STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155783	A. BUILDING 00 B. WING	10/11/2023

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: October 2, 3, 4, 5, 6, 10, and 11, 2023 Facility number: 002661 Provider number: 15583 AIM number: 201056540 Census Bed Type: SNF/NF: 28 SNF: 31 Residential: 35 Total: 94 Census Payor Type: Medicare: 19 Medicaid: 28 Other: 12 Total: 59 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 10/19/2023.	F 0000	/p>	
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on record review and interview, the facility failed to assess a resident's ability to self-administer medication timely for 1 of 1	F 0554	1 a Resident 1 was affected. No adverse effects noted. Self-Administration observation	11/15/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Brittney Plantinga | Executive Director | 11/02/2023

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	resident's reviewed for self-administration of medication. (Resident 1) Finding includes: During an observation, on 10/4/2023 at 9:15 A.M., a locked box was sitting on a table next to Resident 1's recliner. During an interview, on 10/4/2023 at 9:16 A.M., Resident 1 indicated she self-administers most of her nightly medications. A record review was completed, on 10/5/2023 at 2:08 P.M. Resident 1's diagnoses included, but were not limited to: atrophy of thyroid, chronic kidney failure stage 4, hyperlipidemia, heart failure, hypertension, and fibromyalgia. A care plan, dated 3/3/2022, indicated the resident may keep medications at bedside and self-administer: all oral medications, powders, eye drops, and creams. Resident 1's current Self-Administration of Medications assessment had been completed on 3/3/2023. During an interview, on 10/6/2023 at 10:03 A.M., the Director of Health Services indicated the Self-Administration of Medications Assessment, dated 3/3/2023 for Resident 1 was the most current. The Director of Health Services indicated there should have been an assessment completed every quarter and was not. ON 10/10/2023 at 9:45 A.M., the Executive Director provided the policy titled,"Guidelines for Self-Administration of Medications", dated 12/31/2022, and indicated the policy was the one		completed immediately upon finding on 10/2/23. Resident reeducated on lock box usage. 2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; a All residents have the potential to be affected. Nurses will be educated on self-administration observation completion and Self-Administration policy by 11/15/23. All residents requesting self-administer medications will be reviewed for completion of the self-administration observation by 11/15/23. 3 a As a measure of ongoing compliance, the DHS or designee will audit medication observation completion to ensure that self-administration observations are completed according to policy. Audit to consist of five residents monthly x6 months for appropriate medication self-administration. 4 a As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained.	

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	currently used by the facility. The policy indicated, "To ensure the safe administration of medication for residents that request to self-medicate ...7. The assessment will be reviewed quarterly, and PRN (as needed) with change of condition. 8. The assessment will be documented in the EHR (Electronic Health Record) ...." 3.1-11			
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate			

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	its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on interview, and record review the facility failed to develop a person-centered care plan for 1 of 21 residents whose care plans were reviewed. (Resident 10) Finding includes: During an interview, on 10/2/2023 at 11:07 A.M., Resident 10's daughter indicated that he has issues with constipation and was not sure when he last had a bowel movement. A record review for Resident 10 conducted, on 10/03/2023 at 1:33 P.M., indicated diagnoses that included, but were not limited to: metabolic encephalopathy, urinary tract infection, bacteremia, neuromuscular dysfunction of the bladder, and benign prostatic hypertrophy.	F 0656	1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; a Resident 10's Care Plan lacked documentation that addressed constipation. Resident 10 discharged from the facility on 10/4/23. 2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; a All residents in the Health Care Center at risk for and with actual constipation have the potential to be affected by alleged deficient practice. MDS Coordinator and/or Designee will	11/15/2023

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	An admission MDS (Minimum Data Set) assessment indicated Resident 10's cognition was intact. He required extensive assist of 1 staff for bed mobility, dressing, and toileting, and total dependence of 2 staff for transfers. Resident 10's physician orders included, but were not limited to: -9/6/2023 polyethylene glycol powder 17gm (grams) oral once a day for constipation. -8/30/2023 bisacodyl suppository 10mg (milligrams) 1 suppository rectally once a day as needed for constipation. Resident 10's care plan lacked documentation that addressed constipation. During an interview, on 10/6/2023 at 2:03 P.M., the Director of Health Services indicated that constipation should be addressed in the care plan but was not. A current policy provided by the Executive Director, on 10/6/2023 at 9:45 A.M., titled, "Comprehensive Care Plan and Guideline" included, but was not limited to: " ...Problem areas should identify relative concerns ...Comprehensive care plans need to remain accurate and current ...." 3.1-35(b)(1)		complete an initial Health Care Center audit to review all residents with risk for and actual constipation. The MDS Coordinator and/or Designee will conduct an initial audit of all residents' current bowel status and ICD diagnoses of constipation. 3 a As a measure of ongoing compliance, the MDS Coordinator and/or Designee will audit 5 resident care plans weekly for 4 weeks, then twice monthly for 2 months, then monthly for 3 months to ensure accurate reflection of care plan for residents at risk for and with actual constipation. Clinical Assessment Support will reeducate the MDS Coordinator and/or Designee on resident centered comprehensive care plans per the RAI manual and facility policy. 4 a As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained.	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers.			

