STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155412	A. BUILDING 00 B. WING	11/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENWOOD HEALTH AND LIVING COMMUNITY	937 FRY RD GREENWOOD, IN 46142

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F000000	This visit was for a Recertification and State Licensure Survey. Survey dates: November 18, 19, 20, 21, & 22, 2013. Facility number: 000509 Provider number: 155412 AIM number: 100266620 Survey team: Marcy Smith, RN-TC Paula Davidson-Igou, RN Caitlin Lewis, RN Patti Allen, BS (November 18, 19, & 20, 2013) Diana Zgonc, RN (November 20, 21, & 22, 2013) Census bed type: SNF: 2 SNF/NF: 96 Total: 98 Census payor type: Medicare: 14 Medicaid: 72 Private: 12 Total: 98 Extended sample: 04	F000000	This plan of correction is to serve as Greenwood Health and Living Community's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Greenwood Health and Living Community or their management companies that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.	

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

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	These deficiencies reflect state findings in accordance with 410 IAC 16.2. Quality review completed on December 05, 2013; by Kimberly Perigo, RN.			

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F000156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes:			

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	A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits,			

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	and how to receive refunds for previous payments covered by such benefits. Based on observation and record review, the facility failed to ensure the correct ISDH (Indiana State Department of Health) complaint number was posted to report a complaint. This had the potential to affect 84 of 84 residents and visitors. Findings include: During an observation on 11/21/13 at 8:16 a.m., the phone number posted to contact ISDH with a complaint was observed in the front lobby. The phone number was (317) 233-1335. On 11/21/2013 at 7:00 p.m., the complaint number was called and indicated the number had been disconnected. On 11/22/2013 at 5:00 p.m., during the exit conference, the Administrator and Director of Nursing were notified of the incorrect number. No further information was received. 3.1-4(j)(3)(A)	F000156	F 156- NOTICE OF RIGHTS, RULES, SERVICES, CHARGES I. The ISDH complaint phone number posting located in the lobby has been updated to reflect the correct telephone number for the Indiana State Department of Health to report a complaint. II. Residents residing at Greenwood Health and Living had the potential to be affected. III. The correct ISDH complaint phone number was reposted. Education was provided to the Administrator regarding the correct telephone number. IV. The Administrator or designee will audit the posting of the ISDH complaint phone number located in the lobby weekly x 4 weeks, then monthly x 3 months, then quarterly for total duration of 12 months. Any concerns will be addressed. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. V. Plan of Completion date is November 22, 2013.	11/22/2013

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F000224 SS=E	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to ensure each resident was free from verbal and physical mistreatment for 5 of 5 residents reviewed for an allegation of mistreatment in a sample of 1 resident who met the criteria for abuse and 4 residents reviewed for an allegation of mistreatment. (Residents #6, #49, #111, #48, #18) (CNA #7, CNA #9, LPN #2) Findings include: 1. The investigation for Resident #6 was reviewed on 11/21/13 at 12:30 p.m. The incident occurred on 4/6/13 at 10:00 p.m. A handwritten statement, signed and dated by Certified Nursing Assistant (CNA) #6 included the following: CNA #6 reported CNA #7 had sworn at Resident #6 while providing care. CNA #6 indicated CNA #7 said to Resident #6, " 'Are you f------ serious! Why didn't you say you went pee before	F000224	F224- Prohibit Mistreatment/Neglect/Misappropriation- I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice. Resident #6 and resident #49 showed no negative outcomes physical evidence or mental anguish from the alleged incident reported to the ISDH on 4/6/13. CNA #7 was suspended on 4/6/13 and resigned before the investigation complete. CNA #7 no longer works in the facility. The facility sent an addendum to the reportable division of the ISDH which included an update that CNA #7 is no longer employed due to abuse and the CNA was reported to the nurse aide registry. Resident #111 (resident no longer resides in community) showed no negative outcomes physical evidence or mental anguish from the alleged incident reported to the ISDH on 7/17/13. CNA #9 was suspended initially during the abuse investigation and CNA #9 no is no longer employed in the facility. The facility sent an addendum to the reportable division of the	12/22/2013

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	you p----- all over yourself.' " CNA #6 then indicated CNA #7 left the resident on the toilet for "15 minutes." CNA #7, according to CNA #6, was "being rough" with Resident #6, while getting her gown on. CNA #6 then indicated CNA #7 had sworn at another resident that same night, after having provided care to Resident #6. CNA #6 indicated CNA #7 said to Resident #49 that the resident really " 'p----- her off.' " CNA #6 indicated CNA #7 "started yanking her (the resident) and being really rough with her and when she put on Resident #49's oxygen, "she didn't even put it in her nose." CNA #6 then indicated, "she [CNA #7] didn't care" when the resident told her about the oxygen. CNA #6 reported this verbally and physically rough care to a Licensed Practical Nurse (LPN) on 4/6/13, but not immediately after the care occurred. A typewritten report, dated 4/12/13 at 12:00 p.m., signed by the DON (Director of Nursing) indicated she had received a phone call from CNA #7. The CNA had resigned from her position and indicated, "It's no big deal." The five day follow-up report to the ISDH, dated 4/11/13, indicated		ISDH which included an update that CNA #9 is no longer employed due to abuse and the CNA was reported to the nurse aide registry. Resident #48 showed no negative outcomes physical evidence or mental anguish from the alleged incident reported to the ISDH on 10/29/13. LPN #2 was suspended on 10/29/13 initially during the abuse investigation and LPN #2 is no longer employed in the facility. The facility sent an addendum to the reportable division of the ISDH which included an update that LPN #2 is no longer employed due to abuse. Resident #18 showed no negative outcomes physical evidence or mental anguish from the alleged incident reported to the ISDH on 11/19/13. CNA #9 was suspended on during the survey in order for the facility to conduct the abuse investigation and CNA #9 is no longer employed in the facility. The facility reported the abuse allegation to the ISDH and included the information that CNA #9 is no longer employed due to abuse. Employee(s) CNA #17, #19 LPN #15 have received education regarding the CarDon, State and Federal guidelines of reporting abuse allegations timely to the Administrator of the facility. CNA #6 no longer employed at facility. II. The facility will identify other residents that may potentially be affected by the	

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	"Investigation complete and allegation unsubstantiated. Resident and staff interviews unremarkable. Social services continues to provide psychosocial counseling to residents. Resident have no recall of any unprofessional comments or rough treatment. CNA (name) #7 terminated due to unprofessional conduct." An interview with the DON, at 1:30 PM on 11/21/13, indicated CNA #7 was suspended on 4/6/13, and quit while suspended. The DON indicated she was going to terminate CNA #7 for improper conduct. The DON did not believe it was abuse, as she didn't think it was willful. The DON indicated she was going to terminate CNA #7 though, since more than one person reported it (the allegation of abuse) to her. 2. An incident concerning Resident #111 and CNA #9 was reviewed on 11/21/13 at 2:30 p.m. On 7/17/13, the resident's daughter reported on 7/4/13, her mother was spoken to in a, "very gruff tone." This was reported, as the daughter did not tell anyone, 13 days after the reported occurrence. The daughter also indicated the staff "grabbed the resident's cheeks and stated, 'Stop		deficient practice. Residents who reside at Greenwood Health and Living have the potential to be affected by the alleged deficient practice. Resident's with a BIMS of 10 or greater and family/responsible party of each resident will be interviewed using the ISDH QIS abuse questionnaire to ensure all abuse allegations are identified and handled according to Federal, State and CarDon policy and procedures. Any allegations of abuse will be reported to the Administrator immediately and to the Indiana State Department of Health per the Unusual Occurrence reporting guidelines. A review will be completed of allegations of abuse to audit for comprehensive and complete investigation. Any concerns will be addressed. III The facility will put into place the following systematic changes to ensure that the deficient practice does not recur. Director of Clinical Services contacted Administrator and Director of Nursing and re-in-serviced on the importance of timely reporting of allegations of abuse and CarDon's abuse reporting and prevention policy/procedure was reviewed in detail. Director of Clinical Services conducted a 1:1 inservice with the Administrator and Director of Nursing to ensure future allegations are reported timely by their staff members to the Administrator and ensure that	

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	touching yourself down there.' " The daughter indicated the employee was told she was being "a little gruff with my mother." An interview with the DON, at 1:30 p.m. on 11/21/13, indicated CNA #9 was not terminated, because she couldn't determine the incident was willful, only unprofessional in conduct. The incident had been reported to ISDH with no signed/dated statements available for review. The five day follow-up, dated 7/22/13, indicated "investigation complete and unsubstantiated. CNA reinstituted. Resident interviews and staff interviews unremarkable. Social services to continue to provide psychosocial follow up." A review of CNA #9's time card indicated she had been sent home following the report of the occurrence, pending investigation, and did not return to work until the investigation had been completed. 3. An incident concerning Resident #48 and LPN #2 was reviewed on 11/21/13 at 3:00 p.m. A signed and dated (10/29/13) typewritten report was reviewed. The report indicated LPN #2 had been witnessed by the MDS (Minimum Data Set) LPN		investigation protocol was put into place and utilized for allegations of abuse to ensure potentially abusive staff members are not allowed to return to the workplace after an allegation has been made against him/her. A CQI abuse investigation checklist was put into place for the administrator and director of nursing to utilize for each investigation to ensure future investigations have the necessary documentation to determine the decisions of reinstating employees, terminating employees and reporting employees to the ISDH and licensure boards of Indiana. QIS interview tool was utilized to interview residents within the facility and family members to ensure no further risks of harm exists in the current care environment for those residents potentially affected Alleged staffs involved were removed from the working schedule and investigations were conducted by the administrator, director of nursing and oversight by the Clinical Specialist. In-service staff and contracted services on the abuse reporting policy and procedure including; identifying multiple and various forms of abuse, reporting immediately, and overall review of abuse prevention. A post- test was utilized to ensure the staff and contracted services comprehended the abuse	

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	speaking "very abruptly." The MDS nurse indicated she heard the nurse again speak abruptly to Resident #48, while passing his medications. The MDS nurse indicated LPN #2 had said, " 'I'm not taking you now.' " Then the MDS nurse heard the nurse say " 'S---' ." The writer then assisted the resident to the dining room and reported the incident to the DON. Two staff interviews were recorded on a sheet of paper with the investigation. Neither of the interviews were signed nor dated by the staff. Four residents had been interviewed by the Social Services Director. The residents had been identified by initials, with no signature nor date of the interviews. The DON was interviewed on 11/21/13, concerning this incident. The DON indicated LPN #2 had been given a written warning on 11/1/13, after having been suspended during the investigation. The five day follow-up report, dated 11/3/13, indicated the following: "Investigation complete. Staff and resident interviews completed and unremarkable. Social services to continue to provide psychosocial follow up. Nurse educated regarding		guidelines and policy/procedure to protect the residents and families from harm. Social services will assess the resident and families to ensure mental anguish does not exist and refer those affected for appropriate treatment if indicated. The systemic change includes: An investigative protocol has been put into place and utilized for allegations of abuse and dictates that potentially abusive staff members are not allowed to return to the workplace after the allegation until the investigation is completeA CQI abuse investigation checklist has been put into place for the administrator and director of nursing to utilize for each investigation to provide guidance on providing the necessary documentation to determine decisions of reinstating employees or terminating employees and reporting to the ISDH and licensure boards of Indiana.The QIS interview tool is being utilized to interview residents and family members to review for risk of harm.All unusual occurrences are reviewed daily (Monday through Friday) at the morning clinical meeting for thoroughness and completion Education has been provided to all staff regarding the systemic change. Staff members who are suspended related to abuse allegations will be reviewed by the corporate clinical consultant,	

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	customer service, incident determined not willful or malicious. Nurse reinstated." 4. During an interview on 11/19/13 at 9:48 a.m., Resident #18 was asked if she had been abused by staff. She indicated about 3 weeks ago she had a wound on her bottom. The tape had come loose from the dressing. She also indicated a CNA ripped the tape from her skin causing pain and bleeding. She thought the CNA was barred out of her room, but still came in. She indicated, she had told LPN #15 about the incident. During an interview with LPN #15 on 11/21/13 at 3:00 p.m., she indicated Resident #18 had reported the incident to her, but she (LPN #15) didn't report it because she (LPN #15) didn't think it was abuse. The clinical record for Resident #18 was reviewed on 11/20/13 at 2:07 p.m. Diagnoses for Resident #18 included, but were not limited to: rheumatoid arthritis, high blood pressure, pain, Bells palsy, hernia, congestive heart failure, weakness, debility, and osteoarthritis. There were no nursing notes which		corporate director of operations and corporate human resources director prior to being reinstated into the workplace to ensure the alleged deficient practice does not reoccur. IV The facility will monitor the corrective action by implementing the following measures. A CQI audit tool will be utilized to audit allegations of abuse to ensure the facility enacts all the necessary steps of investigation conducted daily, when allegation occurs, by the Clinical Specialist for 30 days and the audit will be reviewed by the CS and DCS weekly x 4 weeks. At the end of the 30 days the frequency will be continued at the same rate until compliance is 100% and then performed monthly by the CS and DCS for 12 months. The clinical specialist or designee will conduct weekly QA audit by randomly interviewing a minimum of 5 staff members weekly for 4 weeks and the results will be discussed with the director of clinical services to determine the ongoing frequency into the next 90 days to ensure staff are complying and understand and can identify abuse situations. The Administrator or designee will audit all allegations of abuse five times per week x 30 days, to monitor for comprehensive and complete investigation. This audit will continue weekly for duration of 12 months. Any concerns will be addressed. The QIS abuse	

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	addressed this issue. The DON provided an investigation report, undated, which indicated Unit Manager #15 had spoken with Resident #18 on 10/23/13, and the previously open area on her buttocks had resolved, prior to this allegation. A skin assessment dated 10/25/13 indicated area to left buttocks (developed in house), identified on 10/22/13 and assessed on 10/23/13. The area to left buttocks measured .4 x 0.5 x 0.1 (size in centimeters), area clean with scant serosanguinous drainage, no odor. This entry was documented as completed on 11/19/13 at 1:42 p.m. (as a late entry for 10/23/13). In an interview on 11/20/13 at 2:54 p.m., the DON indicated she wasn't sure why this entry was documented late. She indicated maybe the nurse just forgot to chart on 10/23/13. An MDS (Minimum Data Set) Assessment, dated 11/1/13, indicated the resident was cognitively intact. She required extensive assist with ADL's, (activities of daily living) transferring, locomotion, and bed mobility. The Incident Report Form, reviewed		questionnaire will be integrated into the facility routine customer service/care program and utilized monthly with residents to create an environment of freedom to report potential abuse without the fear of retaliation. This QIS abuse tool will be performed on at least 10 residents with a BIMS of 10 or higher monthly ongoing. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. V. Plan of Completion date is December 22, 2013.	

