

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240
---	---

(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
F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit included the Investigation of Complaint IN00145753 and IN00145843.</p> <p>Complaint IN00145753-Substantiated. Federal/state deficiency related to the allegation is cited at F385.</p> <p>Complaint IN00145843-Substantiated. Federal/state deficiencies related to the allegations are cited at F241, F309, and F364.</p> <p>Survey dates: March 24, 25, 26, 27, 28, and 31, 2014. April 1, 2, and 3, 2014.</p> <p>Facility number: 000305 Provider number: 155625 AIM number: 100287200</p> <p>Survey team: Barbara Gray, RN-TC Leslie Parrett, RN (March 25, 26, 27, 28, and 31, 2014. April 1, 2, and 3, 2014) Angel Tomlinson, RN</p> <p>Census bed type: SNF/NF: 76 Total: 76</p> <p>Census payor type: Medicare: 11 Medicaid: 60 Other: 5</p>	F000000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a desk review in lieu of a Post Survey Review on or after April 25, 2014. Facility is requesting paper review for IDR due to disagreement with citing of F309, F315, F385, F285.	

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: 155625	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240
---	---

(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
F000241 SS=E	<p>Total: 76</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on April 10, 2014 by Cheryl Fielden, RN. 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation and interview the facility failed to maintain each resident's dignity and respect for the residents eating in the assisted dining room and Alzheimer's dining room for 2 of 2 dining observations for residents eating in the assisted dining room and Alzheimer's dining room.</p> <p>Findings include:</p> <p>On 3/31/14 at 12:10 p.m., interview with confidential staff member indicated she has had problems with dietary concerns on the Alzheimer's unit. She indicated when dietary doesn't send enough food for all the residents and when she goes to get more food the dietary staff say they have to feed all the residents before they can send us more food. The Alzheimer's unit residents do not get to choose what they are served and some of them do not like what they send. When staff try to get the alternate for those residents dietary does not have it available. If dietary does have the alternate available the residents have to wait for all residents in the</p>	F000241	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? * Resident #N and Resident #108 were not harmed by alleged deficient practice. * All staff in-serviced on dignity and respect, set up of meals, providing salt and pepper, providing linen napkins, infection control related to handling of food on 4/15/14 *Hand washing skills validations completed for all staff on 4/15/14 and 4/16/14 *Facility purchased linen napkins for all residents and will no longer use paper napkins at meal times *Residents on Alzheimer's unit and assisted dining room are offered substitutes and condiments per resident choice</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.</p>	04/25/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240
---	---

(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>facility to be served before any of the other residents can have the alternate. The Alzheimer's unit residents get bored and start wandering and sometimes we get them to sit down to eat sometimes we can not. So we end up feeding them peanut butter and jelly, cookies, ensure or mighty milk. Everyone needs to have a fair amount of food no matter what unit they are on. It seems worse on the Alzheimer's unit. The Alzheimer's residents say they are hungry and the ones that do not talk will go get in the refrigerator or the cabinets.</p> <p>Interview on 3/31/14 at 4:50 p.m., with dietary aide # 6 indicated she dips the food up for the assisted and Alzheimer's dining rooms and the facility does not offer the alternate to these two dining rooms. These residents are served what is on the main menu.</p> <p>3/31/14 at 5:00 p.m., observation of dinner meal indicated 4 staff assisting residents in the assisted dining room and 14 residents seated in the dining room.</p> <p>At 5:07 p.m., the first tray was passed, all residents were given their meal on a tray with the plate warmer left under the plate and paper napkin beside of plate warmer on the tray. One resident was provided with salt and pepper shakers on his table. No observation of menu with alternates posted for assisted dining room.</p> <p>Observation of Resident # N eating a paper napkin, staff removed the napkin from her mouth.</p> <p>CNA # 10 observed touching Resident # 108's bun with fingers to spread condiment on sandwich. No observation of handwashing</p>		<p>* Residents who reside in this facility have the potential to be affected by the alleged deficient practice. * All staff in-serviced on dignity and respect, set up of meals, providing salt and pepper, providing linen napkins, infection control related to handling of food on 4/15/14 *Director of Nursing and/or designee conducted skills validations on hand washing for all staff on 4/15/14 and 4/16/14 *Director of Nursing and/or designee conducted skills validations on assist to eat for all nursing staff on 4/15/14 * Alternate menu items are offered to all residents in facility * Menu posted in assisted dining room * Facility purchased linen napkins for all residents and will no longer use paper napkins at meal times *Residents on Alzheimer's unit and assisted dining room are offered substitutes and condiments per resident choice What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? * All staff in-serviced on dignity and respect, set up of meals, providing salt and pepper, providing linen napkins, infection control related to handling of food on 4/15/14 *Director of Nursing and/or designee conducted skills validations on hand washing for all staff on 4/15/14 and 4/16/14 *Director of Nursing and/or</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/03/2014	
NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240			
(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			
F000252 SS=E	<p>or sanitizing hands prior to touching bun.</p> <p>Interview with CNA # 10 indicated she was aware she was not to touch the food with her hands.</p> <p>On 3/31/14 at 5:40 p.m., observation of the dinner meal in the main dining room indicated all residents eating in this dining room were provided with a cloth napkin, salt and pepper. Observation of staff asking the residents their preference between chili and fish sandwiches. Observed menu with alternate posted outside of main dining room entrance door.</p> <p>On 4/2/14 at 11:15 a.m., observation of the lunch meal indicated 14 residents in assisted dining room, observed paper napkins provided for the residents. No observation of a menu posted in or near the assisted dining room.</p> <p>Interview on 4/2/14 at 11:35 a.m., with CNA # 3 indicated she does not know what some of the items are the residents in the assisted dining room are eating and has no idea what the alternate is because they do not have the menu posted in the assisted dining room, so it is not offered. The CNA indicated one resident requested salt and pepper so shakers were provided on his table for him.</p> <p>This federal tag relates to compliant IN00145843</p> <p>3.1-3(t) 483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment,</p>		<p>designee conducted skills validations on assist to eat for all nursing staff on 4/15/14 *</p> <p>Alternate menu items are offered to all residents in facility * Menu posted in assisted dining room *</p> <p>Facility purchased linen napkins for all residents and will no longer use paper napkins at meal times</p> <p>*Residents on Alzheimer's unit and assisted dining room are offered substitutes and condiments per resident choice</p> <p>*Manager overseeing dining rooms will ensure residents in all dining rooms are provided choices, hands are washed appropriately, linen napkins are offered and condiments are provided to residents</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>* A Meal Observation CQI tool will be utilized by Director of Nursing and/or designee weekly x 4 weeks, monthly x 2 months and quarterly X1 for at least 6 months* Audit tools will be submitted to the CQI committee and action plans will be developed as needed if threshold of 100% is not met.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240
---	---

