STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155635		07/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE HEALTH CARE FACILITY	337 GRACE VILLAGE DR WINONA LAKE, IN 46590

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: July 7, 8, 9, 10, 13, 14, 15, 2015 Facility number: 000501 Provider number: 155635 AIM number: 100266260 Census bed type: SNF: 14 SNF/NF: 70 Residential: 51 Total: 135 Census Payor type: Medicare: 13 Medicaid: 42 Other: 80 Total: 135 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	Submission and implementation of this plan of correction shall not constitute an admission by Grace Village Health Care to any allegations of deficiency as contained in the "Summary Statement of Deficiencies" or agreement with any inferences therein, rather, this plan is submitted in accordance with State and Federal requirements Facility requests paper compliance with this Plan of Correction	
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			

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

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

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	residents and misappropriation of resident property. Based on interview and record review, the facility failed to ensure the Administrator was notified immediately in regard to an alleged allegation of abuse. This deficiency affected 1 of 3 reported alleged allegations of abuse reviewed (Resident #107). Findings include: On 7/10/15 at 9:30 A.M. 3 reports of alleged allegations were received from the Director Of Nursing (DON) and reviewed. One report of alleged allegation indicated on 4/19/15 at 9:00 P.M., Resident #107 had spoken to LPN #2 "...during the evening medication pass, 'The morning helper is very rude and 'smart'. Resident (Resident #107's name) calls this girl 'smarty or smart butt.' Resident (Resident #107's name) reported this girl is rough with her and her roommate during morning care...." The alleged allegation of abuse report further indicated "Immediate action taken: (CNA #1's name) is not scheduled to work again until Wednesday 4/22/15. (LPN #2's name) told administrative staff first thing Monday, 4/20/15, morning. (CNA # 1's name) is placed on 3 day suspension while investigation is completed...."	F 0226	**F226 –Develop/Implement Abuse/Neglect Policy** I. Corrective Action Taken For Affected Residents: No residents were adversely affected due to staff not immediately notifying the Health Care Administrator. The abuse allegation investigation was conducted for Resident #107 in accordance with State requirements and by facility policy (other than the immediate notificationof the Administrator.) The allegation was found to be unsubstantiated. II. How Other Resident Potentially Affected Will Be Identified: No other residents were involved in the allegation, however, other residents who received care from the CNA named in the allegation were interviewed as part of the investigation. None of those residents voiced any concerns with their treatment by staff. III. Measures Implemented To Ensure Deficiency Does Not Recur: The nursing staff has been given an additional in-service on the abuse policy with special attention to immediate notification of the Health Care Administrator and to the Director of Nursing or Assistant Director of Nursing. The phone number to reach the Administrator for immediate notification has been provided at each at each nurse's station. The	08/14/2015

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	The most current undated Abuse Policy and Procedures was received from the DON and reviewed on 7/10/15 at 9:30 A.M., indicated "...The Administrator, Social Services and DON shall be notified of the incident immediately." "... If you suspect any type of abuse or neglect is occurring, it is very important that you report it immediately...." Interview on 07/10/2015 10:37 A.M., with the DON indicated on 4/19/15 at 9:00 P.M., when Resident #107 had complained to LPN #2 about CNA #1 being allegedly rough and verbally rude, LPN #2 should have contacted the Administrator immediately. On 07/13/2015 at 1:18 P.M. an interview with LPN #2 indicated, since CNA #1 had already gone home for the day and was not working again until the end of the week, that Resident #107 was safe. That was the reason LPN # 2 did not call the Administrator. LPN #2 indicated she should have called the Administrator when Resident #107 had complained to LPN #2 the evening of 4/19/15 and reported that CNA #1 had been allegedly rough with Resident #107 the morning of 4/19/15. 3.1-28(c)		abuse policy has been revised to include clarification regarding notification (i.e. text message or voicemail). The annual abuse prevention in-services for all employees will stress notification to the Administrator and will include the aforementioned policy revision. (See Att_AA for revised policy and Att_B for in-service log) IV. How Corrective Measures Will Be Monitored To Ensure They Are Effective and Sustained: All allegations of abuse are reviewed in quarterly QA Committee meetings. The QA Committee will review the documentation of any reportable occurrence for the quarter and verify that it shows the Administrator was notified immediately in each case. Specific review for Administrator notification will continue for at least 4 consecutive QA Committee meetings. If there are any reports on which it is found that the Administrator was not immediately notified, additional staff training and disciplinary action (if appropriate) will be applied. Such monitoring will continue until 100% compliance is consistently demonstrated for 12 months.	