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	at 11/20/13 1:45 p.m., had been reported to ISDH on 11/19/13 at 1:00 p.m. It read as follows: "brief description of incident: Resident reported to ISDH that about three weeks ago, a CNA was in her room to assist her to the bed pan, pulled her underwear down which was stuck to her dressing and made a wound to her buttocks. Resident stated she felt like the CNA did it intentionally and was rough with her. Type of injuries: None at this time on head to toe assessment. Immediate action taken: Administrator, family and MD notified, skin and pain assessment completed, ISDH phoned and message left. Preventative measures taken: Investigation ongoing, staff interviews to be completed for north unit nursing staff working at time of incident. CNA #9 suspended pending investigation. Resident interviews to be completed on 100 hall for any concerns. 72 hour social services psychosocial follow up with resident." A completed investigation report was received from the DON, typed on plain paper with no dates or times. The report indicated the following: An interview with UM (Unit Manager) #15 indicated she had spoken with Resident #18 on 10/23/13, related to the open area on her bottom. The			

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	UM indicated the area had resolved and the resident had indicated she wanted the patch on it to protect it, because the new skin was fragile. The resident reported she had a patch on when CNA #9 came in to put her on the bed pan, the patch stuck to her panties, and caused the area on her buttocks to open again. A treatment was ordered and the daughter notified. UM #15 spoke with the resident about stating the staff had been rough with her. The UM asked the resident what happened. The resident stated the day it happened CNA #9 and CNA #16 were putting her on the bed pan. She indicated CNA #9 had " 'ripped her panties down' " and the tape stuck to her bottom causing the area to bleed again. Resident #18 indicated she felt the CNA was rough with her when pulling her panties down. Resident or staff didn't report any feelings of roughness prior to this meeting on 11/19/13. CNA #9 indicated, "the patient put her light on. The employee and another aide went to assist the patient to bathroom, the employees used the EZ lift to transfer her to the private bathroom in her room. The employee began to pull her underwear down and the patient complained that this employee pulled them down to close to her skin and it			

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	rubbed too hard on a sore spot on her coccyx. The patient was lowered onto the toilet. After 20 minutes the employees cleaned her up where there was no skin irritation or any type of bandage, on the complained area, this employee notified the nurse of the c/o [complaint] pain the patient was having on her coccyx area." There was no date or time this interview was conducted. The following statements were received from employees in regard to the investigation: LPN #2 "on the evening of the incident occurred the patient asked this nurse if she could redo the ointment and cover the area back up with the dressing, nurse completed treatment per request, the patient thanked the nurse." No date nor time this interview was conducted. CNA #17, "upon returning to work, resident told this employee that CNA #9 had pulled the bed pan from under her bottom and ripped her skin on her bottom." No date nor time indicated for this interview. CNA #18, "not here on the date in question. When returned to work the next day the resident had open area			

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	on bottom. The patient stated the aide pulled her panties down and the patch stuck on it." No date nor time was indicated for this interview. CNA #19, "This employee was in the patients room watching and learning the patient. She stated the CNA #9 ripped her panties down and never said sorry till after she told another CNA #17." No date nor time indicated for this interview. An interview with the Social Services Director (SSD), on 11/19/13, (no time given) indicated the SSD asked to speak with Resident #18 regarding an incident that occurred the week of 10/21/13. Resident #18 stated on 10-22-13 or 10-23-13, she received care from an aide named [CNA #9] who was working a double shift. Resident #18 stated at that time she had a small wound on her left bottom that had a band-aid on it. Resident #18 reported that on second shift CNA #9 took her to the bathroom at one point in the evening, pulled down her pants and panties and her band-aid stayed intact. She indicated when CNA #9 took her to the restroom on third shift she pulled down her pants and " 'snatched her panties off' " which ripped her band			

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	aid off and opened the wound. She was upset the aide wasn't more careful the second time she took her to the bathroom. Resident #18 made no indication she [the resident] was uncomfortable continuing to receive care from CNA #9. "No tearfulness or distress noted during the interview." A review of CNA #9's time card indicated she had continued to work as assigned to Resident #18, after the reported allegation of mistreatment to Unit Manager, until ISDH was notified of the incident. Review of a facility policy, dated 8/20/2011, titled "Abuse Prevention," received on 11/18/13 at 11:59 a.m., from the DON, indicated the following: "...III. Preventing Resident Abuse:... 2. r. Reporting any allegation of abuse or neglect to the State licensing/certification agency responsible for surveying/licensing the facility immediately with a brief description of the alleged occurrence... IV. Identifying & recognizing signs and symptoms of abuse Policy statement: Our facility will not condone any form of resident abuse or neglect. To aid in abuse prevention, all personnel are to report			

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	any signs and symptoms of abuse/neglect to their supervisor immediately who will report to the administrator immediately. V. Abuse investigations: 1. Should an incident or suspected incident of resident abuse, neglect or injury of an unknown source be reported, the administrator, or his/her designee, will appoint a member of management to investigate the alleged incident. When an alleged or suspected case of mistreatment, neglect, injuries of an unknown source, or abuse is reported, the facility administrator, or his/her designee, will notify the following persons or agencies of such incident when applicable: The State licensing/certification agency responsible for surveying/licensing the facility immediately; The local/State Ombudsman; The Resident's Representative of Record; Adult Protective Services; Law Enforcement Officials; The resident's Attending Physician, and The facility Medical Director." 3.1-27(b)			

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F000225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review and	F000225	F225 Investigate/Report	12/22/2013

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	interview, the facility failed to ensure violations which involved verbal and physical mistreatment had been immediately reported and investigated as indicated by their policy and procedures for for 3 of 5 residents reviewed for an allegation of mistreatment in a sample of 1 resident who met the criteria for abuse and 4 residents reviewed for an allegation of mistreatment. (Residents #6, #49, #18) (CNA #7, CNA #9) Findings include: 1. The investigation for Resident #6 was reviewed on 11/21/13 at 12:30 p.m. The incident occurred on 4/6/13 at 10:00 p.m. A handwritten statement, signed and dated by Certified Nursing Assistant (CNA) #6 included the following: CNA #6 reported CNA #7 had sworn at Resident #6 while providing care. CNA #6 indicated CNA #7 said to Resident #6, " 'Are you f------ serious! Why didn't you say you went pee before you p----- all over yourself.' " CNA #6 then indicated CNA #7 left the resident on the toilet for "15 minutes." CNA #7, according to CNA #6, was "being rough" with Resident #6, while getting her gown on. CNA #6 then		Allegations/Individuals I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice. Resident #6 and resident #49 showed no negative outcomes physical evidence or mental anguish from the alleged incident reported to the ISDH on 4/6/13. CNA #7 was suspended on 4/6/13 and resigned before the investigation complete. CNA #7 no longer works in the facility. The facility sent an addendum to the reportable division of the ISDH which included an update that CNA #7 is no longer employed due to abuse and the CNA was reported to the nurse aide registry. Resident #18 showed no negative outcomes physical evidence or mental anguish from the alleged incident reported to the ISDH on 11/19/13. CNA #9 was suspended on during the survey in order for the facility to conduct the abuse investigation and CNA #9 is no longer employed in the facility. The facility reported the abuse allegation to the ISDH and included the information that CNA #9 is no longer employed due to abuse. Employee(s) CNA #17, #19 LPN #15 have received education regarding the CarDon, State and Federal guidelines of reporting abuse allegations timely to the Administrator of the facility. CNA #6 no longer employed at facility. II. The facility will	

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	indicated CNA #7 had sworn at another resident that same night, after having provided care to Resident #6. CNA #6 indicated CNA #7 said to Resident #49 that the resident really " 'p----- her off.' " CNA #6 indicated CNA #7 "started yanking her (the resident) and being really rough with her and when she put on Resident #49's oxygen, "she didn't even put it in her nose." CNA #6 then indicated, "she [CNA #7] didn't care" when the resident told her about the oxygen. CNA #6 reported this verbally and physically rough care to a Licensed Practical Nurse (LPN) on 4/6/13, but not immediately after the care occurred. A typewritten report, dated 4/12/13 at 12:00 p.m., signed by the DON (Director of Nursing) indicated she had received a phone call from CNA #7. The CNA had resigned from her position and indicated, "It's no big deal." The five day follow-up report to the ISDH, dated 4/11/13, indicated "Investigation complete and allegation unsubstantiated. Resident and staff interviews unremarkable. Social services continues to provide psychosocial counseling to residents. Resident have no recall of any		identify other residents that may potentially be affected by the deficient practice. Residents who reside at Greenwood Health and Living have the potential to be affected by the alleged deficient practice. Resident's with a BIMS of 10 or greater and family/responsible party of each resident will be interviewed using the ISDH QIS abuse questionnaire to ensure all abuse allegations are identified and handled according to Federal, State and CarDon policy and procedures. Any allegations of abuse will be reported to the Administrator immediately and to the Indiana State Department of Health per the Unusual Occurrence reporting guidelines. A review will be completed of allegations of abuse to audit for comprehensive and complete investigation. Any concerns will be addressed. III The facility will put into place the following systematic changes to ensure that the deficient practice does not recur. Director of Clinical Services contacted Administrator and Director of Nursing and re-in-serviced on the importance of timely reporting of allegations of abuse and CarDon's abuse reporting and prevention policy/procedure was reviewed in detail. Director of Clinical Services conducted a 1:1 inservice with the Administrator and Director of Nursing to ensure future allegations are reported	

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	unprofessional comments or rough treatment. CNA (name) #7 terminated due to unprofessional conduct." An interview with the DON, at 1:30 PM on 11/21/13, indicated CNA #7 was suspended on 4/6/13, and quit while suspended. The DON indicated she was going to terminate CNA #7 for improper conduct. The DON did not believe it was abuse, as she didn't think it was willful. The DON indicated she was going to terminate CNA #7 though, since more than one person reported it (the allegation of abuse) to her. 4. During an interview on 11/19/13 at 9:48 a.m., Resident #18 was asked if she had been abused by staff. She indicated about 3 weeks ago she had a wound on her bottom. The tape had come loose from the dressing. She also indicated a CNA ripped the tape from her skin causing pain and bleeding. She thought the CNA was barred out of her room, but still came in. She indicated, she had told LPN #15 about the incident. During an interview with LPN #15 on 11/21/13 at 3:00 p.m., she indicated Resident #18 had reported the incident to her, but she (LPN #15) didn't report it because she (LPN #15) didn't think it was		timely by their staff members to the Administrator and ensure that investigation protocol was put into place and utilized for allegations of abuse to ensure potentially abusive staff members are not allowed to return to the workplace after an allegation has been made against him/her. A CQI abuse investigation checklist was put into place for the administrator and director of nursing to utilize for each investigation to ensure future investigations have the necessary documentation to determine the decisions of reinstating employees, terminating employees and reporting employees to the ISDH and licensure boards of Indiana. QIS interview tool was utilized to interview residents within the facility and family members to ensure no further risks of harm exists in the current care environment for those residents potentially affected Alleged staffs involved were removed from the working schedule and investigations were conducted by the administrator, director of nursing and oversight by the Clinical Specialist. In-service staff and contracted services on the abuse reporting policy and procedure including; identifying multiple and various forms of abuse, reporting immediately, and overall review of abuse prevention. A post- test was utilized to ensure the staff and	

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	abuse. The clinical record for Resident #18 was reviewed on 11/20/13 at 2:07 p.m. Diagnoses for Resident #18 included, but were not limited to: rheumatoid arthritis, high blood pressure, pain, Bells palsy, hernia, congestive heart failure, weakness, debility, and osteoarthritis. There were no nursing notes which addressed this issue. The DON provided an investigation report, undated, which indicated Unit Manager #15 had spoken with Resident #18 on 10/23/13, and the previously open area on her buttocks had resolved, prior to this allegation. A skin assessment dated 10/25/13 indicated area to left buttocks (developed in house), identified on 10/22/13 and assessed on 10/23/13. The area to left buttocks measured .4 x 0.5 x 0.1 (size in centimeters), area clean with scant serosanguinous drainage, no odor. This entry was documented as completed on 11/19/13 at 1:42 p.m. (as a late entry for 10/23/13). In an interview on 11/20/13 at 2:54 p.m., the DON		contracted services comprehended the abuse guidelines and policy/procedure to protect the residents and families from harm. Social services will assess the resident and families to ensure mental anguish does not exist and refer those affected for appropriate treatment if indicated. The systemic change includes: An investigative protocol has been put into place and utilized for allegations of abuse and dictates that potentially abusive staff members are not allowed to return to the workplace after the allegation until the investigation is completeA CQI abuse investigation checklist has been put into place for the administrator and director of nursing to utilize for each investigation to provide guidance on providing the necessary documentation to determine decisions of reinstating employees or terminating employees and reporting to the ISDH and licensure boards of Indiana.The QIS interview tool is being utilized to interview residents and family members to review for risk of harmAll unusual occurrences are reviewed daily (Monday through Friday) at the morning clinical meeting for thoroughness and completion Education has been provided to all staff regarding the systemic change. Staff members who are suspended related to abuse	