(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>allowing the resident to use his or her personal belongings to the extent possible.</p> <p>Based on observation, interview, and record review, the facility failed to ensure 1 of 5 hallways remained free of strong urine odor. This had the potential to affect all 17 residents who resided on the 300 hall Alzheimer's unit.</p> <p>Findings include:</p> <p>During initial tour of the facility on 3/24/14 at 9:20 A.M., the locked Alzheimer's unit smelled strong or urine odor.</p> <p>On 3/25/14 at 2:30 P.M., the locked Alzheimer's unit smelled strong of urine odor.</p> <p>On 3/27/14 at 10:22 A.M., the locked Alzheimer's unit smelled strong of urine odor.</p> <p>On 3/28/14 at 9:12 A.M., the locked Alzheimer's unit smelled strong of urine odor. QMA #11 indicated the staff worked really hard on ridding the unit of the urine odor but it was difficult to get rid of. She indicated the staff had been working on getting rid of the urine odor for quite awhile. She indicated the staff used air fresheners. She indicated the staff also used a chemical spray provided by housekeeping on the residents beds. She indicated the resident's briefs were changed often. She indicated there was a resident that urinated in the hallway but staff cleaned the urination up immediately after it was noticed. She indicated the unit smelled strong of urine to her first thing in the morning when she came to work and then after being at work for awhile she didn't smell it anymore.</p>	F000252	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? * All staff in-serviced on odor prevention on 4/15/14.*Executive Director had new ventilation system installed on the Alzheimer's unit on 4/17/14.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. * Residents who reside in the facility have the potential to be affected by the alleged deficient practice. * All staff in-serviced by the Director of Nursing and/or designee on odor prevention on 4/15/14. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? * All staff in-serviced by the Director of Nursing and/or designee on odor prevention on 4/15/14. * Executive Director had new ventilation system installed on the Alzheimer's unit on 4/17/14. * Executive Director and/or designee will conduct walk through on the Alzheimer's unit each shift daily to monitor odor and to ensure cleanliness of unit.How will the corrective action(s) be monitored to ensure the deficient practice</p>	04/25/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240
---	---

(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 3/28/14 at 9:24 A.M., Housekeeping Staff #12 was observed entering the locked Alzheimer's unit with her cleaning cart. Housekeeping Staff #12 indicated she believed the urine smell came from residents who urinated on the floor and when staff got residents up out of a wet bed. She indicated some residents had really strong urine. She indicated the unit staff were good about cleaning the beds and floors if a resident urinated. She indicated if a resident's bed was unmade, housekeeping cleaned the resident's mattress. She indicated on average she washed down approximately 3 beds a day and some of them would already be washed down when she came on the unit. She indicated she had noticed the smell of urine when she first entered the unit. She indicated the unit usually smelled better after housekeeping finished cleaning.</p> <p>On 3/28/14 at 10:02 A.M., the Executive Director (ED) indicated the Director of Operations had notified another facility that had a ventilation system put in on their locked Alzheimer's unit and "we want to have the same thing done here." She indicated the facility's Maintenance staff had repaired some of the exhaust fans and she felt the urine odor problem was better but "we realize it is still not up to par." She indicated she had not got any quotes for the ventilation system yet. She stated "we just came up with the idea because we have tried everything else." She indicated she had noticed the urine odor smell on and off since her employment began at the facility in April, 2013.</p> <p>On 3/28/14 at 1:39 P.M., the locked Alzheimer's unit smelled strong of urine odor.</p> <p>On 3/31/14 at 9:46 A.M., the locked</p>		<p>will not recur, i.e., what quality assurance program will be put into place? * An Accommodation of Needs CQI tool will be utilized by Director of Nursing and/or designee weekly x 4 weeks, monthly x 2 months and quarterly X1 for at least 6 months* Audit tools will be submitted to the CQI committee and action plans will be developed as needed if threshold of 100% is not met.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/03/2014
NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240		
(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>Alzheimer's unit smelled strong of urine odor.</p> <p>On 3/31/14 at 12:05 P.M., CNA #13 was observed assisting Resident #55 to the toilet in the bathroom adjoined to room 303 on the locked Alzheimer's unit. The bathroom exhaust fan was extremely loud when the light switch on the wall was turned on. CNA #13 indicated the "fan overhead" was extremely loud.</p> <p>On 3/31/14 at 12:27 P.M., the Maintenance Supervisor indicated he had been employed at the facility approximately 6 or 7 weeks and had been working on the exhaust system since he began his employment. He indicated some of the exhaust fans were locking up and not working. He indicated he was not aware of any problem with the exhaust fan in the bathroom adjoined to room 303 on the locked Alzheimer's unit. He indicated he was in the process of getting some of the exhaust fans replaced in the facility. He indicated he had ordered new exhaust fans for rooms 305, 106, the 200 hall CNA room, and room 402. He indicated the facility's exhaust system has had lack of preventable maintenance. He indicated he believed the urine odor on the locked Alzheimer's unit may be due to lack of ventilation and possibly the flooring saturated with urine.</p> <p>On 4/1/14 at 10:40 A.M., the locked Alzheimer's unit smelled strong of urine odor.</p> <p>On 4/3/14 at 2:29 P.M., the Memory Care Facilitator on the locked Alzheimer's unit indicated 17 residents resided on the unit.</p> <p>3.1-19(f)(5)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240
---	---

(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
F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview and record review the facility failed to follow a physician order for mighty milk at meals for nutritional benefits and failed to follow physician order and care plan for cups with hands to promote independence with drinking for 2 of 25 residents sampled for physician orders and careplan's (Resident #C and Resident #N).</p> <p>Findings include:</p> <p>1.) During an observation on 3-31-14 at 11:15 a.m., Resident #C was eating lunch, the resident was not served mighty milk.</p> <p>Review of the record of Resident #C on 3-31-14 at 3:00 p.m., indicated the resident's diagnoses included, but were not limited to, muscle weakness, depression, anxiety and constipation.</p> <p>The observation report for Resident #C dated 11-19-13 indicated the resident was to have mighty milk at lunch and dinner for added calories.</p> <p>The Minimum Data Set (MDS) Quarterly assessment for Resident #C dated 2-7-14 indicated resident's BIMS (Brief Interview for Mental Status) was a 15, with a range of 13-15, indicating the resident is cognitively intact.</p>	F000282	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? * Resident #C and Resident #N were not harmed by alleged deficient practice.* All staff in-serviced by the Director of Nursing and/or designee on following tray cards on 4/15/14. *Resident #C is receiving mighty milk twice daily as ordered *Resident #N is receiving cups with handles for all fluids at all meals and in room</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. * Residents who reside in this facility have the potential to be affected by the alleged deficient practice. * All staff in-serviced by the Director of Nursing and/or designee on following tray cards on 4/15/14. *Audit was conducted for all residents who receive mighty milk and handled cups to ensure all residents with orders for mighty milk and handled cups have it provided</p> <p>What measures will be put into</p>	04/25/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/03/2014
NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240		
(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>The physician orders for Resident #C dated 3-3-14 to 4-3-14 indicated the resident was ordered mighty milk at lunch and dinner twice a day at lunch and supper.</p> <p>During observation on 4-2-14 at 11:56 a.m. Resident #C was eating lunch, the resident was not served mighty milk.</p> <p>Interview with Resident #C on 4-3-14 at 10:20 a.m. indicated sometimes he receives his mighty milk at breakfast, lunch or supper and sometimes he does not receive mighty milk at all.</p> <p>Interview with the Dietary Manager on 4-3-14 at 11:06 a.m. indicated it was the CNA who passed trays responsibility to put mighty milk on residents trays.</p> <p>2. On 3/31/14 at 5:20 p.m., observation of the dinner meal in the assisted dining room indicated Resident # N eating her dinner meal, observed her menu card which indicated "cup with handle for all liquids." Observed Resident # N with a glass of lemonade with no handle on the glass and no cup with a handle was observed for the Resident.</p> <p>On 4/1/14 at 11:10 a.m., observation of lunch meal in the assisted dining room indicated observed Resident # N's menu card which indicated "cup with handle for all liquids." Observed her eating lunch meal with 2 glasses of fluids on the table. There were no handles on the glasses and no cups with handles were observed for the Resident.</p>		<p>place or what systemic changes you will make to ensure that the deficient practice does not recur? * All staff in-serviced by the Director of Nursing and/or designee on following tray cards on 4/15/14. * 100% audit of all resident's tray cards will be completed by 4/25/14 by the Director of Nursing and /or designee. *Audit tool will be completed by Director of Nursing and/or designee during meal service daily for each meal to ensure items on tray cards are provided</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? * Audit tool will be completed by Director of Nursing and/or designee during meal service daily for each meal to ensure items on tray cards are provided * A Meal Observation CQI tool will be utilized by Director of Nursing and/or designee weekly x 4 weeks, monthly x 2 months and quarterly X1 for at least 6 months * Audit tools will be submitted to the CQI committee and action plans will be developed as needed if threshold of 100% is not met.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240
---	---