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	Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, record review and interview, the facility failed to ensure infection control practices were maintained during wound care for a 1 of 1 residents reviewed. (Resident 30) Finding includes: During an observation of Resident 30's wound treatment, on 10/10/2023, the following was observed: - LPN 7 washed her hands and applied gloves. She provided pericare to Resident 30 and upon completion she removed and reapplied new gloves without washing her hands. She then proceeded to clean the coccyx area with gauze that had been soaked in a normal saline solution. She removed and reapplied new gloves without washing her hands and proceeded to measure the area on Resident 30's coccyx. She then removed and reapplied gloves without washing her hands and applied Triad paste to the area. During an interview, on 10/10/2023 at 10:25 A.M., LPN 7 indicated she should have washed her hands or used hand sanitizer after changing her gloves.	F 0686	1 a 2 a All residents receiving treatments have the potential to be affected. Nurses educated on proper dressing change standards. Nursing staff educated on handwashing and appropriate length of time. 3 a As a measure of ongoing compliance, the DHS or designee will audit 5 dressing changes weekly to ensure that treatment is applied correctly with appropriate handwashing noted x4 weeks, then every other week x2 months, then monthly x3 months. 4 a As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained.	11/15/2023

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	On 10/10/2023 ar 11:25 A.M., the Director of Nursing provided the policy titled," Guideline for Handwashing/Hand Hygiene, dated 2/9/2017, and indicated the policy was the one currently used by the facility. The policy indicated"...3. Health Care Workers (HCW) shall use hand hygiene at times such as: ...d. After removing gloves, worn per Standard Precautions for direct contact with excretions or secretions, mucous membranes, specimens, resident equipment, grossly soiled linen, ect...." 3.1-40			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse,			

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	except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, and interview, the facility failed to ensure medication storage areas were free form loose medications; undated opened medications; and medication with no resident identifiers during medication storage reviews for 1 of 2 medication rooms observed and 1 of 2 medication carts observed. (200 Hall Front Medication cart, 100 Hall medication room and 300 Hall medication room) Findings include: 1. During a medication storage observation, on 10/10/2023 at 10:47 A.M., on the 200 Hall front medication cart, with LPN 4, the following was observed: 1 loose pill in the second drawer, an opened bottle of Milk of Magnesia, Miralax and Robitussin undated. During an interview, on 10/10/2023 at 10:50 A.M., LPN 4 indicated there should be no loose pills in the cart and the medications's should have date opened. 2. During a medications storage observation, on 10/10/2023 at 10:52 A.M., on the 100 Hall medication room,with LPN 5, the following was observed: a bottle of sparkling ice drink, a yogurt and a breakfast burrito in a bag all with no resident identifying information. The refrigerator had a red sticky substance on a shelf. During an interview, on 10/10/2023 at 10:53 A.M., LPN 5 indicated the food items should have a residents name and the refrigerator should have been cleaned.	F 0761	1 a No adverse effects noted related to loose pills in medication cart, food stored in the medication room, sticky substance on fridge shelf, or expired eye drops in the medication room. 2 a All residents have the potential to be affected. Staff nurses and qualified medication aids (QMA) to be educated on proper medication storage, labeling, and cleanliness of storage area. 3 4 All medication carts and medication rooms to be audited to ensure that areas are free from loose medications, no expired medications, no unlabeled food for residents, and fridges to be clean and free of debris. As a measure of ongoing compliance, the DHS and/ or designee will audit 3x weekly x4 weeks, 3x week biweekly x8 weeks, and 3x week monthly x 3 months. 5 a As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained.	11/15/2023