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	indicated she wasn't sure why this entry was documented late. She indicated maybe the nurse just forgot to chart on 10/23/13. An MDS (Minimum Data Set) Assessment, dated 11/1/13, indicated the resident was cognitively intact. She required extensive assist with ADL's, (activities of daily living) transferring, locomotion, and bed mobility. The Incident Report Form, reviewed at 11/20/13 1:45 p.m., had been reported to ISDH on 11/19/13 at 1:00 p.m. It read as follows: "brief description of incident: Resident reported to ISDH that about three weeks ago, a CNA was in her room to assist her to the bed pan, pulled her underwear down which was stuck to her dressing and made a wound to her buttocks. Resident stated she felt like the CNA did it intentionally and was rough with her. Type of injuries: None at this time on head to toe assessment. Immediate action taken: Administrator, family and MD notified, skin and pain assessment completed, ISDH phoned and message left. Preventative measures taken: Investigation ongoing, staff interviews to be completed for north unit nursing staff working at time of incident.		allegations will be reviewed by the corporate clinical consultant, corporate director of operations and corporate human resources director prior to being reinstated into the workplace to ensure the alleged deficient practice does not reoccur. IV The facility will monitor the corrective action by implementing the following measures. A CQI audit tool will be utilized to audit allegations of abuse to ensure the facility enacts all the necessary steps of investigation conducted daily, when allegation occurs, by the Clinical Specialist for 30 days and the audit will be reviewed by the CS and DCS weekly x 4 weeks. At the end of the 30 days the frequency will be continued at the same rate until compliance is 100% and then performed monthly by the CS and DCS for 12 months. The clinical specialist or designee will conduct weekly QA audit by randomly interviewing a minimum of 5 staff members weekly for 4 weeks and the results will be discussed with the director of clinical services to determine the ongoing frequency into the next 90 days to ensure staff are complying and understand and can identify abuse situations. The Administrator or designee will audit all allegations of abuse five times per week x 30 days, to monitor for comprehensive and complete investigation. This audit will continue weekly for duration	

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	CNA #9 suspended pending investigation. Resident interviews to be completed on 100 hall for any concerns. 72 hour social services psychosocial follow up with resident." A completed investigation report was received from the DON, typed on plain paper with no dates or times. The report indicated the following: An interview with UM (Unit Manager) #15 indicated she had spoken with Resident #18 on 10/23/13, related to the open area on her bottom. The UM indicated the area had resolved and the resident had indicated she wanted the patch on it to protect it, because the new skin was fragile. The resident reported she had a patch on when CNA #9 came in to put her on the bed pan, the patch stuck to her panties, and caused the area on her buttocks to open again. A treatment was ordered and the daughter notified. UM #15 spoke with the resident about stating the staff had been rough with her. The UM asked the resident what happened. The resident stated the day it happened CNA #9 and CNA #16 were putting her on the bed pan. She indicated CNA #9 had " 'ripped her panties down' " and the tape stuck to her bottom causing the area to bleed again. Resident #18 indicated she		of 12 months. Any concerns will be addressed. The QIS abuse questionnaire will be integrated into the facility routine customer service/care program and utilized monthly with residents to create an environment of freedom to report potential abuse without the fear of retaliation. This QIS abuse tool will be performed on at least 10 residents with a BIMS of 10 or higher monthly ongoing. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. V. Plan of Completion date is December 22, 2013.	

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	felt the CNA was rough with her when pulling her panties down. Resident or staff didn't report any feelings of roughness prior to this meeting on 11/19/13. CNA #9 indicated, "the patient put her light on. The employee and another aide went to assist the patient to bathroom, the employees used the EZ lift to transfer her to the private bathroom in her room. The employee began to pull her underwear down and the patient complained that this employee pulled them down to close to her skin and it rubbed too hard on a sore spot on her coccyx. The patient was lowered onto the toilet. After 20 minutes the employees cleaned her up where there was no skin irritation or any type of bandage, on the complained area, this employee notified the nurse of the c/o [complaint] pain the patient was having on her coccyx area." There was no date or time this interview was conducted. The following statements were received from employees in regard to the investigation: LPN #2 "on the evening of the incident occurred the patient asked this nurse if she could redo the ointment and cover the area back up with the dressing, nurse completed			

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	treatment per request, the patient thanked the nurse." No date nor time this interview was conducted. CNA #17, "upon returning to work, resident told this employee that CNA #9 had pulled the bed pan from under her bottom and ripped her skin on her bottom." No date nor time indicated for this interview. CNA #18, "not here on the date in question. When returned to work the next day the resident had open area on bottom. The patient stated the aide pulled her panties down and the patch stuck on it." No date nor time was indicated for this interview. CNA #19, "This employee was in the patients room watching and learning the patient. She stated the CNA #9 ripped her panties down and never said sorry till after she told another CNA #17." No date nor time indicated for this interview. An interview with the Social Services Director (SSD), on 11/19/13, (no time given) indicated the SSD asked to speak with Resident #18 regarding an incident that occurred the week of 10/21/13. Resident #18 stated on 10-22-13 or 10-23-13, she received care from an aide named [CNA #9]			

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	who was working a double shift. Resident #18 stated at that time she had a small wound on her left bottom that had a band-aid on it. Resident #18 reported that on second shift CNA #9 took her to the bathroom at one point in the evening, pulled down her pants and panties and her band-aid stayed intact. She indicated when CNA #9 took her to the restroom on third shift she pulled down her pants and " 'snatched her panties off' " which ripped her band aid off and opened the wound. She was upset the aide wasn't more careful the second time she took her to the bathroom. Resident #18 made no indication she [the resident] was uncomfortable continuing to receive care from CNA #9. "No tearfulness or distress noted during the interview." A review of CNA #9's time card indicated she had continued to work as assigned to Resident #18, after the reported allegation of mistreatment to Unit Manager, until ISDH was notified of the incident. Review of a facility policy, dated 8/20/2011, titled "Abuse Prevention," received on 11/18/13 at 11:59 a.m., from the DON, indicated the following: "...III. Preventing Resident Abuse:...			

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	2. r. Reporting any allegation of abuse or neglect to the State licensing/certification agency responsible for surveying/licensing the facility immediately with a brief description of the alleged occurrence... IV. Identifying & recognizing signs and symptoms of abuse Policy statement: Our facility will not condone any form of resident abuse or neglect. To aid in abuse prevention, all personnel are to report any signs and symptoms of abuse/neglect to their supervisor immediately who will report to the administrator immediately. V. Abuse investigations: 1. Should an incident or suspected incident of resident abuse, neglect or injury of an unknown source be reported, the administrator, or his/her designee, will appoint a member of management to investigate the alleged incident. When an alleged or suspected case of mistreatment, neglect, injuries of an unknown source, or abuse is reported, the facility administrator, or his/her designee, will notify the following persons or agencies of such incident when applicable: The State licensing/certification			

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	agency responsible for surveying/licensing the facility immediately; The local/State Ombudsman; The Resident's Representative of Record; Adult Protective Services; Law Enforcement Officials; The resident's Attending Physician, and The facility Medical Director." 3.1-28(c) 3.1-28(d)			

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F000226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to ensure implementation of their abuse prevention policy in that residents' allegations of verbal and physical mistreatment had not been immediately reported and investigated as indicated by their policy and procedures for for 3 of 5 residents reviewed for an allegation of mistreatment in a sample of 1 resident who met the criteria for abuse and 4 residents reviewed for an allegation of mistreatment. (Residents #6, #49, #18) (CNA #7, CNA #9) Findings include: 1. The investigation for Resident #6 was reviewed on 11/21/13 at 12:30 p.m. The incident occurred on 4/6/13 at 10:00 p.m. A handwritten statement, signed and dated by Certified Nursing Assistant (CNA) #6 included the following: CNA #6 reported CNA #7 had sworn at Resident #6 while providing care.	F000226	F226 Develop/Implement Abuse/Neglect, etc. Policies I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice. Resident #6 and resident #49 showed no negative outcomes physical evidence or mental anguish from the alleged incident reported to the ISDH on 4/6/13. CNA #7 was suspended on 4/6/13 and resigned before the investigation complete. CNA #7 no longer works in the facility. The facility sent an addendum to the reportable division of the ISDH which included an update that CNA #7 is no longer employed due to abuse and the CNA was reported to the nurse aide registry. Resident #18 showed no negative outcomes physical evidence or mental anguish from the alleged incident reported to the ISDH on 11/19/13. CNA #9 was suspended on during the survey in order for the facility to conduct the abuse investigation and CNA #9 is no longer employed in the facility. The facility reported the abuse allegation to the ISDH and included the information that CNA	12/22/2013

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	CNA #6 indicated CNA #7 said to Resident #6, " 'Are you f------ serious! Why didn't you say you went pee before you p----- all over yourself.' " CNA #6 then indicated CNA #7 left the resident on the toilet for "15 minutes." CNA #7, according to CNA #6, was "being rough" with Resident #6, while getting her gown on. CNA #6 then indicated CNA #7 had sworn at another resident that same night, after having provided care to Resident #6. CNA #6 indicated CNA #7 said to Resident #49 that the resident really " 'p----- her off.' " CNA #6 indicated CNA #7 "started yanking her (the resident) and being really rough with her and when she put on Resident #49's oxygen, "she didn't even put it in her nose." CNA #6 then indicated, "she [CNA #7] didn't care" when the resident told her about the oxygen. CNA #6 reported this verbally and physically rough care to a Licensed Practical Nurse (LPN) on 4/6/13, but not immediately after the care occurred. A typewritten report, dated 4/12/13 at 12:00 p.m., signed by the DON (Director of Nursing) indicated she had received a phone call from CNA #7. The CNA had resigned from her position and indicated, "It's no big		#9 is no longer employed due to abuse. Employee(s) CNA #17, #19 LPN #15 have received education regarding the CarDon, State and Federal guidelines of reporting abuse allegations timely to the Administrator of the facility. CNA #6 no longer employed at facility. II. The facility will identify other residents that may potentially be affected by the deficient practice. Residents who reside at Greenwood Health and Living have the potential to be affected by the alleged deficient practice. Resident's with a BIMS of 10 or greater and family/responsible party of each resident will be interviewed using the ISDH QIS abuse questionnaire to ensure all abuse allegations are identified and handled according to Federal, State and CarDon policy and procedures. Any allegations of abuse will be reported to the Administrator immediately and to the Indiana State Department of Health per the Unusual Occurrence reporting guidelines. A review will be completed of allegations of abuse to audit for comprehensive and complete investigation. Any concerns will be addressed. III The facility will put into place the following systematic changes to ensure that the deficient practice does not recur. Director of Clinical Services contacted Administrator and Director of Nursing and re-in-serviced on the importance	

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	deal." The five day follow-up report to the ISDH, dated 4/11/13, indicated "Investigation complete and allegation unsubstantiated. Resident and staff interviews unremarkable. Social services continues to provide psychosocial counseling to residents. Resident have no recall of any unprofessional comments or rough treatment. CNA (name) #7 terminated due to unprofessional conduct." An interview with the DON, at 1:30 PM on 11/21/13, indicated CNA #7 was suspended on 4/6/13, and quit while suspended. The DON indicated she was going to terminate CNA #7 for improper conduct. The DON did not believe it was abuse, as she didn't think it was willful. The DON indicated she was going to terminate CNA #7 though, since more than one person reported it (the allegation of abuse) to her. 4. During an interview on 11/19/13 at 9:48 a.m., Resident #18 was asked if she had been abused by staff. She indicated about 3 weeks ago she had a wound on her bottom. The tape had come loose from the dressing. She also indicated a CNA ripped the		of timely reporting of allegations of abuse and CarDon's abuse reporting and prevention policy/procedure was reviewed in detail. Director of Clinical Services conducted a 1:1 inservice with the Administrator and Director of Nursing to ensure future allegations are reported timely by their staff members to the Administrator and ensure that investigation protocol was put into place and utilized for allegations of abuse to ensure potentially abusive staff members are not allowed to return to the workplace after an allegation has been made against him/her. A CQI abuse investigation checklist was put into place for the administrator and director of nursing to utilize for each investigation to ensure future investigations have the necessary documentation to determine the decisions of reinstating employees, terminating employees and reporting employees to the ISDH and licensure boards of Indiana. QIS interview tool was utilized to interview residents within the facility and family members to ensure no further risks of harm exists in the current care environment for those residents potentially affected Alleged staffs involved were removed from the working schedule and investigations were conducted by the administrator, director of nursing and oversight by the	

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	tape from her skin causing pain and bleeding. She thought the CNA was barred out of her room, but still came in. She indicated, she had told LPN #15 about the incident. During an interview with LPN #15 on 11/21/13 at 3:00 p.m., she indicated Resident #18 had reported the incident to her, but she (LPN #15) didn't report it because she (LPN #15) didn't think it was abuse. The clinical record for Resident #18 was reviewed on 11/20/13 at 2:07 p.m. Diagnoses for Resident #18 included, but were not limited to: rheumatoid arthritis, high blood pressure, pain, Bells palsy, hernia, congestive heart failure, weakness, debility, and osteoarthritis. There were no nursing notes which addressed this issue. The DON provided an investigation report, undated, which indicated Unit Manager #15 had spoken with Resident #18 on 10/23/13, and the previously open area on her buttocks had resolved, prior to this allegation. A skin assessment dated 10/25/13 indicated area to left buttocks		Clinical Specialist. In-service staff and contracted services on the abuse reporting policy and procedure including; identifying multiple and various forms of abuse, reporting immediately, and overall review of abuse prevention. A post- test was utilized to ensure the staff and contracted services comprehended the abuse guidelines and policy/procedure to protect the residents and families from harm. Social services will assess the resident and families to ensure mental anguish does not exist and refer those affected for appropriate treatment if indicated. The systemic change includes: An investigative protocol has been put into place and utilized for allegations of abuse and dictates that potentially abusive staff members are not allowed to return to the workplace after the allegation until the investigation is completeA CQI abuse investigation checklist has been put into place for the administrator and director of nursing to utilize for each investigation to provide guidance on providing the necessary documentation to determine decisions of reinstating employees or terminating employees and reporting to the ISDH and licensure boards of Indiana.The QIS interview tool is being utilized to interview residents and family members to	

