

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/30/2013
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NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
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F000000	<p>This visit was for a Recertification and State Licensure survey.</p> <p>Survey dates: September 23, 24, 25, 26, 27, 30, 2013</p> <p>Facility number: 000501 Provider number: 155635 AIM number: 100266260</p> <p>Survey Team: Carol Miller RN, TC Diane Nilson RN Rick Blain RN Timothy Long RN</p> <p>Census Bed Type: SNF/NF: 70 SNF: 14 Residential: 44 Total: 128</p> <p>Census Payor Type: Medicare: 18 Medicaid: 38 Other: 72 Total: 128</p>	F000000	Submission and implementation of this plan of correction shall not constitute an admission by Grace Village Health Care to any allegations of deficiency as stated in the "Summary Statement of Deficiencies" or an agreement with any conclusions therein. Rather, this plan is submitted in accordance with State and Federal requirements.	

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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	<p>Residential sample: 7</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed on October 4, 2013, by Brenda Meredith, R.N.</p>			
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F000157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to report a significant change in weight to a physician in a timely manner, for 1 of 3 residents reviewed for weight loss.</p>	F000157	CORRECTIVE ACTIONS TAKEN: Resident #109 was discharged to home on April 26, 2013 after a successful rehabilitation. Administration would note that Resident #109	10/30/2013	

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	<p>Resident #109</p> <p>Finding includes:</p> <p>Resident #109's clinical record was reviewed on 9/24/13 at 11:00 A.M. The record indicated the resident was admitted to the facility on 4/6/13, for rehabilitation following a knee replacement. Resident #109's initial weight on 4/6/13, was 198 pounds (lbs).</p> <p>On 4/7/13, Resident #109's weight was 196.8 lbs. On 4/8/13, Resident #109's weight was 194.6 lbs. On 4/15/13, Resident #109's weight was 188.2 lbs.</p> <p>On 4/10/13, a nutrition assessment indicated the resident's weight was 194.6 lbs, height 67" and body mass index (BMI) was 30.4. The assessment indicated the resident's normal weight was near 190 lbs and the resident was able to feed herself with no chewing or swallowing problems and was consuming 75-100% of meals. The nutrition assessment noted a right knee incision with some swelling. Resident #109 was noted to be a risk for weight loss related to recent knee surgery with swelling and diabetes mellitus. The resident's goal weight was</p>		<p>was seen by her physician during his routine facility visit on April 12, 2013 and made no dietary recommendations/changes despite the documented weight loss. Resident #109 stated she was pleased with her weight loss.</p> <p>OTHER RESIDENTS POTENTIALLY AFFECTED: Charts of all residents are under review to determine if any other current residents have had significant weight losses or gains during the past 6 months without physician notification. If any required notifications are found to have been missed, the notifications will be made, documented and followed up on by the NAR Committee.</p> <p>MEASURES IMPLEMENTED TO PREVENT REOCCURRENCE: The facility policy on "Notification to Physicians" has been reviewed and revised to stress that significant weight changes require physician notification. The "Weighing Residents" policy has been reviewed and revised to clarify what constitutes a significant weight change. All nurses will be in-serviced on the revised policies, which includes the timeframe in which physician notification is to occur. A permanent procedure has been adopted to ensure that physicians have been notified of any significant weight changes, conducted by the Unit Manager (UM) as part of her routine weekly audits. The UM will be</p>		