(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 4/2/14 at 11:15 a.m., observation of lunch meal in the assisted dining room, observed Resident # N eating lunch meal with 2 glasses of fluids, without handles. No cups with handles were observed for the Resident.</p> <p>Review of the record of Resident # N on 4/1/14 at 10:00 a.m., indicated the Resident's diagnoses included, but were not limited to, depressive disorder, NEC, rupture, eye with partial tissue loss, congestive heart failure, NOS, macular degeneration, NOS and osteoporosis, NOS.</p> <p>The Physician recapitulation orders dated 3/3/2014 - 4/3/2014 indicated Diet: pureed diet with thin liquids, all liquids in cup with handle - 2/26/14.</p> <p>The Minimum Data Set (MDS) Assessment for Resident # N dated 2/21/2014 indicated how resident eats and drinks, regardless of skill - extensive assistance of one person needed.</p> <p>Care plan for Nutritional status: Resident receives a pureed fortified diet with thin liquids...Goal: Resident will maintain weight. Approach: liquids in cup with handle for all meals.</p> <p>On 4/3/14 at 11:40 a.m., an interview with the Speech Therapist indicated "the Resident was having difficulty with holding onto her drinking glasses and I noticed she does well with the water cup she has in her room because it has handles on it. I asked her family about using cups with handles and they agreed she would do better if she had cups that have handles. I placed a recommendation in for the Physician for the Resident to use cups with handles."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240
---	---

(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
--------------------	--	---------------	---	----------------------

F000285 SS=D	<p>On 4/3/14 at 10:36 a.m., the Director of Nursing provided a document titled Care Plan Review indicated Resident Care and Safety: Policy: It is the policy of this facility that each resident will have a comprehensive care plan developed based on comprehensive assessment. The care plan will include measurable goals and resident specific interventions based on resident needs and preferences to promote the residents highest level of functioning including medical, nursing, mental and psychosocial needs.</p> <p>On 4/3/14 at 1:40 p.m., the Director of Nursing provided a document titled Compliance with Physician's Orders indicated: Purpose: To ensure the residents receives all medications and treatments as ordered by the prescriber. To ensure all medications, treatments and orders are accurately documented, co-signed by the prescriber and carried out as ordered by the nursing staff.</p> <p>3.1-35(g)(2) 483.20(m), 483.20(e) PASRR REQUIREMENTS FOR MI & MR A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort.</p> <p>A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental illness as defined in paragraph (m)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or</p>			
-----------------	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240
---	---

(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>entity other than the State mental health authority, prior to admission;</p> <p>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and</p> <p>(B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation.</p> <p>(ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission--</p> <p>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and</p> <p>(B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation.</p> <p>For purposes of this section:</p> <p>(i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1).</p> <p>(ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009.</p> <p>Based on interview and record review, the facility failed to coordinate for a resident to receive a yearly Pre-Admission Screening and Resident Review (PASRR), for 1 of 1 residents reviewed for PASRR. (Resident #2)</p> <p>Findings include:</p>	F000285	<p>Facility is requesting paper review for IDR due to disagreement with citing of F 285</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? *Resident #2 was not harmed by alleged deficient practice *Developmental Agency</p>	04/25/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/03/2014
NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240		
(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 #2's record was reviewed on 4/3/14 at 11:26 A.M. Her diagnoses included but were not limited, mild intellectual disabilities, dementia, and schizophrenia.</p> <p>Resident #2's Quarterly Minimum Data Set (MDS) Assessment dated 1/13/14, indicated she was understood and had the ability to understand others. She required supervision of 1 person for bed mobility, walking, and eating. She required extensive assistance of 1 person for personal hygiene. She required extensive assistance of 2 person to toilet. She required limited assistance of 1 person to transfer and dress.</p> <p>A Pre-Admission Screening/Resident Review Certification for Nursing Facility Services for Resident #2 dated 6/12/08, indicated the following: Resident #2 had a developmental disability and a mental illness. She met the PASRR Level II criteria for admission to a nursing facility. She would require a yearly Resident Review.</p> <p>A Social Service Note for Resident #2 dated 3/28/14 at 8:24 A.M., indicated a message had been left for the staff member responsible for Resident #2's Level II services and the need for an update.</p> <p>An interview with the Social Service Designee (SSD) on 4/3/14 at 12:23 P.M., indicated she had finally made contact with the staff who had completed Resident #2's Level II Review on 6/12/08. She indicated that staff had informed her she was not sure why she hadn't kept up on Resident #2's Level II Reviews. The SSD indicated Resident #2 should receive a Level II Review yearly.</p>		<p>was notified on 4/1/14 and 4/17/14 of resident need for yearly screening How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. * Residents who reside in this facility and meet requirements for Level II have the potential to be affected by the alleged deficient practice * Developmental Agency was notified on 4/1/14 and 4/17/14 of resident need for yearly screening *100% audit of all residents requiring Level II will be completed by 4/25/14 by the Director of Nursing and/or designee What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? * 100% audit of all residents requiring Level II will be completed by 4/25/14 by the Director of Nursing and/or designee * Tracking log will be initiated to monitor upcoming yearly reviews of all residents requiring yearly review *Executive Director and/or designee will monitor tracking log to ensure completenessHow will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? *Social Service CQI Tool will be</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/03/2014
NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240		
(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	
F000309 SS=D	<p>An interview with the SSD on 4/3/14 at 2:00 P.M., indicated she had faxed Resident #2's history and physical and her medication regimen to the staff responsible for the Level II Review on 4/2/14. She indicated that staff had not gotten back with her yet.</p> <p>3.1-16(d) 3.1-16(d)(1) 3.1-16(d)(1)(A) 3.1-16(d)(2)(B) 3.1-16(d)(2)(A) 3.1-16(d)(2)(B) 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 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 monitor and have a physician assess a resident with a critically high INR (International Normalized Ratio) lab test for a resident who was experiencing nausea/vomiting and diarrhea for 1 of 3 residents reviewed for infection (Resident #F). Finding include:</p> <p>Review of the record of Resident #F on 3-28-14 at 10:40 a.m. indicated the resident's diagnoses included, but were not limited to, Deep Vein Thrombosis (DVT), hepatitis, congestive heart failure, arthritis and asthma.</p>	F000309	<p>utilized by Director of Nursing and/or designee x 4 weeks, monthly x 2 months, quarterly x 1for at least 6 months* Audit tools will be submitted to the CQI committee and action plans will be developed as needed if threshold of 100% is not met.</p> <p>Facility is requesting paper review for IDR due to disagreement with citing of F 309 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? *Resident #F no longer resides in facility.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? *All residents have the potential to</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240
---	---

