

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155205	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1225 GREENCROFT DR GOSHEN, IN46527
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: October 17-21 and 24, 2011.</p> <p>Facility number: 000112 Provider number: 155205 AIM number: 100288710</p> <p>Survey team: Honey Kuhn, RN, TC Carol Miller, RN (Oct. 17-21, 2011) Christine Fodrea, RN (Oct 17-21, 2011) Tim Long, RN (Oct. 17-21, 2011) Julie Wagoner, RN (Oct. 17-19, 2011)</p> <p>Census bed type: Medicare: 25 Medicaid: 114 Other: 74 Total: 213</p> <p>Census payor type: SNF: 72 SNF/NF: 141 Total: 213</p> <p>Sample: 30</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>	F0000	<p>F 000 Initial Comments</p> <p>This plan of correction constitutes Greencroft Healthcare's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission or that a deficiency exists, or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. We respectfully request a desk review of this Plan of Correction.</p>	

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155205	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1225 GREENCROFT DR GOSHEN, IN46527
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0157 SS=D	<p>Quality review 10/31/11 by Suzanne Williams, RN</p> <p>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 interview and record review, the facility failed to notify the physician timely of a resident's fall with injury which resulted in a change of condition, for 1 of 10 residents reviewed for</p>	F0157	<p>F 157 – Notify of Changes</p> <p>Charts of all residents were audited to make sure physicians were appropriately notified of any changes.</p> <p>Licensed nurses were in-serviced</p>	11/11/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155205	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011
NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1225 GREENCROFT DR GOSHEN, IN46527		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>physician notification in a sample of 24. (Resident #197).</p> <p>Findings include:</p> <p>Resident #197's record was reviewed 10-19-2011 at 1:00 p.m. Resident #197's diagnoses included, but were not limited to, kidney failure, dementia, and depression.</p> <p>A nurse's note for Resident #197 dated 9-1-2011, indicated at 3:55 a.m. Resident #197 was found lying in the hallway, on her right side, next to the doorway to the resident's room. The nurse indicated Resident #197 yelled out in pain during range of motion on her left leg, but did not yell out when range of motion was performed on her other extremities. The note further indicated the physician was notified by fax.</p> <p>A nurse's note dated 9-1-2011 at 4:22 a.m., indicated Resident #197 refused Tylenol for the pain. At 5:50 a.m., the nurse's notes indicated Resident #197 finally accepted Tylenol for left leg pain. The on-call physician was paged at 7:15 a.m. Resident #197 was sent to the hospital at 8:20 a.m. and was admitted with a left hip fracture.</p> <p>In an interview on 10-20-2011 at 9:50</p>		<p>and re-educated on Physician Services Policy (Attachment A). Nurse Team Leader or designee will monitor residents' charts weekly. Findings will be submitted to the DON or designee using the Healthcare Community Reports (Attachment B). This will be ongoing. The DON or designee will submit the summary of findings to the QI committee quarterly for review and recommendation. Alleged date of compliance 11/11/11.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155205	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011
NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1225 GREENCROFT DR GOSHEN, IN46527		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>a.m., Unit Manager #4 indicated she had been the nurse working the night of Resident #197's fall. She indicated Resident #197 yells out a lot when repositioned and always has done so. Unit Manager #4 indicated she had been unable to tell if Resident #197 was calling out truly in pain or if she was really hurt. When asked why she did not notify the physician because she did not cry out with pain in any other extremity, Unit manager #4 indicated she should have called the on call before she did.</p> <p>A current policy dated 2/95 and revised 7/06 titled Physician Services indicated physicians will be notified when resident's physical condition warrants notification and critical incidents will be communicated by telephone.</p> <p>3.1-5(a)(2)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155205	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011
NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1225 GREENCROFT DR GOSHEN, IN46527		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F0225 SS=D	<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 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 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 interviews, the facility failed to thoroughly investigate and report an allegation of abuse for 1 of 3 incidents reviewed for allegations of abuse in sample of 30 residents.</p>	F0225	F 225 – Investigate/Report Allegations/Individuals There were no further complaints from Resident #54. On 9/26/11 NTL #15 was made aware of the concern and an internal	11/11/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155205	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011
NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1225 GREENCROFT DR GOSHEN, IN46527		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>(Resident #54)</p> <p>Findings include:</p> <p>On 10/20/11 at 9:05 A.M. an interview was conducted with resident #54 at the resident's request. The resident indicated an incident occurred about a month before in which she had called a Certified Nursing Assistant (CNA) to her room during the night to assist her to the restroom. Resident #54 indicated CNA #14 told her "you can get your leg fixed or wet the bed." The resident indicated she urinated in her bed that night and the next two nights due "in the fear of stirring things up." Resident #54 indicated the incident happened on a Friday night and she told the unit manager, RN #15, on the following Monday. Resident #54 also indicated around the same time period, CNA #14 had put her to bed by throwing her into bed which she indicated was not comfortable and could have hurt her back</p> <p>An interview with RN #15 on 10/20/11 at 10:30 A.M. indicated she initially heard of the incident from resident #54's daughter on 9/26/11. RN #15 indicated the resident is very confused and fixated on CNA#14 and had made a lot of allegations about CNA #14. RN #15 indicated she talked with several