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	<p>assessed to be below 198 lbs.</p> <p>On 4/11/13, a health care plan for risk for weight loss was started. The goal was to maintain weight with 5 lbs of current weight of 198 lbs.</p> <p>On 9/25/13 at 2:00 P.M., an interview with the Dietitian indicated RN #1, the restorative nurse, brings the weight book to weekly nutrition at risk (NAR) meeting. The Dietitian noted she attended the weekly NAR meetings along with RN #1 and the dietary manager. She indicated she did not know what occurred with Resident #109 at the NAR meetings back in April 2013, as RN #1 keeps the information. The dietitian indicated she did not know how the physician gets notified of a weight loss.</p> <p>On 9/25/13 at 2:10 P.M., an interview with RN #1 indicated resident's weights are done on Mondays. RN #1 noted nurses then put the weights in the computer and the nurse is supposed to report to the physician a weight loss of 3-5 lbs. in 1 week. RN #1 indicated she had notes from the NAR meeting on 4/8/13 and 4/15/13. The 4/8/13 NAR meeting indicated Resident #109's weight as 194.6 lbs and the 4/15/13 meeting indicated the resident's weight as 188.2 lbs, a 3 lbs</p>		<p>responsible for making sure that a physician does receive notification if an audit shows that it did not occur. MONITORING: The DNS, or her designee, will review the audits conducted by the UM weekly for thirty days and then monthly for a minimum of six months. The QA Committee will review the results of the monitoring. If at least 95% compliance is demonstrated, the Committee will decide on either a reduction in the frequency of monitoring or cease the monitoring. If less than 95% compliance is demonstrated, the Committee will require that the original monitoring parameters continue until reviewed again at the following quarterly QA meeting.</p>				

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	<p>weight loss in 7 days. RN #1 indicated her expectation after the 6 lbs. weight loss was identified in 1 week was identified the nurse should have notified the physician at that time.</p> <p>On 9/26/13 at 9:45 A.M., an interview with the Director of Nursing (DON) indicated per facility policy, the physician is to be notified for a weight loss of 3-5 lbs. in 1 week.</p> <p>On 9/26/13 at 11:08 A. M., an interview with the Assistant Director of Nursing indicated there was no evidence of the physician having been notified after the weight loss of over 3-5 lbs. in 1 week on 4/15/13.</p> <p>Review of an undated policy titled "Weighing Residents," provided by the DON on 9/26/13 at 10:07 A.M., indicated a weight loss of 3 lbs. or more or gain of 3 lbs. or more within 7 days, will prompt a notification message in the electronic charting system that the resident needs to be re-weighed. A message will be sent to all nurses, the dietary manager, the Registered Dietitian and all nursing administrative staff.</p> <p>Review of an undated policy titled "Notification to Physicians," provided by the DON on 9/26/13 at 10:07 A.M.,</p>				

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	<p>indicated notifications to the physician will be made per shift when there is a weight loss/gain per policy guidelines.</p> <p>3.1-5(a)(2)</p>			

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F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to assess the need for fluid restrictions for 1 of 1 resident reviewed for dialysis (Resident #141)</p> <p>Finding includes:</p> <p>The record for resident #141 was reviewed on 9/26/2013 at 10:00 A.M. Diagnoses included, but were not limited to, end stage renal disease (kidney failure). The record indicated the resident received dialysis (a process for removing waste and excess fluid from the blood in people with kidney failure) three times weekly.</p> <p>Admission orders from an acute care hospital for Resident #141, dated 9/15/2013, did not indicate any orders for diet restrictions, including any fluid restrictions.</p> <p>Physician orders for Resident #141, dated 9/16/2013, did not indicate any</p>	F000309	<p>CORRECTIVE ACTIONS TAKEN: Resident #141 was discharged to home on 10/9/13 with a referral for home health care services with good rehab potential. The fluid restriction order was maintained during the remainder of his stay and was included with Resident #141's discharge instructions. OTHER RESIDENTS POTENTIALLY AFFECTED: No current residents are receiving dialysis. MEASURES IMPLEMENTED TO PREVENT REOCCURRENCE: The facility "Dialysis" policy has been reviewed and revised to specifically include the instruction that any resident receiving dialysis must be assessed for the need for fluid restrictions. The "Fluid Restrictions" policy has been reviewed and revised to name common conditions for which fluid restrictions may be indicated. The checklist used by nursing staff to complete all required assessments and tasks during admission of a new resident has been modified to remind the admitting nurse to fax the MD for fluid restriction orders</p>	10/30/2013	

