified. The Social Service Director indicated she had faxed the information to the in-patient facilities, but did not have copies of the fax or the fax acknowledgement from the facilities. She indicated she had not documented the referral information. The Social Service Director indicated when the resident was admitted the Guardian had informed her she had no telephone and the facility would need to call the resident's Aunt and the Aunt would get a hold of her. The Social Service Director indicated the resident had been referred to a home health agency (Name provided).</p> <p>During an interview with the Social Service Director, 10/14/15 at 3:50 p.m., she indicated when she calls for a referral for in-patient therapy, she talks to whoever answers the phone and she was unsure who she spoke with for the referrals for in-patient therapy.</p> <p>During a telephone interview on 10/14/15 at 4:30 p.m., the Supervisor at the home health agency indicated they were notified on 09/28/15 of the resident in</p>			

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	<p>need of home health care. She indicated she had informed the Administrator the resident would need prior approval before they could accept him for care due to the skilled services needed and it would take a few days to get the approval. The Supervisor indicated he would refer the resident to another agency. The Supervisor indicated the home health services called the facility again on 09/30/15 and informed the Administrator they were unable to accept the resident and offered to assist in finding home health care for the resident and the Administrator declined the offer for assistance. She indicated the Administrator had not informed her the resident had already been discharged from the facility.</p> <p>During a telephone interview on 10/14/15 at 4:40 p.m., the Care Coordinator at In-Patient facility #1 indicated they had received a call about a referral and had asked the facility to fax the information to them and they had not received a fax from the facility. The Care Coordinator indicated if the paper work had been faxed they would have followed up with the facility and documented the follow up, and there was no documentation to indicated the facility faxed information.</p> <p>During a telephone interview on 10/15/15</p>			

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	<p>at 8:50 a.m., the Assessment Department at In-Patient facility #2 indicated the facility had not received a referral for the resident. She indicated the In-Patient facility normally does not take patients from a long term nursing facility. She indicated had a referral been called, they would have talked to the resident, and there was no documentation to indicate they had spoken with the resident.</p> <p>During an interview on 10/14/15 at 3:50 p.m., the Social Service Director indicated she had spoke with the resident's Guardian and gave her the time the transportation would arrive to discharge the resident to home and she said she would be waiting.</p> <p>During a telephone interview on 10/14/15 at 6:08 p.m., the resident's Aunt indicated the resident's Guardian had no phone and her (Aunt) number was the number they had to call, so they would not have spoken to the Guardian. She indicated the only way the Guardian would have been able to approve the discharge from the facility was for her to drive to the Guardian's house, 27 miles away, and tell her the resident was being discharged home. The Aunt indicated the facility did not give her an option and told her they were sending the resident home. The Aunt indicated the facility had not given</p>			

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	<p>the resident time to adjust to the facility and the resident's Guardian was elderly and in bad health. She indicated the resident resents the Guardian and because of this the Guardian was living in a shelter. She indicated the facility had not spoken to the Guardian about the discharge and the facility just said they were transferring him. The Aunt indicated she had not given the facility permission to discharge the resident.</p> <p>A facility policy, dated 01/15, received from the RN Corporate Consultant as current, titled, "Transfer/Discharge", indicated, "...When a transfer or discharge of a resident is proposed, whether intrafacility or interfacility, provision for continuity of care shall be provided by the facility...Prior to any interfacility...relocation, the facility shall prepare a relocation plan to prepare the resident for relocation and to provide continuity of care...The facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility..."</p> <p>This Federal Tag relates to Complaint IN00184045.</p> <p>3.1-34(a)</p>			

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F 0323 SS=D Bldg. 00	<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 review and interview, the facility failed to ensure a resident had adequate supervision and exiting from the building without supervision was thoroughly investigated, related to a resident leaving the facility unattended for 1 resident reviewed for elopement in a total extended sample of 4. (Resident #K)</p> <p>Finding includes:</p> <p>Resident #K's record was reviewed on 10/15/15 at 9:15 a.m. The resident's</p>	F 0323	<p><b><u>F323 483.25(h) Free of Accident Hazards/Supervision/Devices</u></b> 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.</p> <p><b>1. What corrective actions will be accomplished for those Residents found to have been affected by the deficient practice?</b></p> <p>Resident #K was transferred to</p>	11/06/2015
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	<p>diagnoses included, but were not limited to, diabetes mellitus and organic psychosis.</p> <p>A care plan, dated 09/29/15, indicated the resident had been found to be at risk for elopement due to exit seeking behaviors. The interventions included, redirections, encourage participation in activities of choice.</p> <p>Nurses' Notes indicated: 09/24/15 at 12 p.m.- "Res (resident) arrives to facility...alert but confused...compelled to wander..."</p> <p>09/29/15 no time documented- "...Res roams halls and exit seeks. Res enters others rooms not always easily redirected...placed on 15 min (minute) checks."</p> <p>Mood and Behavior Communication Memo's indicated: 09/29/15 at 1 a.m.- "...Resident went out the front door said he was going out to have a beer. Resident said we could call the cops he wasn't coming in..."</p> <p>09/29/15 (no time documented) -"Exit-Seeking. Trying to go out the employee entrance..."</p> <p>The 15 minute checks, dated 09/29/15,</p>		<p>the hospital on 10-01-2015 and at this time remains atthe hospital. The facility continues to assist the hospital to find placementfor this resident in a secured dementia environment as recommended by a mentalhealth clinician.</p> <p><b>1.Howother Residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken?</b> Each resident with exitseeking tendencies have been assessed by the Director of Nursing to ensure thatthey have not, or are not exiting the building without adequate supervision. Therewere no other residents identified with exiting behaviors at this time.</p> <p><b>1.Whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur.</b> The facility willconduct re-education and an in-service for the staff. The content will includeinformation pertaining providing adequate supervision to residents with exitseeking behaviors, what to do if a resident does elope, who and when to reportan elopement and how to appropriately assess a resident that has been locatedfollowing an occurrence of elopement. Any report of elopement will</p>		