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	(developed in house), identified on 10/22/13 and assessed on 10/23/13. The area to left buttocks measured .4 x 0.5 x 0.1 (size in centimeters), area clean with scant serosanguinous drainage, no odor. This entry was documented as completed on 11/19/13 at 1:42 p.m. (as a late entry for 10/23/13). In an interview on 11/20/13 at 2:54 p.m., the DON indicated she wasn't sure why this entry was documented late. She indicated maybe the nurse just forgot to chart on 10/23/13. An MDS (Minimum Data Set) Assessment, dated 11/1/13, indicated the resident was cognitively intact. She required extensive assist with ADL's, (activities of daily living) transferring, locomotion, and bed mobility. The Incident Report Form, reviewed at 11/20/13 1:45 p.m., had been reported to ISDH on 11/19/13 at 1:00 p.m. It read as follows: "brief description of incident: Resident reported to ISDH that about three weeks ago, a CNA was in her room to assist her to the bed pan, pulled her underwear down which was stuck to her dressing and made a wound to her buttocks. Resident stated she felt like the CNA did it intentionally and		review for risk of harmAll unusual occurrences are reviewed daily (Monday through Friday) at the morning clinical meeting for thoroughness and completion Education has been provided to all staff regarding the systemic change. Staff members who are suspended related to abuse allegations will be reviewed by the corporate clinical consultant, corporate director of operations and corporate human resources director prior to being reinstated into the workplace to ensure the alleged deficient practice does not reoccur. IV The facility will monitor the corrective action by implementing the following measures. A CQI audit tool will be utilized to audit allegations of abuse to ensure the facility enacts all the necessary steps of investigation conducted daily, when allegation occurs, by the Clinical Specialist for 30 days and the audit will be reviewed by the CS and DCS weekly x 4 weeks. At the end of the 30 days the frequency will be continued at the same rate until compliance is 100% and then performed monthly by the CS and DCS for 12 months. The clinical specialist or designee will conduct weekly QA audit by randomly interviewing a minimum of 5 staff members weekly for 4 weeks and the results will be discussed with the director of clinical services to determine the ongoing frequency into the next 90 days to ensure	

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	was rough with her. Type of injuries: None at this time on head to toe assessment. Immediate action taken: Administrator, family and MD notified, skin and pain assessment completed, ISDH phoned and message left. Preventative measures taken: Investigation ongoing, staff interviews to be completed for north unit nursing staff working at time of incident. CNA #9 suspended pending investigation. Resident interviews to be completed on 100 hall for any concerns. 72 hour social services psychosocial follow up with resident." A completed investigation report was received from the DON, typed on plain paper with no dates or times. The report indicated the following: An interview with UM (Unit Manager) #15 indicated she had spoken with Resident #18 on 10/23/13, related to the open area on her bottom. The UM indicated the area had resolved and the resident had indicated she wanted the patch on it to protect it, because the new skin was fragile. The resident reported she had a patch on when CNA #9 came in to put her on the bed pan, the patch stuck to her panties, and caused the area on her buttocks to open again. A treatment was ordered and the daughter notified. UM #15 spoke with		staff are complying and understand and can identify abuse situations. The Administrator or designee will audit all allegations of abuse five times per week x 30 days, to monitor for comprehensive and complete investigation. This audit will continue weekly for duration of 12 months. Any concerns will be addressed. The QIS abuse questionnaire will be integrated into the facility routine customer service/care program and utilized monthly with residents to create an environment of freedom to report potential abuse without the fear of retaliation. This QIS abuse tool will be performed on at least 10 residents with a BIMS of 10 or higher monthly ongoing. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. V. Plan of Completion date is December 22, 2013.	

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	the resident about stating the staff had been rough with her. The UM asked the resident what happened. The resident stated the day it happened CNA #9 and CNA #16 were putting her on the bed pan. She indicated CNA #9 had " 'ripped her panties down' " and the tape stuck to her bottom causing the area to bleed again. Resident #18 indicated she felt the CNA was rough with her when pulling her panties down. Resident or staff didn't report any feelings of roughness prior to this meeting on 11/19/13. CNA #9 indicated, "the patient put her light on. The employee and another aide went to assist the patient to bathroom, the employees used the EZ lift to transfer her to the private bathroom in her room. The employee began to pull her underwear down and the patient complained that this employee pulled them down to close to her skin and it rubbed too hard on a sore spot on her coccyx. The patient was lowered onto the toilet. After 20 minutes the employees cleaned her up where there was no skin irritation or any type of bandage, on the complained area, this employee notified the nurse of the c/o [complaint] pain the patient was having on her coccyx area." There was no date or time this interview was conducted.			

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	The following statements were received from employees in regard to the investigation: LPN #2 "on the evening of the incident occurred the patient asked this nurse if she could redo the ointment and cover the area back up with the dressing, nurse completed treatment per request, the patient thanked the nurse." No date nor time this interview was conducted. CNA #17, "upon returning to work, resident told this employee that CNA #9 had pulled the bed pan from under her bottom and ripped her skin on her bottom." No date nor time indicated for this interview. CNA #18, "not here on the date in question. When returned to work the next day the resident had open area on bottom. The patient stated the aide pulled her panties down and the patch stuck on it." No date nor time was indicated for this interview. CNA #19, "This employee was in the patients room watching and learning the patient. She stated the CNA #9 ripped her panties down and never said sorry till after she told another CNA #17." No date nor time			

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	indicated for this interview. An interview with the Social Services Director (SSD), on 11/19/13, (no time given) indicated the SSD asked to speak with Resident #18 regarding an incident that occurred the week of 10/21/13. Resident #18 stated on 10-22-13 or 10-23-13, she received care from an aide named [CNA #9] who was working a double shift. Resident #18 stated at that time she had a small wound on her left bottom that had a band-aid on it. Resident #18 reported that on second shift CNA #9 took her to the bathroom at one point in the evening, pulled down her pants and panties and her band-aid stayed intact. She indicated when CNA #9 took her to the restroom on third shift she pulled down her pants and " 'snatched her panties off' " which ripped her band aid off and opened the wound. She was upset the aide wasn't more careful the second time she took her to the bathroom. Resident #18 made no indication she [the resident] was uncomfortable continuing to receive care from CNA #9. "No tearfulness or distress noted during the interview." A review of CNA #9's time card indicated she had continued to work			

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	as assigned to Resident #18, after the reported allegation of mistreatment to Unit Manager, until ISDH was notified of the incident. Review of a facility policy, dated 8/20/2011, titled "Abuse Prevention," received on 11/18/13 at 11:59 a.m., from the DON, indicated the following: "...III. Preventing Resident Abuse:... 2. r. Reporting any allegation of abuse or neglect to the State licensing/certification agency responsible for surveying/licensing the facility immediately with a brief description of the alleged occurrence... IV. Identifying & recognizing signs and symptoms of abuse Policy statement: Our facility will not condone any form of resident abuse or neglect. To aid in abuse prevention, all personnel are to report any signs and symptoms of abuse/neglect to their supervisor immediately who will report to the administrator immediately. V. Abuse investigations: 1. Should an incident or suspected incident of resident abuse, neglect or injury of an unknown source be reported, the administrator, or his/her designee, will appoint a member of			

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	management to investigate the alleged incident. When an alleged or suspected case of mistreatment, neglect, injuries of an unknown source, or abuse is reported, the facility administrator, or his/her designee, will notify the following persons or agencies of such incident when applicable: The State licensing/certification agency responsible for surveying/licensing the facility immediately; The local/State Ombudsman; The Resident's Representative of Record; Adult Protective Services; Law Enforcement Officials; The resident's Attending Physician, and The facility Medical Director." 3.1-28(a)			

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F000244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. Based on record review and interview, the facility failed to listen to the views and act upon the grievances of the Resident Council. This had the potential to affect 96 of 98 residents in the facility. Findings include: During an interview with Resident #89 on 11/20/2013 at 2:10 p.m., concerning the Resident Council, she indicated problems with the kitchen have been discussed month after month during Resident Council meetings. Complaints such as, food service and timing have been indicated, along with food being cold and undercooked. During this interview Resident #89 indicated, "Even staff has trouble cutting meat it is so tough." Resident #89 indicated this had been complained about several times and that it continued to get looked over. Resident #89 indicated the Resident Council had requested the Dietary Manager put	F000244	F 244-LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION I. The dietary manager or Administrator has met with resident #89 and all of resident #89 concerns have been addressed and the corrective actions have been implemented. II. Residents residing in the facility had the potential to be affected.The administrator met with the resident council on 12/18/13 and formatted an action plan to address all concerns. III. The systemic change includes:The Resident Council meeting concerns will be reviewed at the clinical meeting attended by all department heads and an action plan will be completed at that time to resolve the concerns.This action plan will be reviewed weekly at the clinical meeting until the concerns are resolved.The action plan for the resident's concerns will be presented to the resident council at their next scheduled meeting and input from the council will be incorporated into the action plan.This presentation will continue until the concerns are	12/22/2013

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	the resident choice meal on the schedule a few months ago and this has yet to be done. On 11/20/13 at 2:35 p.m., Resident Council minutes were reviewed. 1. The Resident Council minutes, dated 10/24/2013, included, but were not limited to,"Lima beans not cooked completely. Food too salty. Meat is too tough." The Resident Council follow up form, dated 10/25/2013, included the concerns of "Meals served late," "Meals are cold," "Lima beans not cooked completely," and "Meat is too tough." The "Action Taken" portion of this form indicated the following actions: "Staff education on meal timing," "Adding new steam table to dining room in Nov.-Dec. Checking with staff/staff education," "Cooks educated," and "changed product." These documents were signed by the Dietary Manager and dated 10/26/2013. The Resident council follow up form, dated 10/25/2013, included the following concern: "Food too salty." There was an "Action Taken" portion		resolvedAny department manager with a grievance concerning their department will request an invitation to the resident council meeting to present resolutions of grievances and obtain input from the residents to determine if the issue is resolved.Education has been provided to department supervisors and activity personnel regarding the systemic change. IV. The administrator or designee will audit all resident council concerns for a follow up action plan and response of the resident council for resolution weekly for 8 weeks, then monthly for a duration of 12 months of monitoring. Temperatures of food, test trays for correct temperatures and palatability, and meals served timely will be audited 5x weekly for 1 month, then 3x weekly for 1 month, then once weekly for 1 month then once monthly for 12 months.The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. V. Plan of Completion date is December 22, 2013.	

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	on the form. This portion was left blank and the signature and date line was blank. The forms lacked documentation to indicate dietary had acted upon residents' grievances regarding late meals, salty, cold food, tough meat, and lima beans which were not cooked thoroughly. No further documentation available. 2. Resident council minutes dated 09/25/2013 at 10:30 a.m., indicated the following concerns: "Label resident choice meal on signs. Turn steam tables on earlier in SDR [South Dining Room]. Not getting what they ordered (when given papers to order food ahead of time)." Resident council follow up forms dated 10/08/2013, had the following concerns listed: "Res[idents] not getting what they ordered (when given paper to order food ahead of time)," "Res[idents] would like the steam tables turned on earlier in the SDR [South Dining Room]," "Reminder to label res[ident]s choice meal on signs," "Meals are cold," and "Meals are served late." The "Action Taken" portion of the forms indicated the following actions: "Cooks educated to take time to read choices but to stick to diet," "Staff			

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	notified to turn on 30 minutes before serving time," "Okay will do next time," "Education given to new staff members," "Residents educated to speak-up and tell staff to re-heat or get fresh plate," and "Education given to new staff members." These forms were signed by the Dietary Manager and dated 10/10/2013. 3. Resident Council Minutes dated 8/22/2013 at 10:30 a.m., indicated the following concerns: "Meals are late. Cream of potato soup too thin. Too much pepper/salt on food. Steaks were tough and cold." The following concerns were written on Resident Council follow up forms dated 8/22/13: "Baked potatoes not always cooked," "Meals served late," "Meals are cold (South)," "Veggies are undercooked," "1. Cream of potato soup too thin. 2. Too much pepper/ salt on food. 3. Steaks were tough and cold." The "Action Taken" portion of the forms indicated the following actions: "Cooks educated: "Held dept. [department] head meeting on subject. Will continue to follow-up," "Staff education to return food to kitchen for reheating if not temping," "Staff education," and "1 and 2 staff			

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	education...will try to improve. 3. Product change." These forms were signed by the Dietary Manager and dated 08/26/2013. 4. Resident Council Minutes dated 7/25/2013 at 10:30 a.m., indicated the following concerns: "Meals are cold. Veggies are undercooked. Baked potatoes are not always done. Res[idents] would like more soups. When they have soups please make sure they have crackers. Res[idents] would like more lunch meat sandwiches." On Resident Council Forms dated 7/25/2013, the following concern was listed: "Res[idents] would like more lunch meat sandwiches," "Veggies are undercooked," "Baked potatoes not always done," "Alt[ernate] meals continue to not always be what is posted," "Meals are cold," and "Res[idents] would like more soups. Also when they have soups please make sure they have crackers." The "Action Taken" portion of the forms indicated the following actions: "We will try but we have to stick with the corporate menu... We will try to offer more on the alternate choice," "Will discuss at staff meeting Aug 7," "Will discuss at dining SVC [service]			