nurses about the accusation and there were no</p>		<p>investigation was initiated. NTL#15 notified the administrator at stand up meeting on 9/27/11. All staff members were in-serviced and re-educated on Policy Reporting Abuse (Attachment C, C1-3) to notify their immediate supervisor any resident complaints immediately. The supervisor will immediately notify the Administrator or designee. The Administrator or designee will initiate an investigation and report per policy. Nurses and QMA's will communicate any alleged abuse/complaints verbally to their NTL immediately and via the 24 hour report sheet. The NTL or designee will be responsible to notify the administrator of any complaints immediately and at the stand up meeting each morning (Monday-Friday). On weekends and holidays all staff will report to the nurse on-call, who will immediately notify the administrator. The DON, ADON, or designee will review/audit the 24 hour report sheets daily for complaints from residents and report to the Administrator immediately. The Administrator or designee will initiate appropriate reporting, investigation, and interventions for protection from harm. These interventions will be communicated with the physician, family, and staff. This will be ongoing. The DON or designee will report the finding of audits to</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155205	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011
NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1225 GREENCROFT DR GOSHEN, IN46527		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>verifications of the incident. RN #15 indicated resident #54 did not tell her about CNA #14 picking her up and throwing her into bed. RN #15 indicated she had told the DON about the incident on 9/26/11.</p> <p>An interview with the Director of Nursing (DON) on 10/20/11 at 10:15 A.M. indicated RN #15 had reported to him about a month before of the incident involving resident #54. The DON did not indicate he notified the Administrator of the incident.</p> <p>An interview with the Administrator on 10/20/11 at 2:15 P.M. indicated she had not been made aware of the incident involving resident #54 on 9/23/11 and first reported to RN #15 and the DON on 9/26/11.</p> <p>Review of the facility policy "Investigation of Abuse and Protection of the Resident" revised 8/06 indicated, under the "Policy" section, the facility "will assure that upon the allegation or identification of abuse, neglect or misappropriation of resident property, the administrator or designee will immediately undertake an investigation of the allegation or event." Under the "Procedure" section: "1. Resident, family or visitor concerns regarding abuse,</p>		<p>QI committee for review and recommendation. Alleged date of Compliance 10/27/11.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155205	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1225 GREENCROFT DR GOSHEN, IN46527
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>neglect, involuntary seclusion or misappropriation of property will be recorded on a grievance/complaint report form...and forwarded to the administrator or designee."; "4. Staff incidents that involve abuse, neglect, involuntary seclusion and/or misappropriation of resident property, will be investigated as follows: a. The staff member involved will be immediately removed from working with residents. The employee may be suspended without pay for up to five days, pending an investigation. d. Appropriated reporting requirements will completed, including: Physician notification by telephone; ISDH by fax; Written report to ISDH, APS and Ombudsman within five days. e. Written statements will be obtained by the administrator and/or designee will review statements for validation of alleged concern."</p> <p>Review of the facility policy "Primary Abuse Prohibition Policy", revised 8/06, under "Policy/Procedure Definitions" section, "1. Abuse: The willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. Also includes deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psycho</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155205	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1225 GREENCROFT DR GOSHEN, IN46527
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0226 SS=D	<p>social well-being. 2. Verbal abuse: The use of oral, written or gestured language that willfully includes, disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples include treats of harm or saying things to frighten a resident. 5. Mental abuse: Includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation."</p> <p>3.1-28(c) 3.1-28(d) 3.1-28(e)</p> <p>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 implement the facility's policy and procedure on abuse investigation and reporting, for 1 of 3 incidents reviewed in a sample of 30 residents. (Resident #54)</p> <p>Findings include:</p> <p>Review of the facility policy "Investigation of Abuse and Protection of the Resident" revised 8/06 indicated, under the "Policy" section, the facility "will assure that upon the allegation or</p>	F0226	<p>F 226 – Develop/Implement Abuse/Neglect Policies There have been no further complaints from Resident #54. Resident #54 daughter alleges her mother has voiced high satisfaction with care both prior to and since the allegation. Facility uses Abaqis software program to monitor resident satisfaction. Issues/concerns identified during interviews are investigated and addressed and/or reported as appropriate. All staff members were in-serviced and re-educated on Policy Reporting Abuse (Attachment C, C1-3) to notify their immediate supervisor any</p>	11/11/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155205	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011
NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1225 GREENCROFT DR GOSHEN, IN46527		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>identification of abuse, neglect or misappropriation of resident property, the administrator or designee will immediately undertake an investigation of the allegation or event." Under the "Procedure" section: "1. Resident, family or visitor concerns regarding abuse, neglect, involuntary seclusion or misappropriation of property will be recorded on a grievance/complaint report form...and forwarded to the administrator or designee."; "4. Staff incidents that involve abuse, neglect, involuntary seclusion and/or misappropriation of resident property, will be investigated as follows: a. The staff member involved will be immediately removed from working with residents. The employee may be suspended without pay for up to five days, pending an investigation. d. Appropriated reporting requirements will completed, including: Physician notification by telephone; ISDH by fax; Written report to ISDH, APS and Ombudsman within five days. e. Written statements will be obtained by the administrator and/or designee will review statements for validation of alleged concern."</p> <p>Review of the facility policy "Primary Abuse Prohibition Policy", revised 8/06, under "Policy/Procedure Definitions" section, "1. Abuse: The willful infliction</p>		<p>resident complaints immediately. The supervisor will immediately notify the Administrator or designee if Administrator is not available. Nurses and QMA's will communicate any alleged abuse/complaints verbally to their NTL immediately and via the 24 hour report sheet. The NTL or designee will be responsible to notify the administrator of any complaints immediately and at the stand up meeting each morning (Monday-Friday). On weekends and holidays all staff will report to the nurse on call, who will immediately notify the administrator. The DON, ADON, or designee will review/audit the 24 hour report sheets daily for complaints from residents and report to Administrator immediately. The Administrator will initiate appropriate reporting, investigation, and interventions for protection from harm. These interventions will be communicated with the physician, family, and staff. This will be ongoing. The DON or designee will report the finding of audits to QI committee for review and commendation. Alleged date of Compliance 10/27/11.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155205	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1225 GREENCROFT DR GOSHEN, IN46527
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. Also includes deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psycho social well-being. 2. Verbal abuse: The use of oral, written or gestured language that willfully includes, disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples include treats of harm or saying things to frighten a resident. 5. Mental abuse: Includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation."</p> <p>On 10/20/11 at 9:05 A.M. an interview was conducted with resident #54 at the resident's request. The resident indicated an incident occurred about a month before in which she had called a Certified Nursing Assistant (CNA) to her room during the night to assist her to the restroom. Resident #54 indicated CNA #14 told her "you can get your leg fixed or wet the bed." The resident indicated she urinated in her bed that night and the next two nights due "in the fear of stirring things up." Resident #54 indicated the incident happened on a Friday night and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155205	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011
NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1225 GREENCROFT DR GOSHEN, IN46527		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>she told the unit manager, RN #15, on the following Monday. Resident #54 also indicated around the same time period CNA #14 had put her to bed by throwing her into bed which she indicated was not comfortable and could have hurt her back</p> <p>An interview with RN #15 on 10/20/11 at 10:30 A.M., indicated she initially heard of the incident from resident #54's daughter on 9/26/11. RN #15 indicated the resident is very confused and fixated on CNA#14 and had made a lot of allegations about CNA #14. RN #15 indicated she talked with several nurses about the accusation and there were no verifications of the incident. RN #15 indicated resident #54 did not tell her about CNA #14 picking her up and throwing her into bed. RN #15 indicated she had told the DON about the incident on 9/26/11.</p> <p>An interview with the Director of Nursing (DON) on 10/20/11 at 10:15 A.M. indicated RN #15 had reported to him about a month before of the incident involving resident #54. The DON did not indicate he notified the Administrator of the incident.</p> <p>An interview with the Administrator on 10/20/11 at 2:15 P.M. indicated she had not been made aware of the incident</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155205	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1225 GREENCROFT DR GOSHEN, IN46527
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0252 SS=E	<p>involving resident #54 on 9/23/11 and first reported to RN #15 and the DON on 9/26/11.</p> <p>3.1-28(a) The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. Based on observation and interview, the facility failed to ensure the carpet on the North unit and the main entrance in front of the service hall entrance was clean and free of stains. This affected 60 of 60 residents who resided on the North unit, of 213 residents residing in the facility.</p> <p>Findings include:</p> <p>During the environmental tour of the facility, conducted on 10/18/11 between 9:45 A.M. - 11:00 A.M. and 1:45 P.M. - 2:30 P.M., the carpet on the north unit hallway and the main entrance hallway in front of the doors to the service hall was noted to be worn, and stained.</p> <p>Interview with the Assistant Maintenance Supervisor, employee #2, on 10/18/11 at 10:50 A.M., indicated "they" had talked about replacing the carpet but there was no set time frame scheduled. He indicated the carpet was cleaned routinely but was stained.</p>	F0252	<p>F 252 – Safe/Clean Comfortable Homelike Environment</p> <p>The facility is committed to creating a safe clean environment. Environmental Services routinely monitors the environment for risk. The facility is planning an extensive new construction and renovation of health care for conversion to households. Staff members are in weekly conversation with the architect and contractor. A capital campaign for the project is occurring now. Final plans and phasing of the project is schedule to be completed this winter.</p> <p>The intent of Administration is to create a safe environment and avoid undue confusion, noise, disruption, and stress for residents. Therefore short term redecorating has not occurred. Replacement of stained carpet will be scheduled when the final plans and phasing have been completed this winter.</p> <p>See Attached cleaning schedule for carpet care (Attachment D). There is also a Spot and Spill hotline and unexpected spills or excessively soiled areas are addressed in a</p>	11/11/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155205	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011
NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1225 GREENCROFT DR GOSHEN, IN46527		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F0279 SS=D	<p>3.1-19(f)</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on record review, observation and interview, the facility failed to develop a care plan following the development of a pressure ulcer for 1 of 5 residents in a sample of 30 reviewed for pressure areas.</p>	F0279	<p>timely manner when not on the routine schedule.</p> <p>During the time of planning and construction the organization is committed to a clean safe environment for all residents. Current carpet condition is clean and does not pose a safety threat. Alleged Date of Compliance 11/11/11. This tag was discussed with ISDH supervisor Brenda Meredith on 11/9/11 and her recommendations included.</p> <p>F 279 – Develop Comprehensive Care Plans</p> <p>The care plan for resident #135 was reviewed and updated for pressure ulcer on 10/19/11. Charts of all residents with pressure</p>	10/28/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155205	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1225 GREENCROFT DR GOSHEN, IN46527
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>(Resident #135)</p> <p>Findings include:</p> <p>The record of Resident #135 was reviewed on 10/18/11 at 10:00 a.m. and indicated Resident #135's diagnosis included, but were not limited to, cerebral vascular accident, debility and arteriosclerosis.</p> <p>On 10/17/11 at 10:25 a.m. during a tour of the facility, the Central Unit Manager RN indicated Resident #135 had a pressure ulcer on her outer aspect of her left foot acquired at the facility.</p> <p>The resident's care plans were reviewed and indicated there was an at risk care plan dated 12/23/10 but there was no care plan initiated after the resident developed the pressure ulcer on 5/30/11.</p> <p>The Pressure Wound Form dated 10/18/11 indicated the pressure ulcer on the resident's outer aspect of her left foot measured at 0.3 centimeters (cm) by 0.2 cm.</p> <p>On 10/19/11 at 8:30 a.m., with Central Unit Manager RN, the pressure area on the resident's outer aspect of her left foot was observed to be superficial without redness.</p>		<p>areas were audited by Nurse Team Leaders and MDS nurses to make sure their care plans were up to date.</p> <p>Licensed nursing staff were in-serviced and re-educated on documentation and updating care plans (Attachment E).</p> <p>NTL or designee will review the 24 hour report sheet daily for new pressure areas. They will audit charts to make sure care plans have been updated and interventions in place. All new pressure areas will be communicated daily via Healthcare Community Reports (Attachment B). The nurse on-call will review the 24 hour report book on weekends and holidays for new pressure areas. They will audit the chart to make sure the care plan is updated and new interventions in place.</p> <p>The DON or designee will submit the findings to the QI committee quarterly for review and recommendations.</p> <p>Alleged date of Compliance 10/28/11.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155205	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011
NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1225 GREENCROFT DR GOSHEN, IN46527		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>On 10/20/11 at 9:10 a.m. the Central Unit Manager RN was interviewed in regard to the lack of care plan after the resident developed a pressure ulcer, and the Central Unit Manager RN indicated a care plan for the pressure ulcer should had been initiated after the pressure ulcer developed.</p> <p>The current policy reviewed on 9/09 for Care Plan - Comprehensive Care Plan Process was reviewed on 10/20/11 at 2:15 p.m. indicated "Purpose: An interdisciplinary team shall develop and maintain a comprehensive care plan for each resident.</p> <p>Policy: A written comprehensive care plan for each resident shall be developed that includes measurable goals, objectives and timetables to meet the resident's needs identified in the comprehensive assessment...Procedure: 3. Care plans shall be revised as changes in the resident's condition dictate. Reviews will be done at least quarterly at a care plan conference by the interdisciplinary team..."</p> <p>3.1-35(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155205	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1225 GREENCROFT DR GOSHEN, IN46527
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0323 SS=G	<p>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>Based on interview and record review, the facility failed to ensure fall interventions were initiated to prevent falls for 3 of 8 residents reviewed for falls in a sample of 30, resulting in a fall with fracture for Resident #197 (Resident #197, Resident #73, Resident #145).</p> <p>Findings include:</p> <p>1. Resident #197's record was reviewed 10-19-2011 at 1:00 p.m. Resident #197's diagnoses included, but were not limited to, dementia, depression, and kidney failure.</p> <p>Review of the most recent MDS (Minimum Data Set: a tool to assist in providing resident care), dated 09/17/11, indicated Resident #197 had short and long term memory loss, and had decision making impairment, resulting in Resident #197 requiring 1 person assist for dressing, hygiene, and bathing.</p> <p>Resident #197 was assessed as being at risk for falls. according to her care plan dated 6-23-2011 due to her history of falls and fast gait. Care plan interventions included nonskid footwear, call light in reach, eyeglasses on, top siderails at night,</p>	F0323	<p>F 323 – Free of Accident Hazards/Supervision/Devices Resident #197, #145, #73 post fall assessments and care plans have been reviewed and revised as needed. These three residents have had no further falls. Charts of all residents who have fallen have been reviewed and revised with appropriate interventions to help reduce the risk of falls and reduce the risk of injury from falls. Licensed nurses were in-serviced and re-educated to evaluate each fall for new interventions (Attachment F). These new interventions will be included on the post fall assessment and on the care plan. New interventions will be communicated to staff via care guides and verbal report. The fall committee will meet on a weekly basis to evaluate if the appropriate interventions are in place and revise interventions as needed. NTL will monitor the 24 hour report book and incident reports to make sure post fall assessments are completed and there are new interventions in place. This will be reported via the Healthcare Community Report Sheets (Attachment B). On weekends and holidays the nurse on call will monitor the 24 hour report book and incident</p>	11/11/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155205	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011
NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1225 GREENCROFT DR GOSHEN, IN46527		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>and reviewing lab results as available. The care plan had been updated 9-7-2011 and 9-21-2011 with additional fall interventions.</p> <p>Nurse's notes dated 5-19-2011 indicated at 1:00 p.m. Resident #197 sustained a fall. The post fall investigation did not indicate any new interventions to prevent falls.</p> <p>Nurse's notes dated 9-1-2011 at 3:55 a.m., indicated Resident #197 had fallen and was complaining of pain in her left leg. Resident #197 had been found on the floor, lying on her right side, in the hallway next to the doorway of the resident's room. The nurse indicated Resident #197 yelled out in pain during range of motion on her left leg, but did not yell out when range of motion was performed on her other extremities. The note further indicated the physician was notified by fax.</p> <p>A nurse's note dated 9-1-2011 at 4:22 a.m. indicated Resident #197 refused Tylenol for the pain. At 5:50 a.m., the nurse's notes record Resident #197 finally accepted Tylenol for left leg pain. The on-call physician was paged at 7:15 a.m. Resident #197 was sent to the hospital at 8:20 a.m. and was admitted with a left hip fracture.</p>		<p>reports to make sure post fall assessments are completed and new interventions are in place. The Healthcare Community Reports Sheets (Attachment B) will be reported to the DON or ADON daily. The DON or designee will report findings to the QI committee quarterly for review and recommendation. Alleged date of Compliance 11/11/11.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155205	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1225 GREENCROFT DR GOSHEN, IN46527
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>In an interview, on 10-20-2011 at 9:50 a.m., Unit Manager #4 indicated she had been the nurse working the night of Resident #197's fall. She indicated Resident #197 yells out a lot when repositioned and always has done so. Unit Manager #4 indicated she had been unable to tell if Resident #197 was calling out truly in pain or if she was really hurt.</p> <p>In an interview on 10-20-2011 at 9:53 a.m. LPN #5 indicated an intervention was to be put into place each time there was a fall. She additionally indicated if the resident cries out with pain after a fall, the resident should have been sent to ER right away and the physician called.</p> <p>2. Resident #145's record was reviewed on 10-18-2011 at 10:35 a.m. Resident #145's diagnoses included but were not limited to; psychosis, high blood pressure and dementia.</p> <p>Resident #145's care plan indicated he was at risk of falls due to confusion and unsteady gait. The care plan also indicated resident #145 was at risk for elopement. Interventions had been added to the care plan on 9-12 indicated to initiate the go green program, 9-26 indicated therapy treatment, 9-30 to take Resident #145 outside when he wanted to go, and 10-10-2011 to leave the courtyard gate</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155205	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011
NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1225 GREENCROFT DR GOSHEN, IN46527		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>open.</p> <p>A review of Resident #145's nurse's notes indicated Resident #145 fell on 8-15, 8-17, 9-9, 9-11, 9-25, 9-27, twice on 9-30, 10-3 and 10-10.</p> <p>A review of Resident #145's Post fall investigations indicated the following: the post fall investigation dated 8-15 indicated there were no fall prevention action put into place; the post fall investigation dated 8-17 indicated Resident #145 was receiving therapy, but no further actions were put into place; the post fall investigation dated 9-9 indicated no actions were put into place to prevent further falls; the post fall investigation dated 9-25-2011 indicated to monitor resident closely when he got up to walk and a referral had been made to therapy; the post fall investigation dated 9-27 indicated no new actions were taken to prevent falls; the post fall investigation dated 9-30-2011 at 4:30 p.m. indicated to remind Resident #145 to ask for help when needed. The Minimum Data Set dated 7-5-2011 indicated Resident #145 had significant memory loss. The post fall investigation dated 9-30-2011 at 6:40 p.m. indicated to remind Resident #145 to ask for help. No other new interventions had been taken to prevent falls. The post fall investigation dated 10-3-2011</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155205	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1225 GREENCROFT DR GOSHEN, IN46527
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>indicated to monitor for fatigue and restless behavior and assist Resident #145 if needed. The post fall interventions dated 10-10-2011 indicated to remind visitors to check with staff before helping residents that are not family members.</p> <p>Unit Manager #4 was interviewed on 10-19-2011 at 9:45 a.m. and indicated no new interventions were put into place for Resident #145.</p> <p>3. Resident #73's record was reviewed 10-19-2011 at 10:10 a.m. Resident #73's diagnoses included, but were not limited to, high blood pressure, heart failure, and pneumonia.</p> <p>Resident #73's Minimum Data Set dated 7-30-2011, indicated Resident #73 was alert and oriented and able to make good decisions.</p> <p>Resident #73's nurse's notes indicated he fell 9-17-2011 trying to adjust his recliner. The immediate prevention measures were to be aware of surroundings. The post fall investigation indicated under action plan there were no new plans to prevent falls at that time.</p> <p>Resident #73's care plan indicated Resident #73 was at risk for falls due to weakness, pain medication use and poor</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155205	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011
NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1225 GREENCROFT DR GOSHEN, IN46527		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>balance. The interventions written 7-22-2011 were to encourage Resident #73 to wear nonskid footwear, instruct in transfer techniques, provide rolling walker, keep call light and personal items in reach, monitor vital signs, blood sugars and effects of medications, and to continue therapy per orders. There were no indications any new interventions were put into place to prevent falls after the fall of 9-17-2011.</p> <p>Unit Manager #4 was interviewed on 10-19-2011 at 9:45 a.m. and indicated no new interventions were put into place for Resident #73.</p> <p>A current policy dated 8/06 and revised 11/09 titled Incident Report indicated documentation would include preventative measures.</p> <p>3.1-45(a)(2)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155205	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1225 GREENCROFT DR GOSHEN, IN46527