(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>The Minimum Data Set Admission Assessment (MDS) for Resident #F dated 1-24-14 indicated the resident's BIMS (Brief Interview for Mental Status) was a 15, with a range of 13-15, indicating the resident is cognitively intact.</p> <p>The Medication Administration Record (MAR) for Resident #F dated 2-1-14 to 3-1-14 indicated the resident was receiving coumadin (anticoagulant medication) 3 milligrams (mg) at 5:00 p.m. for thrombosis and zofran 4 mg for nausea and vomiting PRN (as needed).</p> <p>The laboratory test for Resident #F dated 2-27-14 indicated the resident's INR level was 8.3 critically high (normal results are 2.0-3.5).</p> <p>The progress note for Resident #F dated 2-27-14 indicated the Medical Doctor MD was notified of critically high INR. The MD gave orders to give the resident Vitamin K 5 mg one time and hold the coumadin on 2-28-14 and repeat the INR on 3-1-14.</p> <p>The event report for Resident #F dated 2-27-14 indicated to monitor for complaints of not feeling well/nausea/diarrhea.</p> <p>The progress note for Resident #F dated 2-28-14 indicated the resident was complaining of nausea and given PRN (as needed) zofran.</p> <p>The MAR for Resident #F indicated the resident received zofran 4 mg on 2-26-14, twice on 2-27-14, once on 2-28-14 and once on 3-1-14 for complaints of nausea and vomiting. The documentation indicated the resident had no complaints of nausea and</p>		<p>be affected by the alleged deficient practice</p> <p>*100% audit of all PRN medications was conducted on 4/17/14 by Director of Nursing and/or designee</p> <p>*MD will be notified with each critical lab level by charge nurse; Medical Records nurse will follow up on all lab notifications during clinical meeting</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</p> <p>*100% audit of all PRN medications was conducted on 4/17/14 by Director of Nursing and/or designee; stop dates requested for all PRN orders for nausea/vomiting/diarrhea</p> <p>*Any new PRN order for nausea/vomiting/diarrhea will have a stop date; Director of Nursing and/or designee will monitor to ensure all PRN orders for nausea/vomiting/diarrhea have a stop date</p> <p>*MD will be notified with each critical lab level by charge nurse; Medical Records nurse will follow up on all lab notifications during clinical meeting</p> <p>*Medical Records Nurse will audit lab levels during clinical meeting and ensure MD is notified and also notified by charge nurse on weekends</p> <p>How the corrective action(s)</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240
---	---

(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>vomiting and the request of zofran any of the 25 days prior to 2-26-14.</p> <p>The weights for Resident #F indicated on 2-20-14 the resident weighed 129 pounds and on 2-27-14 the weighed 116 pounds, this indicated the resident lost 13 pounds in 7 days.</p> <p>The progress note for Resident #F dated 3-1-14 at 3:40 p.m. indicated the writer was called to the resident's room to assess the resident. The resident was laying in bed holding his stomach and complaining of abdominal pain. There was a large amount of emesis. The emesis was dark colored blood. The resident was pale in color. The MD was notified of bloody emesis and an order was received to send the resident to the emergency room for treatment and evaluation.</p> <p>The local hospital emergency room notes for Resident #F indicated the resident had abdominal pain for one week with bloody diarrhea for one week. The resident had a White Blood Count (WBC) of 31.2 (normal range is 4.0 to 10.5) indicator of infection and an INR of 9.0 critically high and a low hemoglobin of 12.1 (normal range is 13.5-18.0). The resident received a blood transfusion and was sent to a major medical hospital out of town for further treatment.</p> <p>The major medical hospital in admission notes for Resident #F dated 3-2-14 at 12:31 a.m. indicated the resident presented with coumadin coagulopathy (bloods ability to clot is impaired) with an INR of 9, two FFP (Fresh Frozen Plasma) given and sinus tachycardia (fast heartbeat). The resident had black stools for the past week. The resident was</p>		<p>will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>*A Lab CQI tool will be utilized by Director of Nursing and/or designee weekly x 4 weeks, monthly x 2 months and quarterly X1 for at least 6 months</p> <p>*A Condition Change CQI tool will be utilized by the Director of Nursing and/or designee weekly x 4 weeks, monthly x 2 months and quarterly x 1 for at least 6 months* Audit tools will be submitted to the CQI committee and action plans will be developed as needed if threshold of 100% is not met.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240
---	---

(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>sent for further evaluation. A CT (Computerized Tomography) was completed for the resident. The findings were highly concerning for acute bowel ischemia (large and small intestines become narrow or blocked resulting in the bowels not getting enough oxygen).</p> <p>The preoperative diagnoses dated 3-2-14 for Resident #F was ischemic bowel and sepsis (infection in the blood). The procedure done was a exploratory laparotomy, abdominal washout (diluting or washing with fluid), ilecolectomy and an ileostomy (surgical opening in the skin to allow intestinal waste to pass into an external pouch) done. The resident was then transferred to the ICU (Intensive Care Unit) in critical condition. The resident was discharged back to the facility on 3-21-14.</p> <p>Interview with Resident #Q on 3-25-14 at 10:00 a.m. indicated on 3-1-14 he reported to the facility staff that there was something wrong with Resident #F. Resident #Q indicated Resident #F had lost a lot of weight and was suffering. Resident #Q indicated the week prior to 3-1-14 he would go visit Resident #F and he was very sick and looked bad.</p> <p>Interview with Resident #F on 3-28-14 at 2:20 p.m. indicated he had been sick and experienced abdominal pain three days prior to being sent to the hospital on 3-1-14. The resident indicated he had been experiencing diarrhea for approximately one month before being sent to the hospital and it caused him to very weak. The resident indicated the facility staff was aware he had been experiencing nausea and diarrhea. The resident indicated the diarrhea was green</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240
---	---

(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 dark black and it worried him so he kept telling the staff. The resident indicated he was so ill he couldn't sleep or eat and he had lost a lot of weight during that time. The resident indicated he did not feel the facility responded timely. The resident indicated he did not see a physician at the facility during the time he was ill. The resident indicated the nurses would give him stomach medication but it was not effective. The resident indicated another resident at the facility complained to the staff that I looked really bad and needed help and then they sent me to the hospital. The resident indicated he had infection in his bowels and had to have a bag put on. During observation at this time the resident showed me his ileostomy bag which was located on the right side of his abdomen and was draining dark fluid.</p> <p>Interview with CNA #2 on 3-31-14 at 12:45 p.m. indicated she was Resident #F's aide on 3-1-14 when he was sent to the hospital. CNA #2 indicated the resident was laying around and said he didn't feel good. CNA #2 indicated she reported it to LPN #5. CNA #2 indicated the resident was independent with toileting and she was not aware that he had diarrhea.</p> <p>Interview with CNA #3 on 3-31-14 at 2:05 p.m. indicated she was caring for Resident #F on 3-1-14. CNA #3 indicated she knew Resident #F was sick a couple days prior to 3-1-14 because he would say he didn't feel good and would stay in bed. CNA #3 indicated on 3-1-14 the resident was vomiting a dark black substance with a strong odor.</p> <p>Interview with LPN #5 on 3-31-14 at 4:10 p.m. indicated she was the nurse caring for Resident #F on 3-1-14 when the resident was</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240
---	---

(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>sent to the hospital. LPN #5 indicated she got in report from the previous nurse that the resident had vomited and had blood tinged diarrhea the previous evening and was given zofran. LPN #5 indicated the resident reported to her that he had been complaining of nausea and vomiting for several days. LPN #5 indicated the resident began vomiting dark ruby red with an odor of old blood and she sent him to the emergency room.</p> <p>Interview with RN #7 on 4-1-14 at 10:57 a.m. indicated she gave Resident #F zofran on 2-26-14 and could not remember why she gave it to him.</p> <p>Interview with LPN #8 on 4-1-14 at 10:57 a.m. indicated she gave Resident #F zofran twice on 2-27-14 for an upset stomach. LPN #8 indicated she did not remember if she assessed the resident or documented anything except for what was on the MAR.</p> <p>Interview with RN #9 on 4-1-14 at 11:14 a.m. indicated Resident #F reported to her on 2-28-14 that he had been sick for a week or two and was very nauseous and had diarrhea. RN #9 indicated she told Resident #F to let her see his stool when he had diarrhea, but he would forget and flush the toilet so it was not observed. RN #9 indicated Resident #F reported to her that he had not been able to eat very well because he was nauseous.</p> <p>Interview with the Assisted Director of Nursing (ADON) and Director of Nursing (DON) on 4-1-14 at 2:27 p.m. indicated the event charting for 2-27-14 was documented by the ADON because Resident #F complained of not feeling well. The ADON indicated the resident did not report he had</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240
---	---

