

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155743	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/21/2015
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NAME OF PROVIDER OR SUPPLIER GREEN-HILL MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 501 N LINCOLN AVE FOWLER, IN 47944
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: August 17, 18, 19, 20, and 21, 2015</p> <p>Facility number: 000288 Provider number: 155743 AIM number: 100287380</p> <p>Census bed type: SNF/NF: 36 Total: 36</p> <p>Census payor type: Medicare: 6 Medicaid: 25 Other: 5 Total: 36</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	<p>The creation and submission of this plan of correction does not constitute an admission by this provider or any conclusion set forth in the statement of deficiency or any violation of regulation. Provider desires that the 2567 plan of correction be considered the letter of credible compliance and requests that a desk review be completed in lieu of a revisit on or after 09-11-2015.</p> <p>James D. Sizemore, HFA Administrator</p>	
F 0309 SS=D Bldg. 00	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest</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.

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	<p>practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to ensure each resident received the necessary treatment and services related to the monitoring and assessment of skin discolorations for 1 of 3 residents reviewed for non pressure related skin conditions of the 5 residents who met the criteria for non pressure related skin conditions. (Resident #35)</p> <p>Finding includes:</p> <p>During an observation on 8/17/15 at 11:42 a.m., Resident #35 was observed seated in her wheelchair in her room. Multiple small purple discolorations were observed to the top of both of her arms and hands. The resident's left elbow area was wrapped with gauze, she had a large tan bandage on the top of her left arm, and two large tan bandages on top of her right arm.</p> <p>During an observation on 8/19/15 at 9:55 a.m., Resident #35 was observed seated in her wheelchair in her room. Multiple small purple discolorations were observed to the top of both of her arms and hands. The resident's left elbow area was wrapped with gauze, she had a large</p>	F 0309	<p>F309 483.25 Provide Care/Services for Highest Well Being</p> <p>Each Resident must receive and the family 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>1. What corrective actions will be accomplished for those Residents found to have been affected by the deficient practice?</p> <p>1. Resident #35 had a new skin assessment completed on 08-21-2015 to include the small purple discolorations to the top of both arms and hands.</p> <p>2. Resident #35 care plan was updated to include the purpura, use of aspirin and Xarelto. Care plan updated to reflect easily bruises due to the use of the aspirin and Xarelto</p> <p>3. Resident #35 had her bed rails wrapped in sheepskin on 08-21-2015 and a physician's order obtained for geri-sleeves to aid in preventing further bruising</p> <p>4. No further Residents were</p>	09/11/2015			

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	<p>tan bandage on the top of her left arm, and two large tan bandages on top of her right arm.</p> <p>During an observation on 8/20/15 at 8:51 a.m., Resident #35 was observed sitting up in bed eating breakfast. Multiple small purple discolorations were observed to the top of both of her arms and hands. A small bandage was observed to the resident's left elbow area.</p> <p>Resident #35's record was reviewed on 8/19/15 at 1:23 p.m. The resident's diagnoses included, but were not limited to, coronary artery disease, hypertension, and hyperlipidemia.</p> <p>Review of the Significant Change Minimum Data Set (MDS) assessment, dated 6/5/15, indicated the resident was cognitively intact and required an extensive assist of 2 or more staff for bed mobility and transfers.</p> <p>Review of the Weekly Skin Assessments for August 2015 indicated a skin assessment was completed on 8/19/15 and a new skin alteration had been observed, a skin tear to the right forearm. There was lack of documentation the multiple discolorations to the resident's hands and arms had been addressed.</p>		<p>identified to be affected by the deficient practice.</p> <p>2.Howother Residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken?</p> <p>1.AllResidents have the potential to be affected by the deficient practice</p> <p>2.Afacility wide audit was conducted on 08-27-2015 by the Director of Nursing andAdministrator to determine if all care plans were in place for other Residentshaving the same diagnosis and/or same medication, audit identified no otherResident and all care plans were present</p> <p>3.Aaudit of each Residents skin assessment sheets was conducted to ensure that allresidents with an alteration in skin condition have a current and appropriateskin assessment document in place.</p> <p>3.Whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur.</p> <p>1.Alllicensed nurses were re-educated on facilities Skin Management Program Policyon 09-03-2015 by the Director of Nursing</p> <p>2.Residents#35 care plan was updated to include the purpura, use of aspirin and Xarelto.Care plan updated to</p>				

