

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155783	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GREENLEAF HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1201 E BEARDSLEY ELKHART, IN 46514
---	--

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

R000000	<p>This visit was for the Investigation of Complaint Number IN00146399.</p> <p>Complaint Number IN00146399 - Substantiated. State Residential deficiencies related to the allegations are cited at R0217.</p> <p>Survey date: April 21, 2014</p> <p>Facility number:002661 Provider number:155783 AIM number:201056540</p> <p>Survey team: Christine Fodrea, RN, TC</p> <p>Census bed type: SNF:32 SNF/NF:9 Residential:51 Total:92</p> <p>Census payor type: Medicare:11 Medicaid:9 Other:72 Total:92 Residential Sample:3</p> <p>This deficiency reflects a state residential finding cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed on April 22, 2014, by Brenda Meredith, R.N. 410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency</p>	R000000	<p>Please accept the enclosed information as Greenleaf Health Campus's Plan of Correction for the complaint survey conducted on April 21, 2014. Please contact me if there are any questions. Thank you for your time Judy Plantinga Administrator at Greenleaf Health Campus.</p>	
R000217				

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: 155783	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GREENLEAF HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1201 E BEARDSLEY ELKHART, IN 46514
---	--

(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>(e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows:</p> <p>(1) The services offered to the individual resident shall be appropriate to the:</p> <p>(A) scope; (B) frequency; (C) need; and (D) preference; of the resident.</p> <p>(2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review.</p> <p>(3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request.</p> <p>(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.</p> <p>(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.</p> <p>Based on interview and record review, the facility failed to accurately assess the behavior status of 3 of 3 residents reviewed for behaviors in a sample of 3. (Resident #P, Resident #Q, Resident #R)</p> <p>Findings include:</p> <p>1. Resident #P's record was reviewed</p>	R000217	<p>1. SSD to continue to meet with resident Q and R separately every 2 weeks and as needed to discuss any frustrations they may be having and ensure documentation is on the record. No ill effects have been noted to either resident. Resident R has had no ill effects and service plan has been updated.2. Nursing staff in-serviced on the importance of putting this type of information on</p>	05/07/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155783		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/21/2014	
NAME OF PROVIDER OR SUPPLIER GREENLEAF HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1201 E BEARDSLEY ELKHART, IN 46514			
(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>4-21-2014 at 11:15 A.M. Resident #P's diagnoses included high blood pressure, osteoarthritis, and anemia.</p> <p>Resident #P's evaluation, dated 12-13-13, indicated Resident #P exhibited little interest in doing things, had a poor appetite and little energy. The assessment indicated Resident #P did not take medications for these concerns.</p> <p>A physician's order, dated 11-26-13, indicated Resident #P was to be given Remeron (an antidepressant medication) 15 milligrams (mg) every evening at bedtime.</p> <p>Resident #P's Nurse's Notes indicated, on 1-22-14 at 5:15 P.M., two CNA's encouraged Resident #P to get up for supper. Resident #P refused due to pain. the note further indicated Resident #P's husband was verbally upsetting her. Resident #P continued to refuse to get up, and the husband then went to the dining room by himself.</p> <p>Nurse's notes, dated 3-13-14 at 1:30 P.M., indicated Resident #P chose to stay in bed later than usual and breakfast was provided in bed. The note further indicated Resident #P ate better that day than when her husband was with her.</p> <p>Nurse's notes, dated 4-16-14 at 2:25 P.M., indicated Resident #P told the CNA her husband was yelling at her and requested CNA to put her to bed to "get away from him."</p> <p>In an interview, on 4-21-14 at 9:02 A.M., Resident #P indicated she and her husband have been yelling at each other the whole 50 years of their marriage and it doesn't really bother her. Resident #P indicated she was</p>		<p>the 24 hour report sheet such as behaviors, crying yelling, etc. The 24 hour report sheet will be brought to morning clinical care meeting so any behaviors can be reported to social service director, Assisted living manager and Administrator 5 days a week. 3. The 24 hour report sheet will be brought to daily clinical and nursing staff have been educated on this so the IDT can follow up. 4. SSD has been allotted at least 8 hours per week to work on assisted living to address any social service needs and to go over service care plan when due to ensure any behaviors have plans and will report findings to the Quality Assurance monthly x 6 months to ensure behaviors and interventions are addressed and if no issues being missed then consider it resolved with current system</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155783	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GREENLEAF HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1201 E BEARDSLEY ELKHART, IN 46514
---	--