(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
F000315 SS=D	<p>nausea or vomiting. The DON indicated the nausea, vomiting and diarrhea was being monitored because the resident had reported he did not feel good.</p> <p>This Federal tag relates to Complaint IN00145843.</p> <p>3.1-37(a) 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, interview, and record review, the facility failed to develop an individualized toileting program to restore bladder function for a resident with a decline in urinary continent status for 1 of 3 residents reviewed for urinary incontinence of 4 who met the criteria for urinary incontinence. (Resident #64)</p> <p>Findings include:</p> <p>Resident #64's record was reviewed on 3/31/14 at 3:28 P.M. His diagnoses included but were not limited to, muscle weakness, anxiety, and depression.</p> <p>Resident #64's Admission Minimum Data Set</p>	F000315	<p>Facility is requesting paper review for IDR due to disagreement with citing of F 315</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>*Resident #64 was not harmed during alleged deficient practice *Resident #64 has been reassessed for appropriateness of a toileting program *All staff was in-serviced on identifying changes in toileting needs on 4/15/14</p> <p>How will you identify other residents having the potential</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240
---	---

(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>(MDS) Assessment dated 12/3/13, indicated he was occasionally incontinent of urine.</p> <p>Resident #64's Quarterly MDS Assessment dated 3/5/14, indicated he understood and was able to understand others. He required extensive assistance of 1 person to walk in his room. He required extensive assistance of 2 persons to toilet. He used a walker. He was always incontinent of urine. A trial toileting program (e.g. scheduled toileting, prompted voiding, or bladder training) had not been attempted since his admission or since his urinary incontinence had been noted in the facility.</p> <p>Resident #64's Incontinence Care Plan initiated 11/27/13, indicated he was at risk for incontinence due to his deficits in independence and his diagnoses of dementia and benign prostrate hypertrophy. His goal indicated he would be free from adverse effects of incontinence. Approaches implemented for his urinary incontinence indicated his skin would be assessed and documented weekly and as needed. He would be assisted with incontinent care as needed. Any abnormal findings would be documented and the MD notified. Staff would observe him for any signs of a urinary tract infection. The Incontinence Care Plan did not address any interventions the facility would attempt to restore Resident #64's bladder function.</p> <p>An IDT Bladder Continence Review form for Resident #64, dated 12/6/13, indicated he was occasionally incontinent. He was mentally and physically aware of the need to void and able to use the toilet, commode, urinal or bedpan. He was mentally and physically able to resist voiding to attempt a</p>		<p>to be affected by the same deficient practice and what corrective action will be taken?</p> <p>*All residents have the potential to be affected by the alleged deficient practice</p> <p>*All staff was in-serviced on identifying changes in toileting needs by Director of Nursing and/or designee on 4/15/14</p> <p>*Director of Nursing and/or designee will reassess all completely incontinent residents with 3 day voiding patterns to ensure all residents needing bladder retraining have appropriate interventions by 4/25/14</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>* All staff was in-serviced on identifying changes in toileting needs by Director of Nursing and/or designee on 4/15/14</p> <p>* Director of Nursing and/or designee will reassess all completely incontinent residents with 3 day voiding patterns to ensure all residents needing bladder retraining have appropriate interventions by 4/25/14</p> <p>*All new admissions and residents with significant change will have IDT Bladder Review conducted within 7 days of completed MDS assessment.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/03/2014
NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240		
(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>bladder retraining program. He was continent and did not require a toileting program.</p> <p>A 3 Day Bladder/Bowel Pattern for Resident #64 beginning 3/4/14, and ending 3/6/14, indicated he voided in the toilet 10 times.</p> <p>An IDT Bladder Continence Review form for Resident #64, dated 3/7/14, indicated he was always incontinent. He was not mentally and physically aware of the need to void or be able to use the toilet, commode, urinal, or bedpan. He was not mentally or physically able to resist voiding to attempt a bladder retraining program. He was not appropriate for a scheduled toileting program. Routine incontinent care would be provided.</p> <p>A review of Resident #64's continence status entered into the facility's Kiosk every shift, beginning 2/23/13 until 3/31/13, indicated he had 3 episodes of urinary continence.</p> <p>A Resident Profile for Resident #64 utilized by the staff to coordinate care, indicated he would be assisted with routine incontinent care. No individualized toileting schedule was documented on the Resident Profile sheet.</p> <p>On 3/28/14 at 12:27 P.M., Resident #64 was observed lying in bed on his back. A walker was next to his bed. At that time the Memory Care Facilitator (MCF) indicated he was not bedridden and utilized the walker next to his bed.</p> <p>On 3/31/14 at 11:18 A.M., Resident #64 was observed seated upright in a dining chair in the dining room with peers eating his lunch independently.</p>		<p>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?</p> <p>*A Restorative Nursing/FIT Program CQI tool will be utilized by Director of Nursing and/or designee weekly x 4 weeks, monthly x 2 months and quarterly X1 for at least 6 months* Audit tools will be submitted to the CQI committee and action plans will be developed as needed if threshold of 100% is not met</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240
---	---

(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 3/31/14 at 11:53 A.M., Resident #64 was observed ambulating with the use of a walker to his bedroom. He laid down on his bed with the assistance of LPN #14 who utilized a gait belt. LPN #14 indicated Resident #64 had been transferring better since he had been discharged from therapy. She indicated he was able to follow directions. She indicated Resident #64 was often continent of urine with occasional episodes of incontinence. She indicated Resident #64 was able to use his call light to let staff know he had to toilet.</p> <p>On 3/31/14 at 4:03 P.M., Resident #64 was observed ambulating to the toilet with the use of a walker and stand by assistance from CNA #15. She indicated Resident #64 had put on his call light and was lying in bed when she entered his bedroom. She indicated he required extensive assist to sit up on the bedside and stand. She indicated he was able to walk fairly well after he got started walking. She indicated he had both incontinent and continent episodes of urine. Resident #64 required CNA #15 to lower and pull up his brief and slacks. A moderate amount of urine was observed in Resident #64's brief.</p> <p>On 4/1/14 at 10:44 A.M., Resident #64 was observed getting out of bed and ambulating to the dining room with the use of a walker and the assistance of CNA #16 who utilized a gait belt. CNA #16 indicated Resident #64 was not on any Restorative Programs.</p> <p>On 4/1/14 at 10:56 A.M., the MCF indicated Resident #64 was not on any Restorative Programs.</p> <p>On 4/1/14 at 2:30 P.M., LPN #14 indicated</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/03/2014
NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240		
(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 #64 would put on his call light when he needed to toilet. She indicated he was not on an individualized Restorative Toileting Program. She indicated staff knew when to toilet Resident #64 because every resident on the Alzheimer's unit was toileted every 2 hours.</p> <p>On 4/1/14 at 2:38 P.M., Resident #64 was observed lying on his back in bed awake. He said he was able to feel the sensation to urinate. He said he knew how to put his call light on. He demonstrated pushing his call light button. He indicated he sometimes didn't use his call light because he didn't want to burden the staff.</p> <p>On 4/3/14 at 10:25 A.M., the Assistant Director of Nursing Services (ADNS) indicated Resident #64 had not been appropriate for a Restorative Toileting Program at the time of his last IDT Bladder Continance Review on 3/7/14. She indicated he was always incontinent of urine at that time.</p> <p>On 4/3/14 at 10:31 A.M., the MDS Coordinator indicated Resident #64 had not been placed on a Restorative Toileting Program because he had not had a pattern of urinary incontinence when he completed his 3 Day Voiding Pattern from 3/4/14 to 3/6/14. She indicated Resident #64 had not been reassessed since that 3 day Voiding Pattern. She indicated Therapy would usually let her know in the Medicare meetings if a resident had improved and then staff would decide if the resident needed reassessed.</p> <p>The most recent "Bladder Program" policy and procedure provided by the Director of Nursing Services on 4/2/14 at 9:30 A.M.,</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240
---	---