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	3. During a medication storage observation, on 10/10/2023 at 11:18 A.M., on the 300 Hall medication room with LPN 6, the following was observed: Lubricant eye drops that had expired on 1/2022; glucose tabs with no resident identifiers. During an interview, on 10/10/2023 at 11: 19 A.M., LPN 6 indicated the eye drops should not be in the medication room, and the tabs should have name on them. On 10/10/2023 at 3:15 P.M., the Diretor of Nursing provided the policy titled,"Medication Storage In The Facility", dated 10/2019, and indicated the policy was the one currently used by the facility.The policy indicated"... K. Other foods such as employee lunches and activity department refreshements are not stored in this refrigerator... When the original seal of a manufacture's container or vial that requires a shorter expiration is initially broken, the container or vial will be dated. a.) A "date opened" sticker shall be placed on these medications... F. All expired medications will be removed from the active supply and destroyed in the facility, regarless of amount remaining. 3.1-25(j)(o)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.			

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	§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility			

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	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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, record review and interview, the facility failed to ensure infection control practices were maintained for the cleaning and disinfection of a glucose monitoring machine and durung the administration of a subcutaneous injection for 1 of 1 resident reviewed. (Resident 45) Finding includes: During an observation, on 10/6//2023 at 6:55 A.M., the following was observed: - LPN 3 placed a glucose monitoring machine on the over the bed side table in Resident 45's room. The table had no barrier. LPN 3 cleansed the resident's finger with an alcohol pad and with an opened hand and fanned the area she had just	F 0880	1 a Resident 45 was affected.No adverse effects noted from the alleged occurrence. Nursing staff immediately educated on appropriate administration of insulin and cleaning of glucometers. 2 a All residents receiving glucometer checks and insulin administration have the potential to be affected. Nurses and QMAs educated on appropriate administration of insulin, use of barriers, and cleaning of glucometers. 3 a As a measure of ongoing compliance, the DHS and/or	11/15/2023

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	cleansed with the pad. LPN 3 completed the finger stick and obtained the blood sample, and placed the glucose monitoring machine back on the bed side table. - LPN 3 exited the resident; room and cleaned the accu check machine with an alcohol pad. - LPN 3 obtained the residents insulin pen from the medication cart, and returned to the resident room to administer the insulin. LPN 3 cleansed the abdomen with an alcohol pad, then with an opened hand fanned the area that was just cleansed. During an interview, on 10/6/2023 at 7:07 A.M., LPN 3 indicted she should have used a barrier and should not have fanned the areas. On 10/10/2023 ar 11:25 A.M., the Director of Nursing provided the policy titled," Guideline for Handwashing/Hand Hygiene, dated 2/9/2017, and indicated the policy was the one currently used by the facility. The policy indicated"...3. Health Care Workers (HCW) shall use hand hygiene at times such as: ...d. After removing gloves, worn per Standard Precautions for direct contact with excretions or secretions, mucous membranes, specimens, resident equipment, grossly soiled linen, ect...." On 10/10/2023 at 11:25 A.M., the Director of Nursing provided the policy tilted," Specific Medication Administration Procedures", dated 11/2018, and indicated the policy was the one currently used by the facility. The policy indicated"...Injectable Medication Administration. Equipment Required... F. Barrier(e.g., disposable tray or plastic cup), if supplies or medication will be set down in resident's room...."		designee will audit 5 residents glucose monitoring and insulin administration 3 times weekly x4 weeks, 3x week biweekly x8 weeks, and 3x week monthly x 3 months. 4 a As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	On 10/6/2023 at 9:10 A.M., the Executive Director provided the policy titled, " Cleaning Instructions for Glucometer", undated, and indicated the policy was the one currently used by the facility. The policy indicated"...3. Acceptable cleaning solutions include alcohol and ammonia- based cleaners. Recommended solutions are Sani Cloth HB, Sani Cloth Plus and Super Sani Cloth...." On 10/6/2023 at 10:28 A.M., the Director of Nursing provided the Manufactures guideline for the Cleaning and Disinfecting the Assure Prism Blood Glucose Monitoring System. The guidelines indicated: The cleaning procedure is needed to clean dirt, blood and other bodily fluids off the exterior of the meter before performing the disinfecting procedure. The disinfection procedure is needed to prevent the transmission of blood-borne pathogens. 3.1-18(a)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and Licensure Survey. Survey date: October 10 and 11, 2023 Facility number: 002661 Residential Census: 35 Greenleaf Health Campus was found to be in compliance with 410 IAC 16.2-3.1 in regard to the State Residential Licenure Survey.	R 0000	/p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155783	A. BUILDING 00 B. WING	10/11/2023

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	Quality review completed 10/19/2023.			