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	Staff meeting on Wed. Aug. 7," "I don't understand this... because we always have the products! I will discuss at meeting Aug. 7," "Will address at meeting...Need more information...Room trays? North or South?" and "Fall and Winter menu will becoming soon and there are always more soups available. We always have crackers." These forms were signed by the Dietary Manager and dated 8/6/2013. 5. On a Resident Council Form dated 6/19/2013 at 10:30 a.m., the following concern was indicated "Alt meals not always what is posted." The "Action Taken" portion of the form indicated the following actions taken: "Starting a new meal program in July where res will get to choose their own meal to order." The signature line on this form was blank. There was no date on this form. 6. On Resident Council Forms dated 5/22/2013, the following concerns were listed: "Meals continue to be cold," "Meals continue to be served late," "Potatoes are not getting cooked all the way," and "Alt[ernate] meal not always what is posted." The "Action Taken" portion of the			

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	form indicated the following actions taken: "Staff inservice education," "New meal plan to take place starting July 1st.," "Staff education," and "New menus started in May...all posted meals will be available." 7. Resident Council minutes dated 4/24/13 at 10:30 a.m., indicated the following concerns: "Alt[ernate] meal is not always what is posted. Res[idents] have been told many times that dietary has run out of things. Potatoes are not getting cooked all the way." On a Resident Council Form dated 4/26/2013, the following concern was listed: "Meals continue to be cold." The "Action Taken" portion of the form was left blank. The form was not signed or dated. On a Resident Council Form dated 4/26/2013, the following concern was listed: "Meals continue to be served late." The "Action Taken" portion of the form was left blank and the form was not signed or dated. On Resident Council Form dated 4/26/2013, the following concern was			

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	listed: "Potatoes are not getting cooked all the way (fried, french fries)." The "Action Taken" portion of the form was left blank. The form was not signed or dated. 8. On a Resident Council Form dated 3/20/2013, the following concern was listed: "Meals continue to be cold." The "Action taken" portion listed the following action: "Cooks have been counciled about plating early...wait til nursing is ready to serve" This form was not signed or dated. On a Resident Council Form dated 3/20/2013, the following concern was listed: "Meals continue to be served late. Can we change the times posted to the times the food is actually served?" The "Action Taken" portion of the form had the following action listed: "State regulates meal times and time between meals so we have to comply." This form was signed by the Dietary Manager and dated 4/24/2013. 9. On a Resident Council Form dated 2/26/2013, the following concern was			

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	listed: "Baked potatoes not fully cooked." The "Action Taken" portion of this form was left blank. The form was not signed and was not dated. On a Resident Council Form dated 2/26/2013, the following concern was listed: "Meals continue to be cold." The "Action Taken" portion of this form was left blank. There was no signature or date on this form. On a Resident Council Form dated 2/26/2013, the following concern was listed: "Meals continue to be served late." The "Action Taken" portion of this form was left blank. There was no signature or date on this form. 10. The Resident council minutes dated: 1/22/13 at 2:30 p.m., indicated the following concerns: "Veggies were not cooked in veg[etable] soup. Do not like rice said it is dry, not good, no seasoning. Baked potatoes not fully cooked last time they had them." 11. On a Resident Council Form dated 1/23/2013, the following concern was listed: "Meals continue			

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	to be cold. Meals continue to be served late... Veggies were not cooked in veg[etable] soup. Do not like rice said it is dry, not good, no seasoning. Baked potatoes not fully cooked last time they had them." The "Action Taken" portion of this form was left blank. There was no signature or date on this form. During an interview with the Dietary Manager on 11/21/13 at 11:30 a.m., she indicated 96 of 98 residents received their meals from the facility kitchen. On 11/22/2013 at 9:31 a.m., the Dietary Manager indicated staff had not begun the new dietary program, which was scheduled to have begun in July 2013. Staff were, "slow to get it going." Residents chose meals every 7 days. The procedure for residents to order alternate meals or request substitutes was for the resident to tell a staff member. Residents tell the dietary staff ahead of time or nursing staff and then nursing staff will make dietary staff aware. The policy of temperature taking for food was the temperatures were taken before the first tray was served. If a resident complained of cold food the dietary staff would			

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	check and see if the resident would want something else, or they would reheat the meal for the resident. She also indicated the dietary staff would research why the food was cold and check temperature sheets. She would try to correct the problem and educate the staff on the matter. There are microwaves in both kitchens, but not in the dining rooms. The facility did a monthly test tray with corporate inspection. A new steam table had been obtained two days prior, but the steam table was not in use and was not going to be put to use until after January, because the facility needed to change the policy and procedure for the new steam table, due to it being in a new location. Staff have plugged in the current steam table 30 minutes before breakfast and kept them on "pretty much all day." The staff had been "trying to get it together" in regard to the Resident Council complaints of food service time. The kitchen staff would be ready to serve meals, however the dining room would not be ready. The kitchen staff waited to start serving until the serving staff and the residents were in the dining room. "It's an ongoing solution we're trying to find. Our meals are so big it just happens." She indicated the Resident Council concern forms were			

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	given directly to them in person and she "tries to respond within a few days." There was no procedure to follow up with these Resident Council concern forms. They attended one Resident Council meeting 6 months ago, and the residents who attended that meeting spoke about the menu, but not much else. There has not been a change in distributors. 3.1-3(l)			

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	155412	A. BUILDING 00 B. WING	11/22/2013

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F000248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. Based on observation, interview, and record review, the facility failed to provide an ongoing program of activities designed to meet in accordance with the comprehensive assessment the interests of each resident for 1 of 3 residents reviewed for activities in a sample of 11 who met the criteria for activities review. (Resident #61) Findings include: On 11/20/2013 at 3:20 p.m., Resident #61 was observed lying in bed with eyes open. There were no activities noted at the time. The television in the room was turned off. There was no music playing. There were no reading materials in sight. "Music" was scheduled for 2:30 p.m. on this day. There was no documentation in the resident's record, which indicated she had been invited to participate, or refused to attend the music activity. On 11/21/2013 at 10:36 a.m.,	F000248	F 248- ACTIVITIES MEET INTERESTS/NEEDS OF EACH RESIDENT I. Resident #61 care plan has been reviewed to confirm residents current activity interest is documented and activities has been inserviced on resident #61 activity care plans.II. Residents who reside in the facility have the potential to be affected by the alleged deficient practice.The Activity Director will review the attendance record of all residents for the past 30 days.For those residents that had poor attendance at their activity of choice, the Activity Director will interview the resident to update their of interest activities. III. The systemic change will include:Activity interests for residents will be documented. As well, the attendance record for each resident will be documented. For those residents that choose few interests or seem to prefer quiet time in their room, the Activity department will encourage them to attend their interest activities when scheduled. The Activity Director will document her efforts at encouraging residents to come to	12/22/2013

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	Resident #61 was observed resting in bed with eyes closed. No activity materials were noted on Resident #61's side of the room. The television was turned off and there was no music playing. On 11/21/2013 at 4:20 p.m., Resident #61 was observed to be sitting in her wheelchair in the doorway of her room. The resident was facing in towards the room. The resident was not participating in any activities during this time. On 11/20/2013 at 12:24 p.m., Resident #61's clinical record was reviewed. The resident's diagnoses included, but were not limited to, anemia, heart failure, hypertension, hyperlipidemia, non-Alzheimer's dementia, and depression. The MDS (Minimum Data Set) annual assessment, dated 2/28/2013, indicated the following activities were listed as "very important" to the resident, which included listening to music, participating in religious services or practices, bingo, and going outside in good weather. The care plan, with start date of		activities that they have chosen as their interests.The attendance records will be reviewed every 30 days.If it is discovered that the resident did not attend or had poor attendance at the activities of choice, the activity director will interview the resident to update the activity interests of choice. Care plans for residents will be reviewed at least quarterly and the activity care plans will be reviewed to ensure they reflect the resident preferences and the activity department is meeting the needs of residents in the facility. Education has been provided to activity personnel regarding the systemic change.IV. A contracted consultant will review the Activity Department documentation quarterly toconfirm that this plan of correction is being followed.A CQI activity tool will be utilized to randomly audit 5 residents per week for 4 weeks, 10 residents per month for 12 months to ensure individual activity plans are being enacted. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. V. Plan of Completion date is December 22, 2013.	

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	9/14/2011 and a target date of 02/05/2014, indicated Resident #61's goal was: "Resident will engage in activities of interest such as bingo, special events and/or music on a weekly basis X 90 days." Approaches included, but were not limited to, "Invite and encourage resident to group programs of interests. Provide activity calendar. Provide independent leisure supplies as needed when not participating in group programs. Respect residents right to refuse activities. Thank and praise resident for all participation efforts." The following activities were noted on the activity calendar in which Resident #61's annual MDS assessment indicated as "very important" activities. On 11/3/2013, the activity calendar had, "10:30 Worship Service SDR, [South dining Room] 11:00 Music & Massage AR [location of activity], 2:30 Bingo NDR [North dining room]" listed. On 11/9/2013 the activity calendar had the following listed: "10:00 Vineyard Church Visit, 2:30 pm Bingo." On 11/10/2013, the resident activity calendar had the following listed: "10:30 Worship Service, 2:30 Bingo." On 11/14/2013 the following was listed on the activity			

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	calendar: "11:30 Music and Massage, 4:00 pm Church Service." The Activity calendar listed the following on 11/16/2013, "Bingo 2:30." Resident #61's "Participation Log" for activities in November indicated Resident #61 did not participate in any "music," "Active Games," "Videos/ Movies," "Manicures," "Cooking," "Gardening," "Exercise," "Outings," "Cognitive Games," "Arts &Crafts," "Leisure Cart," "Social Groups," "Family Visits," "Current Events" or "other" activities. Resident #61 participated in "table games/bingo" on 11/2/2013, 11/4/2013, 11/11/2013, 11/17/2013 and 11/18/2013. Resident #61 was listed as unavailable for "table games/bingo" on 11/6/2013 and 11/13/2013. Resident #61 refused "Sensory Stim" activities on 11/6/2013. She did not participate in any other "Sensory Stim" activities. Resident #61 refused "Church/Religion" activities on 11/4/2013 and 11/12/2013. Resident #61 did not participate in any "Church/Religion" activities during November. Resident #61 refused a "special event" activity on 11/11//2013. She did not participate in any other "special event" activities			

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	in November. Resident #61 refused to participate in "Res[ident] Council/ Planning" on 11/20/2013. Resident #61 did not participate in any "Res[ident] Council/ Planning" activities in November. On 11/20/2013 at 8:50 a.m., during an interview Resident #61's daughter, she indicated the resident enjoyed participating in bingo every week. On 11/20/2013 at 3:20 p.m., Resident #61 indicated, "I play bingo a lot." The resident indicated they "eat and lay here" during the day. Resident #61 indicated "there's nothing to do" in the facility. On 11/21/2013 at 12:15 p.m., an interview with the Activities Director indicated Resident #61 "loves bingo and really that's the only one (he/she's) really interested in." She indicated Resident #61 mainly participated in bingo and the facility had bingo four times a week. Resident #61 was interested in religion and 50's music. Resident #61 had family come in often and she did not care for television. The staff went to Resident #61's room to encourage her to participate in activities and provided the resident with a calendar of activities. Staff encouraged the			

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	resident to participate in bingo, any type of music activities and church groups. Staff had not attempted any 1:1's with Resident #61. She indicated newspapers, music, and word finds had been offered to the resident, but these had not been of interest to her. Resident #61 had books and pictures in her room. She was not certain if the resident had any music available in her room. 3.1-33(a)			

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F000254 SS=D	483.15(h)(3) CLEAN BED/BATH LINENS IN GOOD CONDITION The facility must provide clean bed and bath linens that are in good condition. Based on on record review and interview, the facility failed to ensure linens and clothing were washed in a manner that was comfortable for a resident for 1 of 1 residents reviewed for laundry services. (Resident #102) Findings include: The clinical record of Resident #102 was reviewed on 11/21/13 at 9:00 a.m. Diagnoses for Resident #102 included, but were not limited to, emphysema, pruritic (itching) condition, muscle weakness, and dementia without behavioral disturbance. An annual Minimum Data Set assessment, dated 9/12/13, indicated Resident #102 was moderately impaired in her decision making. During an interview with Resident #102 on 11/19/13 at 3:58 p.m., she indicated the facility washed her linens and clothes, because her daughter was to busy. Whenever her linens and clothes were returned to	F000254	F 254- CLEAN BED/BATH LINENS IN GOOD CONDITION I. Resident #102's clothing and bedding are now being washed separately from the community laundry.The Laundry Supervisor was able to obtain a laundry soap from the supplier that is hypoallergenic to wash resident #102's clothing and bedding. II. Residents who reside at Greenwood Health and Living records have been audited in order to identify other residents that may have a reaction from our soap from our health care industry supplier. Nursing Service will communicate to laundry any new admissions that have the potential to be affected by the laundry products. The Laundry Supervisor will in-service her staff on the use of the new product and the importance of washing resident #102's clothing and bedding separately from the community laundry. III. The systemic change will include: Any resident that expresses a need for hypoallergenic laundry detergent will be noted on the face sheet and laundry notified.In addition, this will be noted in the plan of care and C.N.A. assignment sheet so staff is aware to keep the resident's laundry separate from other	12/22/2013

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	her after being washed, she started itching and scratching, "real bad," unless she left everything out to air over night. She indicated one night, "I itched so bad, I put my robe on and went down to the nurses' station and the nurse said it looked like I had 2nd degree burns." The laundry staff had told her they could not wash her clothes and linens separately using different soap. During an interview with laundry staff person #40 on 11/21/13 at 10:03 a.m., she indicated they never washed anyone's clothes or linens separately. She indicated they couldn't do that. Review of Weekly Skin Inspection Tools for Resident #102 indicated the following: 5/4/13 - "left mid abdomen red rash" 5/11/13 - ""Rash...left side of abdomen" 5/18/13 - "rash - sm[all] area on right outer arm...res[ident] reports red itchy rash, small area on right outer arm." 5/25/13 - "Rash...elbow, left back side" 6/15/13 - "Rash - bil[ateral] arms...red itchy rash on bil[ateral arms, skin intact..." 7/2/13 - "red itchy rash on bil[ateral]		laundry.This will be taken to laundry in a separate bag with the resident's name identified on the bag.Education has been provided to laundry and nursing staff regarding the systemic change. IV. The Laundry Supervisor will audit with an interview with any resident that requires special laundry detergent to provide linens and clothing washed in a manner that is comfortable for the resident weekly x 4 weeks, then monthly x 3 months, then quarterly for the remainder of 12 months.In addition, the Laundry Supervisor will audit that the resident's laundry is separated from other's laundry and washed with the hypoallergenic detergent weekly x 4 weeks, then monthly x 3 months, then quarterly for the remainder of 12 months.The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.V. Plan of Completion date is December 22, 2013.	