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	<p>Review of the non pressure related skin condition monitoring sheets in the skin binder indicated monitoring sheets for a skin tear to the left elbow and a skin tear to the right forearm. There was lack of documentation the multiple discolorations to the resident's hands and arms had been addressed.</p> <p>Review of the 8/2015 Medication Administration Record indicated the resident received Aspirin 325 milligrams (mg) daily. The resident had also received Xarelto (a blood thinning medication) 15 mg twice a day starting on 8/16/15.</p> <p>There was a lack of documentation to indicate the resident had a care plan and/or interventions related to the Aspirin and Xarelto usage and risk for bruising.</p> <p>Interview with Resident #35 on 8/19/15 at 9:57 a.m. indicated she usually places "tape" over the discolored areas on her arms so she wouldn't have to see all the "spots" on her arms. She indicated she was unsure how she got the discolorations but she had had them for a while. She indicated she had bumped her left elbow into the bed and scratched herself the other day and the nurse had wrapped it up for her.</p>		<p>reflect easily bruises due to the use of the aspirin adXarelto</p> <p>3.Resident#35 had her bed rails wrapped in sheepskin on 08-21-2015 and a physician's order obtained for geri-sleeves to aid in preventing further bruising</p> <p>4.Anaudit of each Residents skin assessment sheets was conducted to ensure that allresidents with an alteration in skin condition have a current and appropriatesskin assessment document in place.</p> <p>4.Howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place and</p> <p>1.TheDirector of Nursing or designee will complete weekly facility wide audits ofthe skin books to ensure all skins sheets are completed and care plans are inplace. These audits will continue indefinitely.</p> <p>2.TheDirector of Nursing or designee will immediately correct any deficient practiceand re-educate staff immediately should any deficient practice be identified</p> <p>3.TheDirector of Nursing or designee will turn into the quality assurance committeemonthly the findings of their audits for review</p> <p>5.Bywhat date the systemic changes will be completed</p>				

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	<p>Interview with LPN #1 on 8/20/15 at 2:25 p.m. indicated the resident often puts band aids that she kept in her room on her arms because she didn't like to look at her arms. She further indicated it was hard to look at all areas during a skin assessment with the band aids on and she would have to take them off but the resident did not always want to remove them. She further indicated the resident required staff assistance with transfers.</p> <p>Interview with the Regional Director on 8/20/15 at 2:40 p.m. indicated bruises had been monitored to the left wrist and right posterior forearm to elbow and all had been signed off as healed on 8/5/15.</p> <p>Interview with Nurse Consultant #1 on 8/20/15 at 2:40 p.m. indicated the resident had indicated to her she had had the spots on her arms for quite a while but she could not find the discolorations documented anywhere. She indicated there was not a care plan in place for the Aspirin and Xarelto and risk for bruising. She indicated the discolorations should have been documented as they were currently present.</p> <p>Interview with Nurse Consultant #1 on 8/20/15 at 3:00 p.m. indicated she had spoken with the Nurse who completed the resident's skin assessment last night,</p>		1.09-11-2015		

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	<p>RN #1. She indicated RN #1 had considered the areas to the resident's arms purpura. She indicated RN #1 had not documented the discolorations probably because she thought they had already been documented as purpura somewhere else. She indicated the resident was found to have a bruise to her right thumb but RN #1 indicated the bruise to the right thumb was new and had not been there last night.</p> <p>Interview with Nurse Consultant #1 on 8/20/15 at 4:12 p.m. indicated she had not found the purpura documented anywhere. She indicated RN #1 had indicated the purpura was present before but it wasn't as bad as now. She further indicated the purpura was probably worse now because the resident kept putting on and removing bandages to cover the areas.</p> <p>A facility policy, titled, "Skin Management Program," dated 10/2013, and received as current from the Administrator on 8/21/15, indicated "...Residents who receive assistance with bathing and/or peri care will be observed daily by nursing staff and any observance of red areas, open areas, skin tears, bruises, rashes, abrasions, excoriations or other alterations in skin will be reported to the licensed nurse for further</p>			
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F 0332 SS=D Bldg. 00	<p>assessment...A resident with a newly identified skin condition will have the appropriate assessment ongoing monitoring form initiated on the basis of the type of skin condition...A comprehensive head to toe assessment will be completed by a licensed nurse upon admission, readmission and at least weekly thereafter ... Should a pressure or non-pressure related skin condition be identified, the licensed nurse will begin the completion of the appropriate initial assessment/ ongoing monitoring form which is then placed in the Skin Binder..."</p> <p>3.1-37(a)</p> <p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% for 1 of 7 residents observed during 3 medication pass observations. Two errors in medications were observed during 27 opportunities for errors in medication administration. This resulted in a medication error rate of 7.41%.</p>	F 0332	<p>F365 483.25(m)(1) Free of Medication Error Rates of 5% or more The facility must ensure that it is free of medication error rates of five percent or greater</p> <p>1.What corrective actions will be accomplished for those Residents found to have been affected by the deficient practice?</p>	09/11/2015