(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>not afraid of her husband, she does not feel abused, and stated she did not want to be separated from her husband.</p> <p>Resident #P's evaluation, dated 2-26-14, indicated she required staff intervention daily to manage unpredictable behaviors. The service plan was to keep the physician and the responsible party notified of behaviors and changes in behavior. The plan further indicated Resident #P cries a lot and staff helps redirect resident. There was no indication what to direct to, or to monitor for an increase in the crying.</p> <p>In an interview, on 4-21-14 at 12:04 P.M., the SSD (Social Service Director) indicated she did not have anything to do with Assisted Living assessments and interventions. She further indicated any increase in behavior, or depressive symptoms should be reported to the SSD and the Administrator so action could be taken.</p> <p>2. Resident #Q's record was reviewed 4-21-14 at 11:42 A.M. Resident #Q's diagnoses included, but were not limited to, trouble breathing.</p> <p>Resident #Q's assessment, dated 12-13-13, indicated Resident #Q had no behaviors, and had no behavior triggers.</p> <p>Nurse's notes, dated 2-27-2014 at 7:15 P.M., indicated Resident #Q's wife requested to go to bed. When staff approached the room, Resident #Q was heard to be yelling at his wife. LPN #2 intervened, and separated Resident #Q and his wife.</p> <p>Nurse's notes, dated 3-8-2014 at 4:30 P.M., indicated Resident #Q was using a loud tone</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155783		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/21/2014	
NAME OF PROVIDER OR SUPPLIER GREENLEAF HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1201 E BEARDSLEY ELKHART, IN 46514			
(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>with his wife. Staff asked him to lower his voice. Resident #Q complied after a rude statement to the staff.</p> <p>Nurse's notes, dated 3-12-2014 at 12:30 P.M., indicated Resident #Q was loudly berating wife at the dining room table, and the wife began to cry.</p> <p>Nurse's notes, dated 3-18-2014 at 11:00 A.M., indicated Resident #Q was loudly stating to wife she was her own worst enemy because she did not want to get out of bed for dinner.</p> <p>Resident #Q's evaluation and service plan, dated 2-26-2014, indicated he required staff intervention 3-5 times per week, and the intervention was to keep the physician and the responsible party informed of the behavior or changes in the behavior. There was no indication Resident #Q was receiving help to deal with his frustrations, or any direction to staff to assist him to deal with his frustration.</p> <p>In an interview, on 4-21-14 at 12:04 P.M., the SSD indicated she had been meeting with Resident #Q regarding his frustration with his wife's forgetfulness, but had made no notes about the meetings, nor had made any recommendations to staff to assist him with handling her forgetfulness or repetitive questions. The SSD further indicated she had no input into the assessments or intervention initiation, but the staff were to tell her or the Administrator about behaviors so a plan could be initiated.</p> <p>3. Resident #R's record was reviewed 4-21-14 at 2:27 P.M. Resident #R's diagnoses included, but were not limited to</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155783	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GREENLEAF HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1201 E BEARDSLEY ELKHART, IN 46514
---	--

(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>edema, arthritis, and high blood pressure.</p> <p>Resident #R's assessment, dated 2-8-2014, indicated Resident #R had behaviors that required staff intervention 1-2 times per week. there was no indication on the service plan what interventions were undertaken, nor what steps staff could take to help Resident #R manage her behavior.</p> <p>In an interview, on 4-21-2014 at 11:40 A.M., RN #3 indicated staff completing the form were to be sure the interventions were outlined on the service plan.</p> <p>This State tag relates to Complaint Number IN00146399.</p>			