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	arms" Review of Progress Notes for Resident #102 indicated the following: 5/9/13 11:37 p.m. "Resident came to nurse's station complaining of itching. Noted to have redness on left front abdomen around to back and left elbow." The physician was notified and an order for Benadryl. (a medication used to treat allergic symptoms and itchiness) 5/22/13 12:14 a.m. "Resident observed scratching bilateral elbows and left backside." 6/22/13 11:05 p.m. "Resident redness to arms are fading. Resident taking Atarax for itching. Atarax is a medication used to treat anxiety and allergic skin conditions." 7/6/13 8:59 p.m. "...resident has been observed scratching self." A recapitulated physician's order for November, 2013, with an original date of 5/31/13, indicated Resident #102 could have Atarax 25 mg (milligrams) every 6 hours as needed for itching. Review of Medication Administration Records for Resident #102 indicated			

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	she received Atarax 14 times in October, 2013, and 9 times in November. (1st - 19th) During an interview with the Director of Environmental Services on 11/21/13 at 10:00 a.m., she indicated Resident #102's clothes and linens could be washed in the therapy washer. No one had talked with her about Resident #102's itching problem after she got her clothes and linens back from the laundry. If the resident knew what kind of soap doesn't make her itch, the facility will purchase some to be used exclusively for the resident. Resident #102 was present during this conversation. 3.1-19(g)(5)			

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F000282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review, and interview, the facility failed to provide oral care as indicated by the residents' care plans for 2 of 2 residents reviewed for oral care assistance in a sample of 2 residents who met the criteria for oral care assistance. (Residents #45 and #84) Findings include: 1. The clinical record of Resident #84 was reviewed on 11/20/13 at 11:00 a.m. Diagnoses for Resident #84 included, but were not limited to, high blood pressure and dementia. The Minimum Data Set (MDS) (an assessment) dated 10-24-13, indicated the resident had severe cognitive impairment. The resident had no hallucinations or delusions. The MDS indicated no behavioral symptoms noted. The assessment indicated the resident required extensive assistance with ADL's	F000282	F 282-SERVICES BY QUALIFIED PERSONS/PER CARE I. Resident #84 is receiving grooming services according to the care plan related to oral hygiene. Resident #45 was provided a toothbrush and toothpaste during survey and as needed after and is receiving grooming services according to the care plan related to oral hygiene. II. Residents at Greenwood Health and Living who require assistance with oral care have been identified and are receiving services according to the care plan. In addition, any item necessary for completing oral hygiene tasks or individual items requested by the resident are kept within reach for residents. III. The systemic change will include: Residents at Greenwood Health and Living who require assistance with oral hygiene are identified on the CNA assignment sheet. Nurses will complete rounds every shift to monitor for completion of oral hygiene. Residents leaving the dining room after meals will be observed by the charge nurse and nursing aides and will be provided oral hygiene as needed. Education has been provided to	12/22/2013

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	(activities of daily living), transfers, locomotion, and bed mobility. In an interview with Resident # 84's daughter on 11-20-13 at 9:21 A.M., she indicated her mother didn't receive oral care from the staff. She or her daughter had to come in and do oral care for the resident daily. She also indicated the dentist found decay on her mom's teeth. On 11-21-13 at 9:07 a.m., an interview with LPN #22 indicated this resident is given oral care when she wakes up and after she eats meals, as "she spits some of the food out and it's on her face and in her oral cavity so she requires frequent oral care." They used mouth swabs or a toothbrush to clean the resident's teeth. On 11-21-13 at 9:00 a.m., during an observation of Resident #84 after breakfast, the resident's mouth did not appear to have been cleaned. Small particles of food were observed on the resident's lips and around her mouth. The care plan in place indicated the problem of resident is as follows: dependent for ADL's, (Activities of Daily Living) bathing, grooming, R/T		nursing staff regarding the systemic change. IV Director of Nursing or designee will perform a quality improvement audit for those identified residents requiring assistance with oral hygiene are receiving services according to the plan of care. The QA audit tool reviewing of the completion of the rounds completed by nurses for the provision of oral hygiene will be weekly x 4 weeks, then monthly x 3 months, then quarterly for a total of 12 months of monitoring. In addition, random rounds will be conducted by facility administration on five residents weekly x 4 weeks, then monthly x 3 months, then quarterly for a total of 12 months of monitoring. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. V. Plan of Completion date is December 22, 2013.	

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	(related to) dementia. Goals were the resident would have full staff performance for nail care with showers, provide full staff performance for showers per schedule, hygiene, grooming, and dressing needs anticipated /met by staff. Approach: Monitor for pain during bath, provide full staff performance for hygiene, grooming. 2. The clinical record of Resident #45 was reviewed on 11/21/13 at 8:54 a.m. Diagnoses for Resident #45 included, but were not limited to, muscle weakness, difficulty walking, and depression. A care plan for Resident #45, dated 4/9/13, and current through 1/28/14, indicated a problem of, "Resident requires extensive assist with ADL's (Activities of Daily Living) related to ADL deficit. A goal was, "Resident will continue to participate in upper body hygiene/dressing/grooming with staff assist." An approach was, "Oral care BID (2 times per day)." An annual Minimum Data Set (MDS) assessment, dated 9/19/13, indicated Resident #45 needed extensive assist of 1 for personal hygiene care. The			

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	assessment indicated she was independent with her decision making. During an interview with Resident #45 on 11/19/13 at 3:41 p.m., she indicated her teeth were never cleaned. She did not have a toothbrush and she had not had one since she moved into the facility. She indicated, "I take my finger and rub them [her teeth] good." During an observation on 11/20/13 at 4:10 p.m., the Director of Nursing (DON) looked in Resident #45's room for a toothbrush and toothpaste. She indicated, at that time, she did not find either of these items in the resident's room. At that time, the DON gave the resident a toothbrush and toothpaste. During an interview on 11/21/13 at 8:45 a.m., Resident #45 indicated, "I got my toothbrush. I brushed my teeth." 3.1-35(g)(2)			

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	155412	A. BUILDING 00 B. WING	11/22/2013

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F000311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. Based on observation and interview, the facility failed to ensure a resident had the necessary items to maintain good oral hygiene for 1 of 3 residents reviewed for Activities of Daily Living (ADL) services in a sample of 11 who met the criteria for review of treatment and services to maintain ADL's. (Residents #45) Findings include: The clinical record of Resident #45 was reviewed on 11/21/13 at 8:54 a.m. Diagnoses for Resident #45 included, but were not limited to, muscle weakness, difficulty walking, and depression. A care plan for Resident #45, dated 4/9/13, and current through 1/28/14, indicated a problem of, "Resident requires extensive assist with ADL's (Activities of Daily Living) related to ADL deficit. A goal was, "Resident will continue to participate in upper body hygiene/dressing/grooming with	F000311	F 311-TREATMENT/SERVICES TO IMPROVE/MAINTAIN I. Resident #45 was provided a toothbrush and toothpaste during survey and as needed after and is receiving grooming services according to the care plan related to oral hygiene. II. All residents requiring assistance with oral care and have been identified and are receiving services according to the care plan. In addition, any item necessary for completing oral hygiene tasks or individual items requested by the resident are kept within reach for residents. III. The systemic change will include: Residents at Greenwood Health and Living requiring assistance with oral hygiene are now identified on the CNA assignment sheet. Nurses will complete rounds every shift to monitor for completion of oral hygiene. Newly admitted residents will be provided a toothbrush and toothpaste upon admission if they have not brought these items with them. Education has been provided to nursing staff regarding the systemic change. IV Director of Nursing or designee will perform a quality improvement audit for those identified residents	12/22/2013

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	staff assist." An approach was, "Oral care BID (2 times per day)." An annual Minimum Data Set (MDS) assessment, dated 9/19/13, indicated Resident #45 needed extensive assist of 1 for personal hygiene care. The assessment indicated she was independent with her decision making. During an interview with Resident #45 on 11/19/13 at 3:41 p.m., she indicated her teeth are never cleaned. She did not have a toothbrush and she had not had one since she moved into the facility. She indicated, "I take my finger and rub them [her teeth] good." During an observation on 11/20/13 at 4:10 p.m., the Director of Nursing (DON) looked in Resident #45's room for a toothbrush and toothpaste. She indicated, at that time, she did not find either of these items in the resident's room. At that time, the DON gave the resident a toothbrush and toothpaste. During an interview on 11/21/13 at 8:45 a.m., Resident #45 indicated, "I got my toothbrush. I brushed my teeth."		requiring assistance with oral hygiene are receiving services according to the plan of care. The QA audit tool reviewing of the completion of the rounds completed by nurses for the provision of oral hygiene and that appropriate supplies to complete oral hygiene are available will be weekly x 4 weeks, then monthly x 3 months, then quarterly for a total of 12 months of monitoring. In addition, random rounds will be conducted by facility administration on five residents weekly x 4 weeks, then monthly x 3 months, then quarterly for a total of 12 months of monitoring. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. V. Plan of Completion date is December 22, 2013.	

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	3.1-38(a)(2)			

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F000312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, record review, and interview, the facility failed to ensure oral care was provided to a dependent resident for 1 resident who needed total assistance with oral care. (Resident #84) Findings include: The clinical record of Resident #84 was reviewed on 11/20/13 at 11:00 a.m. Diagnoses for Resident #84 included, but were not limited to, high blood pressure and dementia. The Minimum Data Set (MDS) (an assessment) dated 10/24/13, indicated the resident had severe cognitive impairment. The resident had no hallucinations or delusions. The MDS indicated no behavioral symptoms noted. The resident required extensive assistance with ADL's (activities of daily living), transfers, locomotion, and bed mobility.	F000312	F 312-ADL CARE PROVIDED FOR DEPENDENT RESIDENTS I. Resident #84 is receiving grooming services according to the care plan related to oral hygiene. II. Residents at Greenwood Health and Living who require assistance with oral care have been identified and are receiving services according to the care plan. In addition, any item necessary for completing oral hygiene tasks or individual items requested by the resident are kept within reach for residents. III. The systemic change will include: Residents at Greenwood Health and Living who require assistance with oral hygiene are identified on the CNA assignment sheet. Nurses will complete rounds every shift to monitor for completion of oral hygiene. Residents leaving the dining room after meals will be observed by the charge nurse and nursing aides and will be provided oral hygiene as needed. Education has been provided to nursing staff regarding the systemic change. IV Director of Nursing or designee will perform a quality improvement audit for those identified residents	12/22/2013

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	In an interview with Resident #84's daughter on 11/20/13 at 9:21 a.m., she indicated her mother didn't receive oral care from the staff. She or her daughter had to come in and do oral care for the resident daily. She also indicated the dentist found decay on her mom's teeth. On 11/21/13 at 9:07 a.m., an interview with LPN #22 indicated this resident is given oral care when she wakes up and after she eats meals, as "she spits some of the food out and it's on her face and in her oral cavity so she requires frequent oral care." They used mouth swabs or a toothbrush to clean the resident's teeth. On 11/21/13 at 9:00 a.m., during an observation of Resident #84 after breakfast, the resident's mouth did not appear to have been cleaned. Small particles of food were observed on the resident's lips and around her mouth. The care plan that was in place indicated the problem of resident is as follows: dependent for ADL's, (activities of daily living) bathing, grooming, R/T (related to) dementia. Goals were the resident would have		requiring assistance with oral hygiene are receiving services according to the plan of care. The QA audit tool reviewing of the completion of the rounds completed by nurses for the provision of oral hygiene will be weekly x 4 weeks, then monthly x 3 months, then quarterly for a total of 12 months of monitoring. In addition, random rounds will be conducted by facility administration on five residents weekly x 4 weeks, then monthly x 3 months, then quarterly for a total of 12 months of monitoring. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. V. Plan of Completion date is December 22, 2013.	