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	<p>fluid restrictions were indicated.</p> <p>A note by the Registered Dietitian (RD), dated 9/21/2013, indicated Resident #141 required 1875 cc's (cubic centimeters) of fluids daily based on his weight and had no fluid restrictions.</p> <p>The RD was interviewed on 9/25/2013 at 1:55 P.M. During the interview, the RD indicated she had noticed there were no orders specifying fluid restrictions for Resident #141 when she had completed his admission assessment and thought it was unusual due to his diagnosis of end stage renal disease and need for dialysis. The RD further indicated she had asked nursing staff on 9/18/2013 to obtain clarification from the physician for the need for fluid restrictions. The RD indicated she did not know if the nursing staff had followed up on her request.</p> <p>The Director of Nursing (DON) was interviewed on 9/25/2013 at 2:30 P.M. During the interview, the DON indicated she could find no indication in the record of the RD asking the nursing staff to obtain physician clarification regarding fluid restrictions for Resident #141.</p>		<p>for a dialysis patient. The charting software has been programmed to remind the nurse to obtain fluid restriction orders when the button is clicked to document that a resident is receiving dialysis. All nurses will be in-serviced on the updated dialysis and fluid restriction policies and instructed on the additions to the admission checklist and charting software. MONITORING: The DNS, or her designee, will ensure that all nurses have participated in the required in-services. She will conduct a weekly audit for thirty days to confirm that any resident admitted with orders for dialysis or any existing resident who was given orders for dialysis was assessed for the need for fluid restrictions and that the physician was consulted. She will conduct the same audit on a monthly basis for a minimum of twelve months thereafter and report her findings to the QA Committee. If no concerns are noted, the QA Committee will allow the monitoring to cease. If concerns are noted, the QA Committee will review the corrective measures, implement new measures if needed and the monitoring process will start over.</p>		

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	<p>On 9/25/2013 at 3:00 P.M., the DON indicated nursing staff had just called the dialysis to ask for clarification on the need for fluid restrictions for Resident #141. The DON indicated the physician at the dialysis center ordered a 1440 cc (cubic centimeter) daily fluid restriction for Resident #141.</p> <p>A physician order, dated 9/25/2013, indicated orders had been obtained for Resident #141 for fluid restrictions of 1440 cc daily.</p> <p>A note by the RD, dated 9/26/2013, indicated "1440 fluid restriction added today from renal doc (sic)."</p> <p>3.1-37(a)</p>			

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F000323 SS=E	<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 observation and interview, the facility failed to ensure 1 of 3 dining rooms (main dining room) were free of potential hazards.</p> <p>Finding includes:</p> <p>During the initial tour of the facility, on 9/23/13 at 10:00 A.M., the main dining room was noted to have numerous 12" x 12" floor tiles with protruding edges. A total of 13 floor tiles were noted to have protruding edges, up to 1/4" above the floor.</p> <p>On 9/26/13, at 10:00 A.M., an interview was conducted with the Environmental Services Director in the main dining room. He indicated he had previous occasions with loose, protruding tiles and had replaced them. He indicated he would have someone replace the loose, protruding tiles.</p> <p>3.1-45(a)(1)</p>	F000323	<p>CORRECTIVE ACTIONS TAKEN: All of the floor tiles noted to have raised edges or corners were replaced on the same day they were pointed out by the State surveyor. OTHER RESIDENTS POTENTIALLY AFFECTED: All residents of the health care unit who utilize the dining room were potentially affected by the raised tile edges. No residents have had falls or accidents reported to be associated with the condition of the tiles.</p> <p>MEASURES IMPLEMENTED TO PREVENT REOCCURRENCE: The entire floor in the dining room is budgeted for replacement within six months. Inspection of the flooring will be added to a preventative maintenance (PM) schedule conducted by the Environmental Services (ES) department on a weekly basis. ES staff (including maintenance technicians and housekeepers) will be trained to report any damaged tiles they see directly to the head of their department. The department head will assign a member of the maintenance team to repair or replace any damaged tiles within 24 hours of a report.</p> <p>MONITORING: The Director of</p>	10/30/2013			

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			ES will review the preventative maintenance logs monthly and conduct his own personal inspection of the floors until the floor replacement project has been completed.He will report on the status of the flooring to the QA Committee.The Committee will determine if any additional measures are needed based on his reports.	