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	<p>(Residents #56)</p> <p>Finding includes:</p> <p>During a medication pass observation on 8/20/15 at 9:25 a.m., LPN #1 prepared Resident #56's medications, which included gabapentin (Neurontin, a pain medication) 800 milligrams (mg) and gabapentin 100 mg to equal a total dose of gabapentin 900 mg. LPN #1 then administered the medications to the resident.</p> <p>Resident #56's record was reviewed on 8/20/15 at 9:45 a.m. The resident's diagnoses included, but were not limited to, chronic pain, hypertension, and bipolar disorder.</p> <p>Review of the August 2015 Physician Order Summary (POS), indicated the following orders:</p> <ul style="list-style-type: none"> -gabapentin 100 mg capsule by mouth every 8 hours with 800 mg to equal 900 mg dose at 6 a.m., 2 p.m., and 10 p.m. -gabapentin 800 mg tablet by mouth every 8 hours with 100 mg to equal 900 mg dose at 6 a.m., 2 p.m., and 10 p.m. -Vitamin C 250 mg tablet by mouth 2 times a day x 42 days at 8 a.m. and 4 p.m. for wound healing, ordered 7/28/15. <p>Review of the August 2015 Medication</p>		<p>1. Resident #56's physician was notified of the medication error on 08-20-2015 and re-ordered the Vitamin C to restarted for an additional 30-days and ordered his Gabapentin be corrected to reflect the correct medication administration times.</p> <p>2. No further Residents were directly affected by the deficient practice</p> <p>2. How other Residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</p> <p>1. All Resident have the potential to be affected by the deficient practice</p> <p>2. An audit of the each Residents Medication administration Record was completed to ensure that all Residents medications are administered at the time prescribed and any medication with an automatic stop date are not bracketed to stop too soon.</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <p>1. LPN #1 was re-educated to the medication administration policy and procedure on 08-20-2015</p> <p>2. All licensed nurses were re-educated to the medication administration policy and procedure on 09-03-2015</p>				

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	<p>Administration Record (MAR), indicated the gabapentin medication administration times of 6 a.m., 2 p.m., and 10 p.m. had been written over and now read 12 a.m., 8 a.m., and 4 p.m. The order for the Vitamin C had been stopped on 8/9/15 and was highlighted in yellow marker. "Stop date 9/9/15" was written next to the Vitamin C order.</p> <p>Interview with LPN #1 on 8/20/15 at 9:47 a.m. indicated she had administered the gabapentin because the administration time had been changed to 8 a.m. She further indicated she had not given the Vitamin C because the order had been completed and was highlighted off the MAR. After reading the note beside the Vitamin C order, "stop date 9/9/15," she indicated she was unsure if the stop date should have been 8/9/15 but if not the Vitamin C medication should have been given.</p> <p>Interview with Nurse Consultant #1 on 8/20/15 at 10:06 a.m. indicated the Vitamin C should have been given and the stop date was 9/9/15. She further indicated she was unsure why the gabapentin administration times had been changed. She indicated the gabapentin order had been written for every 8 hours and the pharmacy most likely had assigned the administration times on the</p>		<p>3. Resident #56's physician was notified of the medication error on 08-20-2015 and re-ordered the Vitamin C to restarted for an additional 30-days and ordered his Gabapentin be corrected to reflect the correct medication administration times.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place and</p> <p>1. The Director of Nursing or designee will complete weekly medication administration record (MAR) audits for 60-days to ensure that no medication time has been changed without a physician's order and medications with stop dates are stopped as prescribed. DON or designee will then audit bi-weekly for 30-days then quarterly thereafter</p> <p>2. The Director of Nursing or designee will submit the audit findings to the quality assurance committee for review monthly any deficient practice identified during the audits will be corrected immediately and staff re-educated as warranted</p> <p>5. By what date the systemic changes will be completed</p> <p>1.09-11-2015</p>				

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	<p>POS. She further indicated if the resident had requested a different medication administration time or the times needed to be changed the Physician should have been notified and an order should have been written to change the medication administration times.</p> <p>A facility policy, dated 10/2014, titled, "Physician Orders," received from Nurse Consultant #1 as current on 8/20/15 at 10:23 a.m., indicated, "...Order Clarification Requests: 1...if there is any question regarding the 5 Rights (i.e., right resident, right medication, right dose, right route, right frequency), the licensed nurse will attempt to contact the prescribing physician to obtain a clarification of any order in question..."</p> <p>A facility policy, dated 10/2014, titled, "Medication Administration," received from Nurse Consultant #1 as current on 8/20/15 at 10:23 a.m., indicated, "...time element: 1. Medications are to be administered within 1 hour of the scheduled administration time...33. The individual medication administration records (MARs) should be reviewed at the end of medication pass to ensure all ordered medications were administered..."</p> <p>3.1-25(b)(9)</p>						