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F 0282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview and record review, the facility failed to follow a health care plan for fall prevention for 1 of 3 residents (#23) reviewed for falls. Findings include: On 7/8/15 at 9:35 AM, an interview with the Assistant Director of Nursing (ADON) indicated Resident #23 had a fall on 6/10/15 in her room out of her recliner which resulted in a bruise to her face. Review of a health care plan, updated on 6/11/15, for falls related to a fall in the past 30 days indicated one of the staff interventions was to keep the call light in reach. Observations of Resident #23 in her room were made on 7/13/15 at: 1:34 P.M.; 2:47 P.M.; and 3:15 P.M.. On each observation, the resident was sitting in her wheelchair and her call light was on an over-the-bed table, out of reach of the resident. On the observation on 7/13/15	F 0282	**F282 Services By Qualified Persons/Care Plan** I. Corrective Action Taken For Affected Residents: When it was pointed out to the nurse on duty that Resident #23's call light was not within her reach, the nurse immediately made the correction. II. How Other Residents Potentially Affected Will Be Identified: All residents would potentially be affected by not having their call lights within reach. Keeping call lights in reach of residents is considered to be a standard. No other residents were noted to have been found without their call lights within reach. III. Measures Implemented To Ensure Deficiency Does Not Recur: Department orientation checklists for newly hired Certified Nursing Assistants (CNAs) and licensed nurses include training for the use of the call light system. Existing CNAs will receive remedial training and then be required to show competency with the placement of call light buttons. This skills check off will also be conducted on an annual basis. A licensed nurse will supervise the	08/14/2015

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	at 3:15 P.M., LPN #10 also observed Resident #23 and indicated the call light was out of reach and should have been within reach for the resident. 3.1-35(g)(2)		check offs and verify competency in all required areas. A skills check off will be required for all newly hired CNAs. They must demonstrate that they know and understand all the procedures pertaining to use of the call system including proper placement of call light buttons within reach of residents. (See Att_C for checklist and covered material) IV. How Corrective Measures Will Be Monitored To Ensure They Are Effective And Sustained: The Director of Nursing, or her designee, will conduct a daily inspection of at least 5 resident rooms for one month to verify that each resident has their call light within reach. Weekly inspections will be made for the following two months and random inspections thereafter for a minimum of six months will continue. A log and report on the results of the inspections will be provided to the quarterly QA Committee meeting. Monitoring must continue according to this plan until 100% compliance is sustained. The QA Committee will review the corrective measures and recommend additional steps if 100% compliance is not met within six months. (See Att_D for monitoring logsheet)	
F 0431 SS=D Bldg. 00	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the			

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	services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.			
	Based on observation, interview, and record reviews, the facility failed to ensure Lantus insulin (diabetic medication) was discarded after opened for 28 days. This deficiency affected 1 of 3 medication carts reviewed (Hall 2).	F 0431	**F431 Drug Records,Label/Store Drugs and Biologicals** I. Corrective Action Taken For Affected Residents: The remainder of the expired insulin was discarded. Resident #50 was observed and no side effects from receiving the outdated dose of insulin were evident. II. How	08/14/2015

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	Findings include: On 7/14/15 at 1:00 P.M. with LPN #3, the top drawer of the medication cart contained a vial of lantus insulin, dated as opened on 6/8/15. Interview with LPN # 3 indicated she had given Resident #50 the lantus insulin from this vial that morning. An undated document from the Facility's Pharmacy, received from the Assistant Director Of Nursing on 7/14/15 at 2:30 P.M., indicated for Lantus insulin "...Discard 28 days after initial use or removing from refrigeration." 3.1-25(o)		Other Residents Potentially Affected Will Be Identified: All other residents taking insulin were identified and their pens or vials audited to ensure they were within acceptable usage dates. III. Measures Implemented To Ensure Deficiency Does Not Recur: A new policy was written and added to the nursing policy and procedure manual to correspond with pharmacy guidelines for proper handling and administration of insulin. All nurses are being in-serviced on the policy and it will be included in new nurse orientations. A staff member has been designated to conduct bi-weekly audits of insulin pens and vials as a permanent responsibility. (See Att_E for new policy and Att_F for in-service logsheet) IV. How Corrective Measures Will Be Monitored To Ensure They are Effective and Sustained: The facility pharmacy routinely audits the medication carts once per month. The Director of Nursing, or her designee, will audit the insulin pens' and vials' “date opened” stickers to ensure that there are no expired insulins in use. The audits will be conducted on a weekly basis for 3 months and a bi-weekly basis for at least 3 months subsequent to that. The Director of Nursing will provide a report on the results of the audits at the quarterly QA Committee Meetings. Monitoring shall continue until 100%	

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			compliance is maintained for three consecutive months. The QA Committee will determine any additional or modified corrective measures to be implemented if 100% compliance is not attained by the end of 6 months of these corrective measures. (See Att_G for monitoring logsheet)	