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0329 SS=D	<p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure residents were free from unnecessary drugs, related to duplicate therapy and regarding the failure to administer as needed (PRN) anti-anxiety medications only after non-pharmacological interventions were attempted or were unsuccessful, for 3 of 30 residents reviewed for medications in a sample of 30. (Resident #135, Resident #145, and Resident #193)</p> <p>Findings include:</p> <p>1. The record of Resident # 135 was reviewed on 10/18/11 at 10:00 a.m. and</p>	F0329	<p>F 329 – Drug Regimen is free from unnecessary drugs</p> <p>Resident #135 Ferrous Sulfate was discontinued on 10/18/11. There were no adverse reactions noted. Resident #135 and #145 PRN orders remain unchanged. The PRN Anxiolytic MAR was revised to reflect the non-pharmacological outcome.</p> <p>Charts and MAR's were audited for all residents with MD order for PRN Anxiolytic to make sure each have the revised PRN Anxiolytic MAR in the MAR book.</p> <p>Licensed nurses were in-serviced and re-educated on making sure all non-pharmacological interventions and outcomes were documented</p>	11/11/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155205	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011
NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1225 GREENCROFT DR GOSHEN, IN46527		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>indicated Resident #135's diagnoses included, but were not limited to, anemia.</p> <p>On 9/20/11 the resident had a laboratory test drawn for Serum Iron and the result was 43, and normal is 30-160 ug/dl.</p> <p>The Pharmacy Consult Report dated 9/29/11 indicated "She is currently receiving Ferrous Sulfate (an iron supplement) 1 tablet daily this only offers 65 mg (milligrams) of elemental iron and 150-200 mg of elemental iron daily is needed to treat and reverse an iron deficiency. Please consider discontinuation of Ferrous Sulfate and the initiation of Niferex Forte 150 mg 1 capsule QD (every day) which does contain 150 mg of elemental iron."</p> <p>The October 2011 Physician Order Sheet indicated administer ferrous sulfate 325 milligrams daily since 12/3/10.</p> <p>The October 2011 Medication Administration Record indicated the resident had received Niferex 150 mg 1 capsule a day since 10/11/11 and ferrous sulfate 325 mg 1 tablet a day since 12/3/10. The resident had received the 2 iron supplement together for the past 7 days.</p> <p>On 10/19/11 at 8:30 a.m. the Director Of</p>		<p>(Attachment G). PRN Anxiolytic will only be administered when non-pharmacological interventions fail and are documented on PRN Anxiolytic MAR.</p> <p>Licensed nurses were in-serviced and re-educated on transcription of orders, order notation, faxing, and documentation (Attachment H). NTL will audit the 24 hour report book for changes in medication regimen and audit charts for proper transcription of orders. Findings will be submitted to the DON or designee via the Healthcare Community Reports (Attachment B). This will be ongoing.</p> <p>The DON or designee will submit a summary of findings to the QI committee quarterly for review and recommendation.</p> <p>Alleged date of Compliance 11/11/11.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155205		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 1225 GREENCROFT DR GOSHEN, IN46527			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Nursing (DON) was interviewed in regard to the Pharmacy Recommendation and the 2 iron medications being administered together. The DON indicated on the Pharmacy Recommendation the Resident's Physician did not circle to discontinue the ferrous sulfate so only the niferex order was transcribed. The DON indicated the RN who transcribed the order should had clarified the order with the Physician.</p> <p>The policy received from the Director Of Nursing on 10/21/11 at 9:30 a.m. revised on 10/09 Physician Drug and Treatment Orders indicated "Purpose: To ensure that all medication ...orders are administered and carried out upon the order of a Physician...Policy: ...All orders that are unclear shall by clarified with the physician...."</p> <p>2. Resident #193's clinical record was reviewed on 10/18/11 at 10:35 A.M.. The record indicated the resident had a physician's order from 4/23/11 for Lorazepam 0.5 milligrams (mg) PRN for increased anxiety.</p> <p>Review of the Medication Administration Records (MARs) from August, September and October (through 10/18) 2011 indicated ten episodes where the resident received PRN Lorazepam 0.5 mg without</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155205	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011
NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1225 GREENCROFT DR GOSHEN, IN46527		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>non-pharmacological interventions attempted first on: 8/1/11; 8/8/11; 8/11/11; 8/12/11; 8/13/11; 8/26/11; 8/29/11; 9/16/11; 9/27/11; 10/16/11.</p> <p>Review of the PRN Anxiolytic MAR's from August, September and October (through 10/18) 2011 indicated the resident had received Lorazepam 0.5 mg PRN nineteen times after non-pharmacological intervention outcomes were successful (the resident was calm and quiet) on: 8/6/11; 8/14/11; 8/22/11; 8/23/11; 8/24/11; 8/27/11; 8/28/11; 8/30/11; 9/2/11; 9/3/11; 9/11/11; 9/22/11; 9/24/11; 9/26/11; 9/30/11; 10/10/11; 10/11/11; 10/12/11; 10/14/11.</p> <p>An interview with RN #15 on 10/19/11 at 3:00 P.M. indicated no information concerning Lorazepam tracking for anti-anxiety medications.</p> <p>3. Resident #145's record was reviewed 10-18-2011 at 10:35 a.m. Resident #145's diagnoses included but were not limited to dementia, high blood pressure, and depression.</p> <p>Resident #145's current physician's orders indicated an order had been written for the medication Ativan (an anti anxiety) on 9-27-2011 to be given 1 milligram every 8 hours as needed for agitation.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155205	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011
NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1225 GREENCROFT DR GOSHEN, IN46527		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Resident #145's Medication Administration Record dated 9-2011 indicated the medication Ativan had been given on 9-30-2011 once on day shift for agitation and once on evening shift. On the day shift non- pharmacological interventions were documented without outcome. On the evening shift, the outcome of the non- pharmacological interventions attempted were documented as successful, but the Ativan was given anyway. Times of administration of the medication were not documented.</p> <p>Resident #145's Medication Administration Record dated 10-2011 indicated the medication Ativan had been given on 10-1 and 10-3. On 10-1-2011, the non-pharmacological interventions attempted were documented as successful and resulted on Resident #145 becoming calm and quiet, but the medication Ativan was given anyway. On 10-3-2011, there were no non-pharmacological interventions documented as attempted prior to the medication Ativan being given. Times of administration of the medication were not documented.</p> <p>In an interview on 10-20-2011 at 9:50 a.m. Unit Manager #4 indicated there was no tracking for non-pharmacological interventions prior to the administration of medication.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155205	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011
NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1225 GREENCROFT DR GOSHEN, IN46527		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F0364 SS=E	<p>A current policy dated 2/95 and revised 9/08 titled Medication-Antipsychotic Drugs indicated as needed antianxiety medications should be used only after other non- pharmacological interventions had been tried.</p> <p>3.1-48(a)(1) 3.1-48(a)(4)</p> <p>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 the residents receiving pureed meals received the appropriate serving size for vegetable portion and failed to ensure residents on pureed diets received the bread exchange. This potentially affected 5 of 5 residents who received pureed foods.</p> <p>Findings include:</p> <p>During observation of the pureed process, conducted on 10/19/11 between 10:45 A.M. - 11:00 A.M., the cook was noted</p>	F0364	<p>F 364 – Nutritive Value/Appear Palatable/Prefer Temp All pureed vegetable recipes in computrition have been reviewed and adapted to include a 4 ounce portion of cooked vegetable and then blended with an appropriate liquid if needed for each recipe serving. Cooks have been in-serviced and re-educated on this change and reminded to follow the recipe (Attachment I).Recipes in Computrition can only be modified by the Food Services Director, Production Manager, and/or Registered Dietitian via computer security</p>	11/10/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155205	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011
NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1225 GREENCROFT DR GOSHEN, IN46527		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>to puree 160 ounces of cooked cauliflower with 5 cups of cheese sauce. Review of the recipe for pureed cauliflower with cheese sauce indicated they were to puree 160 ounces of cooked cauliflower with prepared cheese sauce "until smooth." The instructions indicated they were to add milk if needed to make a "smooth consistency." The serving size for the regular menu was 4 ounces of cooked cauliflower with an additional 1 ounce of cheese sauce on top. However, the serving size for the pureed cauliflower with the cheese sauce already mixed in was 3 ounces.</p> <p>Interview with the dietary manager, employee #1, on 10/19/11 at 11:00 A.M., indicated the facility's dietician had written the menus and recipes and she did not know why the portion sizes were smaller for the pureed diets.</p> <p>In addition, the regular menu indicated residents who were unable to select their food items were to be served the following: "crumb baked pollock (1 portion), parslied red potatoes (4 ounces), cauliflower with cheese sauce (4 ounces), lettuce layer salad (4 ounces), wheat bread (one slice), and chocolate delight dessert (1 piece)." The puree menu indicated the following was to be served; "3 ounces of pureed pork or chicken with gravy, 4</p>		<p>access.Pureed menus were reviewed by the Registered Dietitian and additional carbohydrate choices were added when needed to replace the bread exchange. This was completed on 11/9/11.The Production Manger will audit the 4 oz vegetable portion size and additional carbohydrates in recipes weekly for the first five weeks of a new menu cycle (Attachment J). Audit information will be given the Registered Dietician.The Registered Dietician or designee will submit a summary of findings to the QI committee quarterly for review and recommendation.Alleged date of Compliance 11/10/11.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155205	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011
NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1225 GREENCROFT DR GOSHEN, IN46527		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>ounces of mashed ranch potatoes, 3 ounces of cauliflower with cheese sauce, 4 ounces of pureed fruit of the day, 1 piece of chocolate delight dessert or 4 ounces of chocolate pudding with topping."</p> <p>Interview with the dietary manager, employee #1, on 10/19/11 at 11:00 A.M., indicated the Registered Dietician was on medical leave and was not available for interview. She indicated the facility's temporary dietician would not know why the portion sizes and/or menued items were different and would not know why the pureed diets did not receive a bread product or extra carbohydrate to assure they received the same calories and nutrition. She did indicate the residents on pureed diets were receiving pureed fruit as well as the chocolate dessert. She indicated they were not receiving the layer salad. She also indicated they were receiving either the pureed canned pork or chicken instead of the menued crumb baked pollock, mashed potatoes instead of the menued parslied red potatoes. She indicated the menus had been set "a long time ago" by the dietician and a former food service supervisor.</p> <p>3.1-21(a)(1)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155205	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011
NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1225 GREENCROFT DR GOSHEN, IN46527		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F0371 SS=E	<p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, record review, and interview, the facility failed to ensure the main kitchen and patio kitchen ceilings above food prep and serving areas were clean and free from dust. In addition, the facility failed to ensure the food in the refrigerator in 1 of 1 activity room was labeled, dated, and not expired. This deficiency had the potential to affect 212 residents whose meal preparation was initiated in the main kitchen of 213 residents in the facility.</p> <p>Findings included:</p> <p>1. During the kitchen sanitation tour of the main kitchen, conducted on 10/17/11 between 10:20 A.M. - 11:00 A.M., the ceilings throughout the kitchen, especially around the air vents, were noted to be discolored and heavily laden with visible dust. The dust was noted to coat the edges of light and exhaust vent fixtures and electrical cords.</p> <p>Interview with the Assistant Dietary Manager, on 10/17/11 at 10:50 A.M., indicated maintenance was scheduled to clean the ceilings but had not yet made it</p>	F0371	<p>F 371 – Food Procedure Store/Prepare/Serve-Sanitary</p> <p>The vents, lights, and cords in the kitchen pantry were cleaned on 10/24/11. All pantries were inspected for ceiling cleanliness. The refrigerator was cleaned on 10/18/11 and all expired and undated items were discarded. A checklist (Attachment M2) was posted on the refrigerator door identifying daily checks of items in refridgerator.</p> <p>The routine cleaning schedule to maintain cleanliness of food serving/prep areas was updated by the food service director (Attachment K). The cleaning will occur monthly. The cleaning will be documented by the evening food service supervisor.</p> <p>Food Services Staff were in-serviced and re-educated on the appropriate cleaning methods by the Food Service Director (Attachment L). All Activity staff were in-serviced and re-educated on procedures for Refrigerator Cleaning and weekend coverage procedures (Attachment M1).</p> <p>The Food Service Director or designee will audit cleaning of food service prep areas weekly. This will be ongoing. Findings will be</p>	11/10/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155205	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011
NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1225 GREENCROFT DR GOSHEN, IN46527		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F0502 SS=D	<p>to the main kitchen.</p> <p>During observation of the patio serving kitchen, conducted on 10/17/11 at 11:15 A.M., the drop tile ceiling was noted to have dust around the edges of the framing, around the air vent and over the steam table area and food prep areas.</p> <p>2. During the environmental tour, conducted on 10/18/11 between 9:45 A.M. - 11:15 A.M., the refrigerator in the activity room was noted to have a 1/2 gallon of milk, with an expiration date of 09/13/11, and undated white solid block of what appeared to be cream cheese, a partially used, undated plastic squeeze bag of whipped topping which indicated the item was to be used within two weeks if thawed, an opened, undated, partially used can of evaporated milk. In addition, the bottom shelf was dirty with food crumbs and dried spilled liquids.</p> <p>3.1-21(i)(3) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. Based on interviews and record reviews, the facility failed to ensure laboratory tests were done in a timely manner as ordered by the physician. This deficiency affected 2 of 30 residents</p>	F0502	<p>reported to the Registered Dietician or designee. The Life Enhancement Director or designee will monitor the daily cleaning checklist daily for compliance. The Registered Dietician will report findings to the QI committee for review and recommendation. The Life Enhancement Director or designee will submit compliance of daily cleaning checklist to QI Committee for review and recommendation. Alleged date of Compliance 11/10/11.</p> <p>F 502 – Administration Laboratory work was completed for resident #45. Results were within normal limits. Laboratory work for resident #192 is schedule for December 2011. Chart audits were completed to</p>	11/11/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155205	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1225 GREENCROFT DR GOSHEN, IN46527
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>reviewed for laboratory tests in a sample of 30 (Residents #45, #192).</p> <p>Findings include:</p> <p>1. The record of Resident #192 was reviewed on 10/18/11 at 1:30 p.m., and indicated Resident #192's diagnoses included, but were not limited to, diabetes.</p> <p>The Physician's Order dated 4/22/08, indicated to obtain a Hemoglobin A1C every 4 months.</p> <p>The Laboratory Report indicated two Hemoglobin A1C's were drawn on 10/12/10 and 4/19/11 which was 6 months after the first Hemoglobin A1C was drawn.</p> <p>On 10/20/11 at 9:00 a.m. the Central Unit Manager RN was interviewed in regard to the Hemoglobin A1C (Hgb A1C) had not been drawn for 6 months and she indicated the order for the Hgb A1C had expired at the laboratory after 1 year. The Central Unit Manager RN indicated the Laboratory sends a report with all the current Laboratory tests listed on it every month and the report is checked by the nurse with the current Physician's Order Sheet.</p>		<p>make sure all residents' routine laboratory orders were completed. Licensed nurses and QMA's were in-serviced and re-educated on the laboratory procedure (Attachment N). NTL or designee will monitor all orders received on a daily basis to make sure laboratory tests were carried out correctly. NTL and/or unit secretary will audit rewrites against laboratory summaries to make sure laboratory orders are correct. These audits are monitored via Healthcare Community Reports (Attachment B). The DON or designee will submit summary of findings to the QI committee quarterly for review and recommendation. Alleged date of Compliance 11/11/11.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155205	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011
NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1225 GREENCROFT DR GOSHEN, IN46527		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>2. Resident #45's record was reviewed 10-17-2011 at 2:00 p.m. Resident #45's diagnoses included, but were not limited to, high blood pressure, brain injury and chronic pain.</p> <p>Resident #45's current physician's order for a BMP (Basal Metabolic Profile) to be drawn every 4 months indicated the original order was written on 7-01-08.</p> <p>A review of the lab results for Resident #45 indicated BMP results for 3-28-2011 and 10-17-2011. There were no BMP lab results available on the chart for the period between March and October 2011.</p> <p>In an interview on 10-18-2011 at 10:30 a.m., Unit Manager #4 indicated there were no other BMP's drawn for Resident #45.</p> <p>A current policy dated 4-96 and revised 6-04 and 9-06 titled Laboratory Assessment Guidelines indicated physicians will determined the need and order labs as indicated.</p> <p>3.1-49(a)</p>				