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F 0465 SS=E Bldg. 00	<p>3.1-48(c)(1)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, record review, and interview, the facility failed to ensure the environment was safe, clean, and in good repair related to rusted vents, a loose electrical outlet, marred and gouged walls and doors, and a chipped windowsill on 4 of 4 hallways throughout the facility. (West, South, East, North)</p> <p>Findings include:</p> <p>During an Environmental tour with the Administrator and Regional Director on 8/21/15 at 9:40 a.m., the following areas were observed:</p> <p>1. West hall: A. The inner bathroom door for the shared bathroom between rooms 10 and 11 was marred. Two residents shared this bathroom.</p> <p>2. South hall: A. Room 20: There were large chips out of the windowsill. Two residents resided</p>	F 0465	<p>F465 483.70(h)Safe/Functional/Sanitary/Comfortable Environment The facility must provide a safe, functional, sanitary and comfortable environment for Residents, staff and the public 1.What corrective actions will be accomplished for those Residents found to have been affected by the deficient practice? 1.No Resident was affected by the deficient practice 2.How other Residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? 1.All Residents have the potential to be affected by the deficient practice 2.Bathroom doors between Rm 10 and 11 were repaired on 08-24-2015 3.Room 20 windowsill ledge was repaired on 08-24-2015 4.Room 40 protruding electrical outlet was repaired, all mars were repaired and removed</p>	09/11/2015

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	<p>in this room.</p> <p>B. Room 40: There were mars on the bathroom wall and the outlet on the wall to the right of the bed was protruding and not secured to the wall. One resident resided in this room and used this bathroom.</p> <p>3. East hall: A. Room 39: The wall and corner near the bathroom were gouged and the bathroom sink faucet had a greenish buildup. One resident resided in this room.</p> <p>B. Room 42: The bathroom wall and door were marred and the paint was peeling off the room wall next to the bathroom door. One resident resided in this room.</p> <p>C. Room 45: The bathroom floor vent was rusted. One resident resided in this room.</p> <p>4. North hall: A. Room 23: There were gouges to the wall behind the nightstand, the wall corner by the bathroom was gouged and peeling, and the room floor vent was rusted. One resident resided in this room.</p> <p>At the time of the tour, the Administrator</p>		<p>from the walls on 08-24-2015</p> <p>5.Room 39 the wall and corner near the bathroom were repaired, the greenish discoloration on the faucet was removed and cleaned on 08-24-2015</p> <p>6.Room 42 bathroom wall and door were repaired and re-painted on 08-24-2015</p> <p>7.Room 45 bathroom floor vent was replaced on 08-25-2015</p> <p>8.Room 23 all gouges were repaired and wall was painted on 08-24-2015, the vent wasreplaced on 08-24-2015</p> <p>3.What measures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur.</p> <p>1.The Maintenance Supervisor and Housekeeping Supervisor were re-educated on daily cleaning requirement and preventative maintenance duties by the Administratoron 08-27-2015</p> <p>2.AllHousekeeping staff were re-educated on the daily cleaning requirements on09-03-2015 by the Housekeeping Supervisor and Administrator</p> <p>3.A facility wide inspection was conducted by the Administrator, Maintenance Supervisor and Housekeeping/Laundry Supervisor to identify any other gouges, mars, scuff marks, loose outlets, rusty vents or discolored</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155743	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/21/2015
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NAME OF PROVIDER OR SUPPLIER GREEN-HILL MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 501 N LINCOLN AVE FOWLER, IN 47944
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	<p>indicated these areas were due to daily use by the residents and were normally repaired during maintenance checks.</p> <p>Review of maintenance logs on 8/21/15 at 10:20 a.m. indicated both rooms 10 and 23 were checked on 8/17/15, the same day as the initial room observations were made, and were found to be in no need of repair.</p> <p>3.1-19(f)</p>		<p>faucets on 09-03-2015 all areas identified with any concerns were repaired or cleaned immediately</p> <p>4.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place and</p> <p>1.The Maintenance Supervisor or designee will conduct facility wide inspections weekly to ensure no marks, scuff marks, gouges, and loose outlets are present. Any area identified was corrected immediately. These weekly audits will continue for 60-days then bi-weekly for 30-days then quarterly thereafter</p> <p>2.The Housekeeping/Laundry Supervisor will conduct facility wide room inspections weekly for 60-days then bi-weekly for 30-days to ensure no discolored faucets are present. If any faucet is identified as being discolored the faucet will be cleaned immediately</p> <p>3.Housekeeping/Laundry Supervisor or and Maintenance Supervisor will submit to the quality assurance committee findings. Any deficient practice identified will be corrected immediately.</p> <p>5.By what date the systemic changes will be completed 1.09-11-2015</p>	