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	full staff performance for nail care with showers, provide full staff performance for showers per schedule, hygiene, grooming, and dressing needs anticipated /met by staff. Approach: Monitor for pain during bath, provide full staff performance for hygiene, grooming. 3.1-38(a)(3)(C)			

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F000362 SS=F	483.35(b) SUFFICIENT DIETARY SUPPORT PERSONNEL The facility must employ sufficient support personnel competent to carry out the functions of the dietary service. Based on interview, record review, and observation, the facility failed to provide residents with food at the posted scheduled time. This had the potential to effect 96 residents who ate out of the facility kitchen, of a facility census of 98. Findings Include: 1. On 11/21/13, when entered the kitchen at 7:50 a.m., the cook and two dietary aides were preparing trays for the South Unit. The dietary food cart left the kitchen at 8:15 a.m., and arrived on the South Unit at 8:18 a.m., eighteen minutes past the posted breakfast schedule of 8:00 a.m. With one person assigned to pass approximately 14 breakfast trays, at 8:51 a.m., all trays had been delivered. During an interview, at that time, with the Dietary Manager, she indicated the posted serve time for South Unit hall trays was 8:00 a.m., and the first breakfast tray had not been served until 8:20 a.m., twenty minutes past the posted schedule.	F000362	F 362-SUFFICIENT DIETARY SUPPORT PERSONNEL I. We have renewed our commitment to the posted meal time of 8:00am for the breakfast service in the north dining room.In addition, the room service trays will be ready to distribute at 8:00am.The south dining room posted meal service time is also 8:00am as well as the room tray service. The south dining room and room tray service will begin at 8:00 am. The posted time for lunch is 12:30pm and the evening meal service is at 6:00pm.We will be ready to serve at 12:30pm for lunch and 6:00pm for evening meal.II. Residents who reside at Greenwood Health and Living have the potential to be affected by the alleged deficient practice. III. The systemic change will include:The dietary staff schedules have been reviewed and changes have been made to the work schedules to accommodate the residents and ensure meal service is completed according to the posted times.Education has been provided to dietary staff regarding the systemic change. IV. Meals being served timely CQI tool will be used, randomly over all 3 meals, 5x weekly for 1 month,	12/22/2013

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	The hall cart for the North Unit left the kitchen 8:25 a.m., and arrived on the unit at 8:28 a.m., twenty eight minutes past the posted breakfast schedule of 8:00 a.m. With one person assigned to pass approximately 4 breakfast trays, at 8:41 a.m., all trays had been delivered. In an interview, at that time, with the Dietary Manager, she indicated the posted serve time for the North Unit cart trays was 8:00 a.m., and the first breakfast tray had not been served until 8:30 a.m., thirty minutes past the posted schedule. The last tray was delivered to a resident's room at 8:41 a.m., 41 minutes after the posted breakfast schedule time of 8:00 a.m. The first breakfast tray for the North Main Dining Room was serve at 8:36 a.m., from the main kitchen, 36 minutes past the posted schedule of 8:00 a.m.. The first breakfast tray for the South Main Dining Room was serve at 8:37 a.m., from the satellite kitchen 37 minutes past the posted schedule of 8:00 a.m.. 2. During a dining observation of the lunch meal on 11/18/113 at 12:22		then 3x weekly for 1 month, then once weekly for 1 month, then once monthly for 12 months to ensure meals are served timely according to the established time/schedule. The facility will receive corporate dietary consultant and a senior dietary designee oversight daily 5 days per week for 30 days and then the frequency will be re-evaluated. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.V. Plan of Completion date is December 22, 2013. Addendum 12/31/13: Meals being served timely CQI tool will be used, randomly over all 3 meals, 5xweekly Sunday through Saturday for 1 month, then 3xweekly Sunday through Saturday for 1 month, then once weekly Sunday through Saturday for 1 month, then once monthly Sunday through Saturday for total of 12 months of monitoring to ensure meals are served timely according to the established time/schedule.	

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	p.m., in the south dining room, Residents #4 and #23 were observed seated at the assist to feed table. Their trays were delivered and staff began feeding them at 1:27 p.m., 65 minutes after they were first observed seated at the table. On 11/18/13 at 12:00 p.m., Dietary Manger provided scheduled meal times. Breakfast: 8:00 a.m. Lunch: 12:30 p.m. Dinner: 6:00 p.m. For the North, South Dining Rooms and North, South Units room trays. 3.1-20(h)			

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F000364 SS=F	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. Based on interview, record review, and observation, of meal delivery service and food temperatures of foods, the facility failed to ensure residents were provided with food meeting their taste requirements for palatability. This had the potential to effect 96 of 98 residents who received their meals from the facility kitchen. Findings Include: 1. On 11/21/ 13 at 7:50 a.m., entered the kitchen to observe the breakfast meal. The cook and two dietary aides were preparing trays for the south unit. The dietary cart left the kitchen at 8:15 a.m., and arrived on the unit at 8:18 a.m. With one person assigned to pass approximately 14 breakfast trays, at 8:51 a.m., all trays had been delivered and a test tray was pulled from the cart. The food temperatures on the test tray were taken by the Dietary Manager and were as follows: scrambled eggs 96 degrees Fahrenheit, french toast: 92 degrees Fahrenheit, sausage 95	F000364	F 364-NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP I. The dietary manager or Administrator has met with resident #85, #18 and #109 and all of these resident food concerns have been addressed and the corrective actions have been implemented. It is the policy and practice of Greenwood Health and Living to listen to the views of the residents and act upon their grievances and recommendations to ensure their concerns are addressed timely and in a satisfactory manner. In order to act and give appropriate response to the resident concerns: When a resident complains their food is cold the facility will ensure the meal is replaced immediately with a fresh hot meal to ensure the meal is nutritive, of value, quality in appearance and at an acceptable temperature. II. Residents residing in the facility had the potential to be affected by the alleged deficient practice. III. The facility's systemic change will include:Facility will prepare foods according the menu and standardized recipes provided by	12/22/2013

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	degrees Fahrenheit, oatmeal 111 degrees Fahrenheit. The scramble eggs had a greasy coating that was starting to harden and they tasted cold. The french toast tasted cold and was hard to cut. The oatmeal tasted cold was starting to jell. The sausage was cold and was covered with a hard greasy film. In an interview, at that time, with the Dietary Manager, she indicated she could see the hardening greasy film on the scramble eggs and sausage, and could see the oatmeal was starting to jell. The posted serve time for the cart trays was 8:00 a.m. and the last cart tray for South Unit was 8:51 a.m.. The hall cart for the North Unit left the kitchen 8:25 a.m., and arrived on the unit at 8:28 a.m. With one person assigned to pass approximately 4 breakfast trays, at 8:41 a.m. all trays had been delivered and a test tray was pulled from the cart. The food temperatures on the test tray were taken by the Dietary Manager and were as follows: scrambled eggs 109 degrees Fahrenheit, french toast: 104 degrees Fahrenheit, sausage 105 degrees Fahrenheit, oatmeal 133 degrees Fahrenheit. The scramble eggs had a greasy coating they and		CarDon and per each resident's physician ordered diet.The cook will taste test food before it leaves the kitchen to ensure food is cooked thoroughly and not overcooked.Food flavor, appearance, palatability and temperature will be reviewed at the monthly resident council meeting and any concerns will be addressed. Education has been provided to dining services regarding the systemic change. IV. The administrator or designee will audit all resident council concerns for a follow up action plan and response of the resident council for resolution weekly for 8 weeks, then monthly for a duration of 12 months of monitoring. Temperatures of food, test trays for correct temperatures and palatability, and meals served timely will be audited 5x weekly for 1 month, then 3x weekly for 1 month, then once weekly for 1 month then once monthly for 12 months.The administrator of Greenwood Health and Living will randomly visit meal service and interview 3 residents 5x weekly for 1 month, to discuss the food quality and service. The administrator will visit 3 residents weekly for 1 month after that to discuss the food quality, then 3 residents monthly for a duration of 12 months. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3	

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	tasted luke warm. The french toast tasted luke warm and was dark brown and chewy. The oatmeal tasted okay. The sausage was luke warm and was dark brown and black, and crunchy. It tasted burnt. In an interview, at that time, with the Dietary Manager, she indicated she could see the sausage was burnt, the greasy coating on the scramble eggs, the french toast looked over done. The posted serve time for the cart trays was 8:00 a.m. and the last cart tray for North Unit was 8:41 a.m. During an interview with Dietary Manager on 11/21/13 at 11:20 a.m., she indicated they had had some food concerns in resident council for the past few of months and she had some concerns after she saw the food delivered today. 2. During an interview on 11/19/13 at 9:39 a.m., Resident #109 was asked if the food was served at the correct temperature. The resident indicated it was, "Sometimes cold." In an interview with Resident #109 on 11/20/13 at 1:22 p.m., she indicated, "Lunch was cold." The grilled cheese was cold, the cheese wasn't melted." She indicated originally she was given		months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.V. Plan of Completion date is December 22, 2013. Addendum 12/31/13: Meals being served timely CQI tool will be used, randomly over all 3 meals, 5xweekly Sunday through Saturday for 1 month, then 3xweekly Sunday through Saturday for 1 month, then once weekly Sunday through Saturday for 1 month, then once monthly Sunday through Saturday for total of 12 months of monitoring to ensure meals are served timely according to the established time/schedule.	

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	the lunch meal of "some kind of potatoes chopped up and spinach." The meal was cold and she didn't like it, so she then asked for a substitute of grilled cheese. 3. During an interview with Resident #85 on 11/18/13 at 3:39 p.m., she indicated the food was cold. During an interview with this resident on 11/21/13 at 9:24 a.m., she indicated the breakfast meal, "wasn't hot. It would be better if it was hot." 4. During an interview with Resident #18 on 11/19/13 at 9:58 a.m., she indicated she was at the end of the hall and always the last to get her tray, and, "It's cold." In an interview with the Dietary Manager on 11/21/13 at 11:30 a.m., she indicated 96 of the 98 residents residing in the facility received their meals from the facility kitchen. Review of the Resident Council Minutes, with permission of the Council President given 11/20/13, indicated from January of 2013 to November of 2013, the residents had complained of meals being delivered late, cold, and poor quality of palatability. The residents indicated in the meeting minutes of no			

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	155412	A. BUILDING 00 B. WING	11/22/2013

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	improvement for 11 months of complaining of the same problems. 3.1-21(a)(2)			

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F000441 SS=D	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. (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. (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 must isolate the resident. (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. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation and record review, the facility failed to follow	F000441	F 441-INFECTION CONTROL, PREVENT SPREAD, LINENS I.	12/22/2013

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	infection control practices related to handwashing observed during medication pass for 1 resident and 1 LPN observed during medication pass. (Resident #67 and LPN #2) Findings include: On 11/21/2013 at 3:29 p.m., LPN #2 was observed preparing medications for Resident #67. LPN #2 was not observed to perform hand washing before preparing the medication. LPN #2 was observed to drop a single pill on the top of the medication cart. She then continued to pick the dropped pill up bare handed and placed the pill into Resident #67's medication cup. LPN #2 handled a capsule barehanded to open and pour powder into medication cup. Review of a facility policy, titled Handwashing/Hand Hygiene, dated 12/2007, received from the Director of Nursing on 11/22/13 at 3:30 p.m., indicated, "In most situations, the preferred method of hand hygiene is with an alcohol-based hand rub. If hands are not visibly soiled, use an alcohol-based hand rub containing 60-95% ethanol or isopropanol for all the following situations... d. Before preparing or handling medications."		LPN #2 has been educated regarding proper hand hygiene before preparing or handling medications. Resident #67 is receiving medications with proper hand hygiene practices. II. Residents who reside at Greenwood Health and Living have the potential to be affected by the alleged deficient practice. III The systemic change will include: Licensed nurses and Qualified Medication Aides have been reeducated on the proper hand hygiene before preparing or handling medications.Licensed nurses and Qualified Medication Aides will complete a competency check for medication administration and hand hygiene before preparing or handling medications.In addition, this competency check will be completed upon hire and annually. Education has been provided to licensed nurses and QMAs regarding the systemic change. IV Director of Nursing or designee will monitor a medication pass with one nurse on each unit, randomly over all three shifts including weekends, weekly x 4 weeks, then monthly x 3 months, then quarterly for a total of 12 months of monitoring. Any concerns will be addressed. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at	

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	3.1-18(l)		100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. V. Plan of Completion date is December 22, 2013.	

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F000490 SS=E	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on record review and interview, the facility failed to ensure it was administered in a manner to effectively ensure each resident was free from verbal and physical mistreatment for 5 of 5 residents reviewed for an allegation of mistreatment in a sample of 1 resident who met the criteria for abuse and 4 extended residents reviewed for an allegation of mistreatment. (Administrator and Director of Nursing) (Residents #6, #49, #111, #48, #18) (CNA #7, CNA #9, LPN #2) The immediate jeopardy, which began on 4/6/13 at 10:00 p.m., was identified on 11/21/13 at 5:00 p.m. On 11/21/13 at 5:00 p.m., the Administrator and Director of Nursing were notified of the immediate jeopardy concerning verbal and physical mistreatment. The immediate jeopardy was removed on 11/22/13 at 4:45 P.M.	F000490	F 490- EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice. It is the policy of CarDon and Associates that the Administrator of a CarDon community receives reports of abuse allegations and the administrator will oversee investigations of abuse or designate a facility leader to conduct interviews surrounding the abuse allegations. The facility administrator will make reports to the ISDH reportable division of the ISDH whenever possible or ensure his/her designee reports and conducts reporting and investigations in a manner that is thorough to ensure abuse is prevented and reported according to the facility policy, State and Federal guidelines. Resident #6 and resident #49 showed no negative outcomes physical evidence or mental anguish from the alleged incident reported to the ISDH on 4/6/13. CNA #7 was suspended on 4/6/13 and resigned before the investigation	12/22/2013

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	There was sufficient evidence the immediacy of the deficient practice was able to be removed, as indicated by evidence obtained from the facility as follows: The facility was in the process of changing their policy and procedure. All staff were inserviced on the facility's abuse policy, before the staff were allowed to return to work. All cognitively intact residents were interviewed related to abuse and 7 more incidences were identified by the facility and reported. The families of cognitively impaired residents were interviewed, in regard to abuse. Even though the facility's corrective action removed the immediate jeopardy, the facility remained out of compliance at a lower scope and severity level. Findings include: 1. The investigation for Resident #6 was reviewed on 11/21/13 at 12:30 p.m. The incident occurred on 4/6/13 at 10:00 p.m. A handwritten statement, signed and dated by Certified Nursing Assistant (CNA) #6 included the following: CNA #6 reported CNA #7 had sworn at Resident #6 while providing care. CNA #6 indicated CNA #7 said to Resident #6, " 'Are you f------ serious! Why didn't you say you went pee before		complete. CNA #7 no longer works in the facility. The facility sent an addendum to the reportable division of the ISDH which included an update that CNA #7 is no longer employed due to abuse and the CNA was reported to the nurse aide registry. Resident #111 (resident no longer resides in community) showed no negative outcomes physical evidence or mental anguish from the alleged incident reported to the ISDH on 7/17/13. CNA #9 was suspended initially during the abuse investigation and CNA #9 no is no longer employed in the facility. The facility sent an addendum to the reportable division of the ISDH which included an update that CNA #9 is no longer employed due to abuse and the CNA was reported to the nurse aide registry. Resident #48 showed no negative outcomes physical evidence or mental anguish from the alleged incident reported to the ISDH on 10/29/13. LPN #2 was suspended on 10/29/13 initially during the abuse investigation and LPN #2 is no longer employed in the facility. The facility sent an addendum to the reportable division of the ISDH which included an update that LPN #2 is no longer employed due to abuse. Resident #18 showed no negative outcomes physical evidence or mental anguish from the alleged incident	