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F000364 SS=E	<p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation, record review and interview, the facility failed to ensure food temperatures were obtained prior to service from a steam table in 1 of 3 dining rooms with the potential to affect 40 residents served in the dining room.</p> <p>Finding includes:</p> <p>On 9/23/13 at 11:35 A.M., food was observed being delivered in an enclosed cart to the first floor main dining room from the kitchen on the second floor. The food was observed to be in metal serving pans. The serving pans were observed to be placed into an electric steam table by staff. At 12:00 P.M., the staff were observed to begin placing the food (meat with gravy, potatoes, and vegetables) on to plates and then began serving the residents. The staff were not observed to obtain the temperature of the food prior to serving it to the residents.</p> <p>The Assistant Dietary Director was</p>	F000364	<p>CORRECTIVE ACTIONS TAKEN: No residents were documented to have been affected by the deficiency cited. Forty residents were served in the dining room. None of the residents offered feedback that their food was served at an improper temperature. Facility administration would note that the lack of a temperature check just prior to serving is not necessarily an indicator that the food was not actually served at a proper temperature, although the absence of complaints does lead to the assumption that it was served at an acceptable temperature to the residents.</p> <p>OTHER RESIDENTS POTENTIALLY AFFECTED: Residents on the unit receiving room trays could have been potentially affected by the deficiency. Again, no residents provided feedback that their meals were served at an improper temperature.</p> <p>MEASURES IMPLEMENTED TO PREVENT REOCCURRENCE: Facility policy and procedure for "Food Temperatures" has been reviewed and revised to better clarify food temperature</p>	10/30/2013	

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	<p>interviewed on 9/23/2013 at 12:05 P.M. During the interview, the Assistant Dietary Director indicated food temperatures were not routinely obtained at the steam table prior to being served to the residents.</p> <p>On 9/24/2013 at 11:30 A.M., food was observed being delivered in an enclosed cart to the first floor main dining room from the kitchen on the second floor. The food was observed to be in metal serving pans. The serving pans were observed to be placed into an electric steam table by staff. At 11:55 A.M., the staff were observed to begin placing the food (herb roasted chicken, macaroni and cheese, and vegetables) on to plates and then began serving the residents. The staff were not observed to obtain the temperature of the food prior to serving it to the residents.</p> <p>The facility's Registered Dietitian (RD) was interviewed on 9/25/2013 at 1:55 P.M. During the interview, the RD indicated food temperatures were to be obtained in the kitchen and then once again at the steam table in the dining room just prior to being served.</p> <p>An undated facility policy entitled "Temperatures - Food", was provided by the Assistant Dietary Director on</p>		<p>parameters and requirements. All dining service employees will be in-serviced and trained on the revised policy and procedure. New dining service employees will be trained on the "Food Temperatures" policy during their orientation and existing staff will be in-serviced annually. The Director of Dining Services (CDM), or her designee, will ensure that all dining service staff have completed their required in-services on food temperature policy and procedure. MONITORING: The CDM and/or the Registered Dietician (RD) will observe frontline staff serving meals at least twice per week for thirty days to ensure that the revised policy and procedure is followed. The CDM and/or the RD will observe frontline staff serving meals at least twice per month for six months thereafter. Observations will be made at breakfast, lunch and dinner and will be conducted in a random and unannounced manner. The results of the observations will be documented and reviewed with the QA Committee. The Committee will determine the effectiveness of the corrective measures. Ninety-five percent compliance must be achieved and maintained in order for the monitoring to be discontinued.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/30/2013
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	<p>9/30/2013 at 9:45 A.M. The policy indicated "Food temperatures will be obtained and recorded prior to meal service and any inappropriate temperatures will be corrected to ensure proper serving temperature." The policy further indicated "Using a food thermometer, obtain final temperatures for all menu items, hot and cold, prior to serving." The policy further indicated "Temperature checks should be taken 15 minutes prior to tray service."</p> <p>3.1-21(a)(2)</p>			

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R000000	Grace Village Health Care Facility was found to be in compliance with 410 IAC 16.2 IAC in regard to the State Residential Licensure Survey.	R000000	Submission and implementation of this plan of correction shall not constitute an admission by Grace Village Health Care to any allegations of deficiency as stated in the "Summary Statement of Deficiencies" or an agreement with any conclusions therein. Rather, this plan is submitted in accordance with State and Federal requirements.		