(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 the following: The facility would promote independence and dignity with an appropriate bladder program based on each resident's ability. "Procedure: 1. Each resident will have a 3 day voiding pattern initiated within 72 hours of admission and/or any change in continence status. 2. A new 3-day voiding patten will only be completed if there is a change in level of continence including when a catheter is removed. 3. The resident should be checked and offered toileting every hour during the waking hours; checked every two hours during the night during the 3 days of voiding pattern. 4. The charge nurse on each shift is responsible for overseeing the 3 day voiding pattern... 5. The MDS Coordinator/Unit Manager should review the voiding patterns on a daily basis to determine pattern, compliance, and continence status. >If it is determined at the end of the 1st day the resident is totally incontinent and cannot be placed on a toilet or bedpan (or use a urinal) due to physical limitations and inability to comprehend, discontinue the voiding pattern and provide routine incontinent care. >If it is determined at the end of the 1st day the resident is totally continent, discontinue the voiding pattern. 6. A bladder assessment will be completed upon admission, annually or with significant change MDS. 7. After completion of the 3 day pattern the MDS Coordinator/Unit Manger will complete the IDT bladder continence review and determine if the resident is a candidate for one of the following: >Check and change (routine incontinent care). >Scheduled toileting program. >Formal bladder re-training program. Check and change: >If a Resident is totally incontinent and unable to be placed on a toilet or bedpan, resident should be checked and changed every two hours.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240
---	---

(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
F000323 SS=D	<p>Scheduled toileting program: >If a voiding pattern can be determined, develop an individualized resident specific program, update the care plan and resident care records/assignment sheets. >If a voiding pattern cannot be determined, resident should be toileted upon rising, before or after meals, and at bedtime. Bladder Retraining Program: 1. A resident should be considered for a bladder re-training program if the following conditions are met: >A voiding pattern could be established. >Resident is mentally and physically aware of the need to void and able to use the toilet, commode, urinal, or bedpan. >Resident is mentally and physically able to resist voiding to attempt a bladder retraining program...."</p> <p>3.1-41(a)(2) 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, interview, and record review, the facility failed to utilize a gait belt to transfer and ambulate a resident who needed extensive assistance to prevent accidents, for 2 of 4 transfer/ambulation observations, of 3 residents who were reviewed for rehabilitation services, of 12 residents who met the criteria for rehabilitation services. (Resident #64)</p> <p>Findings include: Resident #64's record was reviewed on</p>	F000323	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? *Resident #64 was not harmed during alleged deficiency practice *Resident #64 activity level was changed from up ad lib to up with assist after therapy assessment *Gait belt skills validations for all nursing staff were conducted on 4/15/14 and 4/16/14</p> <p>How will you identify other</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/03/2014	
NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240			
(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>3/31/14 at 3:28 P.M. His diagnoses included but were not limited to muscle weakness and anxiety.</p> <p>Resident #64's Quarterly Minimum Data Set (MDS) Assessment dated 3/5/14, indicated he was understood and was able to understand others. He required extensive assistance of 2 persons for bed mobility. He required extensive assistance of 2 persons for transfer. He required extensive assistance of 1 person to walk in his room. He required extensive assistance of 2 persons to toilet. He used a walker.</p> <p>Resident #64's Fall Care Plan initiated 11/27/13, indicated he was at risk for falls due to his muscle weakness and use of a walker. His fall risk approaches indicated he would have a call light in reach. He would wear non skid footwear when up. His personal items would be kept in reach. He would receive a therapy screen. His Fall Care plan did not address the level of assistance he would receive for transfer/ambulation nor did it address if any assistive devices would be utilized by the resident or staff for safety.</p> <p>A Resident Profile for Resident #64 utilized by the staff to coordinate care, did not indicate the level of assistance he required for transfer/ambulation nor did it indicate if any assistive devices needed to be utilized by the resident or staff for safety.</p> <p>A Physical Therapist Progress and Discharge Summary for Resident #64 dated 3/17/14, indicated Resident #64 continued to require assistance for bed mobility and transfers for safety.</p>		<p>residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>*All residents have the potential to be affected by the alleged deficient practice</p> <p>*Gait belt skills validations were conducted by Director of Nursing and/or designee for all nursing staff on 4/15/14 and 4/16/14</p> <p>* All staff was in-serviced on gait belt policy by Director of Nursing and/or designee on 4/15/14</p> <p>*Therapy and/or designee will assess resident's activity level upon admission and/or with a significant change.</p> <p>*C.N.A. profiles will be updated accordingly by Director of Nursing and/or designee</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>* Gait belt skills validations were conducted by Director of Nursing and/or designee for all nursing staff on 4/15/14 and 4/16/14</p> <p>* All staff was in-serviced on gait belt policy by Director of Nursing and/or designee on 4/15/14</p> <p>*100% audit of all resident's activity levels by Director of Nursing and/or designee by 4/25/14 to ensure appropriate for residents current status</p> <p>*Therapy and/or designee will assess resident's activity level upon admission and/or with a</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240
---	---

(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 #64 was observed ambulating to the bathroom adjoined to his bedroom on 3/31/14 at 4:03 P.M., with stand by hands on assistance from CNA #15. No gait belt was visible around Resident #64's waist.</p> <p>Resident #64 ambulated with a slow steady gait and the use of a walker. CNA #15 indicated he had required extensive assistance to sit up on the side of the bed and extensive assistance to stand up and hold onto his walker. She indicated after he began ambulating "he was O.K." While in the bathroom, Resident #64 was observed twice per request, to slowly push himself up from a sitting position to a standing position with the use of bilateral arm rest attached to his toilet riser. After toileting, Resident #64 ambulated with a slow steady gait into the dining room with stand by assistance from CNA #15. He ambulated slightly bent over at the waist, with both feet turned slightly outward. At that time, CNA #15 indicated she did not normally use a gait belt when transferring or ambulating Resident #64. She indicated she had lost her gait belt and had been without one for approximately 2 weeks. Said she had not requested another gait belt from the facility. She indicated Resident #64 was the only resident on the Alzheimer's unit that would require the use of a gait belt. She indicated she probably should have been using the gait belt to assist Resident #64.</p> <p>Resident #64 was observed being transferred out of bed on 4/1/14 at 10:44 A.M., with assistance from CNA #16. CNA #16 lifted Resident #64's legs off of the bed and positioned him to a sitting position on the side of the bed. She then placed a gait belt around his waist. CNA #16 held onto the gait belt around Resident #64's waist and requested he stand on the count of 3. On his</p>		<p>significant change.</p> <p>*C.N.A. profiles will be updated accordingly by Director of Nursing and/or designee</p> <p>*All nursing staff is provided a gait belt</p> <p>*Director of Nursing and/or designee will ensure each staff member has a gait belt for use with transfers</p> <p>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?</p> <p>*A Resident Care Round CQI tool will be utilized by the Director of Nursing and/or designee weekly x4 weeks, monthly x2 months and quarterly x1 for at least 6 months</p> <p>*Audit tools will be submitted to the CQI committee and action plans will be developed as needed if threshold of 100% is not met</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240
---	---