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	<p>indicated at 9:15 p.m. the resident was located "other" and walking.</p> <p>An Indiana State Department of Health (ISDH) incident, dated 09/29/15 at 9:15 a.m., indicated, "Resident fond walking outside by staff members. Staff returned resident inside...Provider believes Residents (sic) was outside less than 5 minutes. Doors were all checked and were secure."</p> <p>An investigation, dated 09/30/15, indicated the staff on duty determined the resident exited the facility at the north entrance door and proceeded south where RN #4 found him and returned the resident back inside the facility.</p> <p>The Mood and Behavior Communication Memo, dated 09/29/15 at 9:35 p.m., indicated the resident was exit seeking, and was attempting to leave out the front door, a CNA intercepted and began interventions of walking with resident, one on one, and redirection, and the resident's behavior was unchanged. The form indicated the resident was attempting to leave through the employee exit and had pushed the CNA outside of the door with him, the CNA was able to get the resident back into the building and the resident then went out the door by the office (north door).</p>		<p>beimmediately reported to the Administrator and or his representative. Allelopement events will be thoroughly investigated by the Administrator/ Directorof Nursing and or Designee. TheAdministrator will ensure that any resident elopement is properly investigatedand further reported in accordance with State law.</p> <p><b>1.Howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place and</b></p> <p>All reports of residentelopement will be properly reported and investigated. Should a concern be noted, immediatecorrective action will occur. The documentation regarding the investigationwill be maintained by the Director of Nursing and or the Administrator or Designee.The Quality Assurance Team shall be presented with theinformation/investigation, results of the investigation pertaining to allresident elopement events since the last meeting, any noted concerns, and anycorrective actions. The Quality Assurance Team shall review the documentationto ensure proper investigation completed and further reporting done asnecessary in accordance with State law on an ongoing basis for a minimum of 6months.</p>		

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	<p>During an interview on 10/15/15 at 9:40 a.m., the RN Nurse Consultant indicated the resident had exited the building but the staff always were able to see him.</p> <p>During an interview on 10/15/15 at 10:45 a.m., Nursing Assistant (N.A), who had worked on 09/29/15, indicated the resident had seen staff coming in from the employee entrance and the resident went through the double doors to the entrance. She indicated he did not get outside until he pushed her through the door and they were both standing on the back step. She indicated the resident was never out of her sight. She indicated another time, the had walked out the door by the office and walked around to the front of the building and the nurse found him outside.</p> <p>During an interview on 10/15/15 at 10:55 a.m., RN #4 indicated the resident had been going in and out and someone had been walking with him and said he had been outside, but she could not remember who the employee was who told her. She indicated when she was told he was outside, she may had been busy, so was unsure who brought him back in.</p> <p>During an interview on 10/15/15 at 10:10 a.m., the Administrator indicated he had</p>		<p><b>5.) By what date the systemic changes will be completed</b> 11-06-2015</p>	

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	<p>seen the memo of the elopement and interviewed N.A. #5 and N.A. #5 indicated no one had seen the resident leave the building. He indicated no other staff were interviewed. The Administrator indicated he was notified of the elopement on 09/30/15 when he read the behavior form.</p> <p>A facility policy, dated 10/14, titled "Accident and Incident Reporting", received from the RN Consultant as current, indicated, "...Administrative personnel must be notified immediately of the following occurrences:...Resident Elopement..."</p> <p>A facility policy, dated 10/14, titled, "Elopement (Missing/wandering Resident)", received from the RN Consultant as current, indicated, "...Upon re-location of the missing resident...At a minimum, the following must occur:Assess the appropriateness of current room location...Initiate one-on-one supervision or every fifteen minute checks dependent upon the resident's demeanor and exit-seeking behavior..."</p> <p>3.1-45(a)(2)</p>			

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