(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>first attempt to stand, Resident #64 was not able to and sat back down. He was able to stand on his 2nd attempt and was able to assist by pushing himself up from the bed mattress with his hands, requiring moderate assistance from CNA #16. He stood a minute before he began to ambulate with the use of a walker and assistance from CNA #16 who held onto his gait belt. His gait was slow and steady with his feet turned outward and slightly bent over at the waist.</p> <p>On 4/3/14 at 9:42 A.M., Physical Therapist #17 indicated staff were trained to use a gait belt when transferring a resident who requires assistance. Physical Therapist #17 indicated staff should use a gait belt when assisting Resident #64 to transfer.</p> <p>On 4/3/14 at 2.33 P.M., CNA #10 was observed assisting Resident #64 at his bedside. Resident #64 was standing close to his bed with his back to the bed. CNA #10 raised Resident #64's brief and pants while he was standing close to his bed. She requested Resident #64 sit down on his bed after his brief and pants were raised. CNA #10 placed a gait belt around Resident #64's waist. Resident #64 stood from the bed, requiring stand by assistance with CNA #10 holding onto the gait belt. He held onto his walker and began ambulating into the hallway with stand by assistance from CNA #10 holding onto the gait belt. CNA #10 indicated Resident #64 usually had a hard time standing when he first woke up but he had been awake and was able to stand more independently with stand by assistance. CNA #10 indicated if Resident #64 had just woke up and it was hard for him to stand she would have placed the gait belt on him before requesting him to stand the first time. She</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/03/2014	
NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240			
(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			
F000364 SS=E	<p>indicated since he was able to stand independently that time to have his brief and slacks pulled up she hadn't placed a gait belt.</p> <p>3.1-45(a)(2). 483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>Based on observation, interview and record review the facility failed to serve food that had flavor and tasteful for 2 residents reviewed for nutrition of 10 residents who met the criteria for nutrition and three random resident interviews, this had the potential to effect 78 residents who were served from the kitchen (Resident #S, #T, #R, #C and Resident #D.)</p> <p>Findings include:</p> <p>1.) During observation on 3-25-14 at 12:13 p.m. Resident #S and Resident #T was sitting in the dining room. Interview with Resident #S at this time indicated the facility food was bland and either over cooked or under cooked. Resident #S indicated it was very seldom the facility served a decent meal. Resident #T indicated the quality of the food served at the facility was very poor. Resident #S and Resident #T indicated they both had to eat a lot of grilled cheese sandwiches because of the poor food quality.</p> <p>Interview with Resident #R on 3-28-14 at 12:31 p.m. indicated the facility food was</p>	F000364	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? *Resident #S, T, R, C, D were not harmed by the alleged deficiency *Alternate meals offered to alleged affected residents *Residents are offered a choice for main entrée for all 3 meals. *Recipes are created with seasonings provided</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken deficient practice? * All residents have the potential to be affected by the alleged deficient practice *Salt and pepper is provided to residents to season food to taste for each meal *New cook book purchased by Dietary Manger to provide new</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240
---	---

(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>"garbage". Resident #R indicated the facility had taco's for lunch on this day and it was tasteless. Resident #R indicated the facility served beef stew not too long ago that looked like it had been ground up with a grinder. Resident #R indicated the facility food had gone from bad to worse. Resident #R indicated the food quality was poor. Resident #R indicated the facility response to complaints about food was they had to follow a recipe.</p> <p>A test tray was requested on 3-31-14 at 11:55 a.m. the test tray had roast beef and gravy, noodles and spinach. Surveyor #1 and Surveyor #2 both tasted the food and agreed the roast beef with gravy and noodles was bland and had no taste.</p> <p>Interview with the Dietary Manager on 3-31-14 at 12:00 p.m. indicated the roast beef was precooked and the noodles were suppose to be buttered noodles. The Dietary Manager indicated the facility does not use seasoning they went by recipes and they did not alter the recipe. The Dietary Manager indicated there were residents that complained about the food. The Dietary Manager indicated the facilities alternate meal was usually what was left over from the day before.</p> <p>Interview with Resident #C on 3-31-14 at 2:30 p.m. indicated the food at the facility was not good. Resident #C indicated the was bland. Resident #C indicated the facility served leftovers a lot and he was "stuck eating grilled cheese almost every evening".</p> <p>Review of the record of Resident #C on 3-31-14 at 3:00 p.m. indicated the resident's diagnoses included, but were not limited to,</p>		<p>recipes</p> <p>*Test tray will be served to management daily prior to start of meal and evaluation form completed</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>*Salt and pepper is provided to residents to season food to taste</p> <p>*New cook book purchased by Dietary Manger to provide new recipes</p> <p>*Test tray will be served to management daily prior to start of meal and evaluation form completed</p> <p>*Resident Council meeting will be held to discuss palatability of food monthly</p> <p>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?</p> <p>*A Meal Observation CQI tool will be utilized by Director of Nursing and/or designee weekly x 4 weeks, monthly x 2 months and quarterly X1 for at least 6 months* Audit tools will be submitted to the CQI committee and action plans will be developed as needed if threshold of 100% is not met</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240
---	---

(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>muscle weakness, depression, anxiety and constipation.</p> <p>The Minimum Data Set (MDS) Quarterly assessment for Resident #C dated 2-7-14 indicated resident's BIMS (Brief Interview for Mental Status) was a 15, with a range of 13-15, indicating the resident is cognitively intact.</p> <p>Interview with Resident #D on 4-1-14 at 11:37 a.m. indicated she was unable to eat the food the facility served. Resident #D indicated she could not tolerate the food they served at the facility. Resident #D indicated the food at the facility upset her stomach. Resident #D indicated she told the staff that brought her food that she could not eat it, but the staff did nothing about it. Resident #D indicated a family member brought in snacks and food so she would have something to eat.</p> <p>Review of the record of Resident #D on 4-2-14 at 12:40 p.m. indicated the resident's diagnoses included, but were not limited to, insomnia, osteoporosis, esophageal reflux and fatigue.</p> <p>The MDS Quarterly assessment for Resident #D dated 2-22-14 indicated the resident's BIMS was a 15.</p> <p>Interview with the Dietary Manager on 4-3-14 at 11:17 a.m. indicated 78 residents at the facility were served from the kitchen.</p> <p>This Federal tag relates to Complaint IN00145843.</p> <p>3.1-21(a)(2)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240
---	---

(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
F000385 SS=D	<p>483.40(a) RESIDENTS' CARE SUPERVISED BY A PHYSICIAN</p> <p>A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician.</p> <p>The facility must ensure that the medical care of each resident is supervised by a physician; and another physician supervises the medical care of residents when their attending physician is unavailable.</p> <p>Based on interview and record review, the facility failed to receive a timely physician's response related to an abnormal lab value, for 1 of 3 residents reviewed for infections. (Resident #B)</p> <p>Findings include:</p> <p>Resident #B's record was reviewed on 3/28/14 at 2:12 P.M. Diagnoses included but were not limited to, dementia and adult failure to thrive.</p> <p>Resident #B's Quarterly Minimum Data (MDS) Assessment dated 2/12/14, indicated she was usually understood and usually had the ability to understand others. She required extensive assistance of 1 person for toileting and was always incontinent of urine.</p> <p>A Care Plan for Resident #B initiated 3/4/14, indicated she had a strong foul urine odor. Resident #B's intervention approaches indicated she would receive labs as ordered by her physician. She would receive any medication ordered by her physician. The MD would be notified of any abnormal labs.</p>	F000385	<p>Facility is requesting paper review for IDR due to disagreement with citing of F 385</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>*Resident #B was not harmed by alleged deficient practice *All nursing staff was in-serviced on 4/15/14 regarding MD response regarding abnormal lab results *Resident #B was not treated due to was asymptomatic and did not meet criteria</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>*Residents residing in the facility have the potential to be affected by the alleged deficient practice. *Director of Nursing Services and/or designee in-serviced all</p>	04/25/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240
---	---

(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>The MD would be notified of any changes in cognition. Fluids would be encouraged.</p> <p>A Urine Culture for Resident #B collected on 3/4/14 and verified on 3/5/14, indicated on the final result the lab specimen was a contaminated.</p> <p>A Urine Culture for Resident #B collected on 3/10/14 and verified on 3/12/14, indicated on the final result the lab specimen was contaminated.</p> <p>Progress notes for Resident #B indicated the following: On 3/3/14 at 12:41 P.M., Resident #B was noted to have dark yellow urine with a foul odor. The MD had been notified. On 3/3/14 at 9:02 P.M., the facility received a new order for a Urinalysis and a Culture and Sensitivity. On 3/4/14 at 12:03 P.M., Resident #B's urine continued to have a strong foul odor. On 3/4/14 at 1:00 P.M., a urine specimen was obtained from Resident #B. On 3/5/14 at 3:37 A.M., the facility was awaiting the results of the Urinalysis and Culture and Sensitivity results. On 3/5/14 at 8:00 A.M., Resident #B was lethargic. She denied any pain or discomfort. On 3/5/14 at 10:34 P.M., the facility continued to await the Culture and Sensitivity results. On 3/6/14 at 1:25 P.M., the Urinalysis and Culture and Sensitivity results were sent to the MD and the facility was awaiting orders. On 3/6/14 at 1:40 P.M., a facility nurse contacted the physicians office and spoke to his nurse, regarding Resident #B's urine results. The nurse at the physicians office indicated she would call the facility back with orders. On 3/10/14 at 9:35 A.M., a facility nurse contacted the physicians office "regarding/following up" on Resident #B's recent urine results. The physicians nurse</p>		<p>nursing staff on 4/15/14 regarding MD response regarding abnormal lab results</p> <p>* Medical Records Nurse will audit all lab results during clinical meeting to ensure MD is notified</p> <p>*Infection Control Nurse will follow up on labs related to infections during clinical meeting</p> <p>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</p> <p>*Director of Nursing Services and/or designee in-serviced all nursing staff on 4/15/14 regarding MD response regarding abnormal lab results</p> <p>* Medical Records Nurse will audit lab levels during clinical meeting and ensure MD is notified on same day</p> <p>*Infection Control Nurse will follow up on labs related to infections during clinical meeting</p> <p>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?</p> <p>*A Lab CQI tool will be utilized by Director of Nursing and/or designee weekly x 4 weeks, monthly x 2 months and quarterly X1 for at least 6 months* Audit tools will be submitted to the CQI committee and action plans will be developed as needed if threshold of 100% is not met.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240
---	---

(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 she would call the facility back after speaking with the MD. On 3/10/14 at 11:35 A.M., a facility nurse contacted the physicians office and spoke with the physicians nurse. The physicians nurse stated "I don't think the MD is going to treat for urine results." The facility sent a fax to the physicians office to verify he did not plan to treat Resident #B related to her urine results. The facility was awaiting a response. On 3/10/14 at 2:39 P.M., the facility received a response related to the verification of not treating Resident #B for her urine results. The MD responded to the fax with a new order to repeat the Urinalysis and Culture and Sensitivity. On 3/10/14 at 8:36 P.M., urine results were obtained from Resident #B and the specimen sent to a local hospital for testing. The Interdisciplinary Team had met for a change in condition review for Resident #B. The urinalysis drawn of 3/3/14 had showed contamination. A urinalysis was redrawn on 3/11/14. The preliminary results showed no growth and the final results showed contamination. The MD had been notified of the results and no treatment had been ordered. The facility had sent a fax to the physicians office to verify he did not want any treatment. Resident #64 had been asymptomatic and accepting fluids well. The facility was awaiting his response. On 3/18/14 at 4:49 P.M., a facility nurse contacted a nurse at the physicians office related to Urinalysis and Culture and Sensitivity results. The facility nurse informed the physicians nurse that Resident #B was asymptomatic with no further complaints. The physicians nurse had indicated the 2nd Urinalysis was negative and the facility could resolve the event.</p> <p>On 3/31/14 at 10:07 A.M., the Director of</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240
---	---

(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
F000441 SS=D	<p>Nursing Services indicated the facility had contacted the physicians office several times regarding Resident #B's urine lab results. She indicated the physicians nurse informed the facility she would get back with them. She indicated the facility staff had informed the physicians office nurse Resident #B was asymptomatic. She indicated the facility did not receive an order for the results of 3/6/14, lab results until 3/10/14. She indicated the physician had ordered another Urinalysis and Culture and Sensitivity at that time.</p> <p>This Federal tag relates to Complaint IN00145753.</p> <p>3.1-22(b)(1) 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240
---	---

(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>must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation and interview the facility failed to provide a safe and sanitary dining environment for 1 of 14 residents observed for dining in the assisted dining room. (Resident # 108)</p> <p>Findings include:</p> <p>CNA # 10 observed touching Resident # 108's bun with fingers to spread condiment on her sandwich. No observation of handwashing or sanitizing hands prior to touching bun.</p> <p>Interview with CNA # 10 indicated she was aware she was not to touch the food with her hands she was to use gloves or utensils.</p> <p>Review of the record of Resident # 108 on 4/3/14 at 11:00 a.m., indicated the Resident's diagnoses included, but were not limited to, senile dementia, osteoporosis, NOS, iron deficiency anemia, NEC, open angle glaucoma, NOS and venous insufficiency,</p>	F000441	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? *Resident #108 was not harmed by alleged deficient practice *Hand washing skills validations for all staff were completed on 4/15/14 and 4/16/14 *All staff was in-serviced on infection control related to handling of food on 4/15/14 *Residents are receiving food in safe and sanitary manner How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? *Residents residing in the facility have the potential to be affected by the alleged deficient practice *Hand washing skills validations for all staff were completed on 4/15/14 and 4/16/14 by the Director of Nursing and/or designee *All staff was in-serviced on infection</p>	04/25/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/03/2014
NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240		
(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	
	NOS. The Minimum Data Set (MDS) Assessment for Resident # 108 dated 1/24/2014 indicated how resident eats and drinks, regardless of skill - extensive assistance of one person needed. 3.1-18(b)(l)		control related to handling of food on 4/15/14 What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? *Hand washing skills validations for all staff were completed on 4/15/14 and 4/16/14 by the Director of Nursing and/or designee *All staff was in-serviced on infection control related to handling of food on 4/15/14 *Management staff assigned to dining rooms will monitor hand washing to ensure food is served in a safe and sanitary manner 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? *A Meal Observation CQI tool will be utilized by Director of Nursing and/or designee weekly x 4 weeks, monthly x 2 months and quarterly X1 for at least 6 months* Audit tools will be submitted to the CQI committee and action plans will be developed as needed if threshold of 100% is not met		