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	you p----- all over yourself.' " CNA #6 then indicated CNA #7 left the resident on the toilet for "15 minutes." CNA #7, according to CNA #6, was "being rough" with Resident #6, while getting her gown on. CNA #6 then indicated CNA #7 had sworn at another resident that same night, after having provided care to Resident #6. CNA #6 indicated CNA #7 said to Resident #49 that the resident really " 'p----- her off.' " CNA #6 indicated CNA #7 "started yanking her (the resident) and being really rough with her and when she put on Resident #49's oxygen, "she didn't even put it in her nose." CNA #6 then indicated, "she [CNA #7] didn't care" when the resident told her about the oxygen. CNA #6 reported this verbally and physically rough care to a Licensed Practical Nurse (LPN) on 4/6/13, but not immediately after the care occurred. A typewritten report, dated 4/12/13 at 12:00 p.m., signed by the DON (Director of Nursing) indicated she had received a phone call from CNA #7. The CNA had resigned from her position and indicated, "It's no big deal." The five day follow-up report to the ISDH, dated 4/11/13, indicated		reported to the ISDH on 11/19/13. CNA #9 was suspended on during the survey in order for the facility to conduct the abuse investigation and CNA #9 is no longer employed in the facility. The facility reported the abuse allegation to the ISDH and included the information that CNA #9 is no longer employed due to abuse. Employee(s) CNA #17, #19 LPN #15 have received education regarding the CarDon, State and Federal guidelines of reporting abuse allegations timely to the Administrator of the facility. CNA #6 no longer employed at facility. II. The facility will identify other residents that may potentially be affected by the deficient practice. Residents who reside at Greenwood Health and Living have the potential to be affected by the alleged deficient practice. Resident's with a BIMS of 10 or greater and family/responsible party of each resident will be interviewed using the ISDH QIS abuse questionnaire to ensure all abuse allegations are identified and handled according to Federal, State and CarDon policy and procedures. Any allegations of abuse will be reported to the Administrator immediately and to the Indiana State Department of Health per the Unusual Occurrence reporting guidelines. A review will be completed of allegations of abuse to audit for comprehensive and complete	

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	"Investigation complete and allegation unsubstantiated. Resident and staff interviews unremarkable. Social services continues to provide psychosocial counseling to residents. Resident have no recall of any unprofessional comments or rough treatment. CNA (name) #7 terminated due to unprofessional conduct." An interview with the DON, at 1:30 PM on 11/21/13, indicated CNA #7 was suspended on 4/6/13, and quit while suspended. The DON indicated she was going to terminate CNA #7 for improper conduct. The DON did not believe it was abuse, as she didn't think it was willful. The DON indicated she was going to terminate CNA #7 though, since more than one person reported it (the allegation of abuse) to her. CNA #7's behavior was not reported to the registry. 2. An incident concerning Resident #111 and CNA #9 was reviewed on 11/21/13 at 2:30 p.m. On 7/17/13, the resident's daughter reported on 7/4/13, her mother was spoken to in a, "very gruff tone." This was reported, as the daughter did not tell anyone, 13 days after the reported occurrence. The daughter also indicated the staff "grabbed the		investigation. Any concerns will be addressed. III The facility will put into place the following systematic changes to ensure that the deficient practice does not recur. Director of Clinical Services contacted Administrator and Director of Nursing and re-in-serviced on the importance of timely reporting of allegations of abuse and CarDon's abuse reporting and prevention policy/procedure was reviewed in detail. Director of Clinical Services conducted a 1:1 inservice with the Administrator and Director of Nursing to ensure future allegations are reported timely by their staff members to the Administrator and ensure that investigation protocol was put into place and utilized for allegations of abuse to ensure potentially abusive staff members are not allowed to return to the workplace after an allegation has been made against him/her. A CQI abuse investigation checklist was put into place for the administrator and director of nursing to utilize for each investigation to ensure future investigations have the necessary documentation to determine the decisions of reinstating employees, terminating employees and reporting employees to the ISDH and licensure boards of Indiana. QIS interview tool was utilized to interview residents within the facility and family members to	

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	resident's cheeks and stated, 'Stop touching yourself down there.' " The daughter indicated the employee was told she was being "a little gruff with my mother." An interview with the DON, at 1:30 p.m. on 11/21/13, indicated CNA #9 was not terminated, because she couldn't determine the incident was willful, only unprofessional in conduct. The incident had been reported to ISDH with no signed/dated statements available for review. The five day follow-up, dated 7/22/13, indicated "investigation complete and unsubstantiated. CNA reinstituted. Resident interviews and staff interviews unremarkable. Social services to continue to provide psychosocial follow up." A review of CNA #9's time card indicated she had been sent home following the report of the occurrence, pending investigation, and did not return to work until the investigation had been completed. 3. An incident concerning Resident #48 and LPN #2 was reviewed on 11/21/13 at 3:00 p.m. A signed and dated (10/29/13) typewritten report was reviewed. The report indicated LPN #2 had been witnessed by the		ensure no further risks of harm exists in the current care environment for those residents potentially affected Alleged staffs involved were removed from the working schedule and investigations were conducted by the administrator, director of nursing and oversight by the Clinical Specialist. In-service staff and contracted services on the abuse reporting policy and procedure including; identifying multiple and various forms of abuse, reporting immediately, and overall review of abuse prevention. A post- test was utilized to ensure the staff and contracted services comprehended the abuse guidelines and policy/procedure to protect the residents and families from harm. Social services will assess the resident and families to ensure mental anguish does not exist and refer those affected for appropriate treatment if indicated. The systemic change includes: An investigative protocol has been put into place and utilized for allegations of abuse and dictates that potentially abusive staff members are not allowed to return to the workplace after the allegation until the investigation is completeA CQI abuse investigation checklist has been put into place for the administrator and director of nursing to utilize for each investigation to provide guidance	

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	MDS (Minimum Data Set) LPN speaking "very abruptly." The MDS nurse indicated she heard the nurse again speak abruptly to Resident #48, while passing his medications. The MDS nurse indicated LPN #2 had said, " 'I'm not taking you now.' " Then the MDS nurse heard the nurse say " 'S---' ." The writer then assisted the resident to the dining room and reported the incident to the DON. Two staff interviews were recorded on a sheet of paper with the investigation. Neither of the interviews were signed nor dated by the staff. Four residents had been interviewed by the Social Services Director. The residents had been identified by initials, with no signature nor date of the interviews. The DON was interviewed on 11/21/13, concerning this incident. The DON indicated LPN #2 had been given a written warning on 11/1/13, after having been suspended during the investigation. The five day follow-up report, dated 11/3/13, indicated the following: "Investigation complete. Staff and resident interviews completed and unremarkable. Social services to continue to provide psychosocial		on providing the necessary documentation to determine decisions of reinstating employees or terminating employees and reporting to the ISDH and licensure boards of Indiana.The QIS interview tool is being utilized to interview residents and family members to review for risk of harmAll unusual occurrences are reviewed daily (Monday through Friday) at the morning clinical meeting for thoroughness and completion Education has been provided to all staff regarding the systemic change. IV The facility will monitor the corrective action by implementing the following measures. A CQI audit tool will be utilized to audit allegations of abuse to ensure the facility enacts all the necessary steps of investigation conducted daily by the Clinical Specialist for 30 days and the audit will be reviewed by the CS and DCS weekly x 4 weeks. At the end of the 30 days the frequency will be continued at the same rate until compliance is 100% and then performed monthly by the CS and DCS for 12 months. The clinical specialist will conduct weekly QA audit by randomly interviewing a minimum of 5 staff members weekly for 4 weeks and the results will be discussed with the director of clinical services to determine the ongoing frequency into the next 90 days to ensure staff are complying and	

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	follow up. Nurse educated regarding customer service, incident determined not willful or malicious. Nurse reinstated." 4. During an interview on 11/19/13 at 9:48 a.m., Resident #18 was asked if she had been abused by staff. She indicated about 3 weeks ago she had a wound on her bottom. The tape had come loose from the dressing. She also indicated a CNA ripped the tape from her skin causing pain and bleeding. She thought the CNA was barred out of her room, but still came in. She indicated, she had told LPN #15 about the incident. During an interview with LPN #15 on 11/21/13 at 3:00 p.m., she indicated Resident #18 had reported the incident to her, but she (LPN #15) didn't report it because she (LPN #15) didn't think it was abuse. The clinical record for Resident #18 was reviewed on 11/20/13 at 2:07 p.m. Diagnoses for Resident #18 included, but were not limited to: rheumatoid arthritis, high blood pressure, pain, Bells palsy, hernia, congestive heart failure, weakness, debility, and osteoarthritis.		understand and can identify abuse situations. The Administrator or designee will audit all allegations of abuse five times per week x 30 days, to monitor for comprehensive and complete investigation. This audit will continue weekly for duration of 12 months. Any concerns will be addressed. The Director of Clinical Services and the Director of Operations at the corporate level will audit the progress of the administrator and director of nursing services adherence to the standards set forth in this plan of correction each week x 12 weeks then a frequency will be re-evaluated at that time to ensure the facility Greenwood Health and Living is receiving effective administration over the residents wellbeing. The QIS abuse questionnaire will be integrated into the facility routine customer service/care program and utilized monthly with residents to create an environment of freedom to report potential abuse without the fear of retaliation. This QIS abuse tool will be performed on at least 10 residents with a BIMS of 10 or higher monthly ongoing. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as	

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	There were no nursing notes which addressed this issue. The DON provided an investigation report, undated, which indicated Unit Manager #15 had spoken with Resident #18 on 10/23/13, and the previously open area on her buttocks had resolved, prior to this allegation. A skin assessment dated 10/25/13 indicated area to left buttocks (developed in house), identified on 10/22/13 and assessed on 10/23/13. The area to left buttocks measured .4 x 0.5 x 0.1 (size in centimeters), area clean with scant serosanguinous drainage, no odor. This entry was documented as completed on 11/19/13 at 1:42 p.m. (as a late entry for 10/23/13). In an interview on 11/20/13 at 2:54 p.m., the DON indicated she wasn't sure why this entry was documented late. She indicated maybe the nurse just forgot to chart on 10/23/13. An MDS (Minimum Data Set) Assessment, dated 11/1/13, indicated the resident was cognitively intact. She required extensive assist with ADL's, (activities of daily living) transferring, locomotion, and bed mobility.		needed, if compliance is below 100%. V. Plan of Completion date is December 22, 2013.	

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GREENWOOD HEALTH AND LIVING COMMUNITY	937 FRY RD GREENWOOD, IN 46142

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	The Incident Report Form, reviewed at 11/20/13 1:45 p.m., had been reported to ISDH on 11/19/13 at 1:00 p.m. It read as follows: "brief description of incident: Resident reported to ISDH that about three weeks ago, a CNA was in her room to assist her to the bed pan, pulled her underwear down which was stuck to her dressing and made a wound to her buttocks. Resident stated she felt like the CNA did it intentionally and was rough with her. Type of injuries: None at this time on head to toe assessment. Immediate action taken: Administrator, family and MD notified, skin and pain assessment completed, ISDH phoned and message left. Preventative measures taken: Investigation ongoing, staff interviews to be completed for north unit nursing staff working at time of incident. CNA #9 suspended pending investigation. Resident interviews to be completed on 100 hall for any concerns. 72 hour social services psychosocial follow up with resident." A completed investigation report was received from the DON, typed on plain paper with no dates or times. The report indicated the following: An interview with UM (Unit Manager) #15 indicated she had spoken with Resident #18 on 10/23/13, related to			

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	the open area on her bottom. The UM indicated the area had resolved and the resident had indicated she wanted the patch on it to protect it, because the new skin was fragile. The resident reported she had a patch on when CNA #9 came in to put her on the bed pan, the patch stuck to her panties, and caused the area on her buttocks to open again. A treatment was ordered and the daughter notified. UM #15 spoke with the resident about stating the staff had been rough with her. The UM asked the resident what happened. The resident stated the day it happened CNA #9 and CNA #16 were putting her on the bed pan. She indicated CNA #9 had " 'ripped her panties down' " and the tape stuck to her bottom causing the area to bleed again. Resident #18 indicated she felt the CNA was rough with her when pulling her panties down. Resident or staff didn't report any feelings of roughness prior to this meeting on 11/19/13. CNA #9 indicated, "the patient put her light on. The employee and another aide went to assist the patient to bathroom, the employees used the EZ lift to transfer her to the private bathroom in her room. The employee began to pull her underwear down and the patient complained that this employee pulled			

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	them down to close to her skin and it rubbed too hard on a sore spot on her coccyx. The patient was lowered onto the toilet. After 20 minutes the employees cleaned her up where there was no skin irritation or any type of bandage, on the complained area, this employee notified the nurse of the c/o [complaint] pain the patient was having on her coccyx area." There was no date or time this interview was conducted. The following statements were received from employees in regard to the investigation: LPN #2 "on the evening of the incident occurred the patient asked this nurse if she could redo the ointment and cover the area back up with the dressing, nurse completed treatment per request, the patient thanked the nurse." No date nor time this interview was conducted. CNA #17, "upon returning to work, resident told this employee that CNA #9 had pulled the bed pan from under her bottom and ripped her skin on her bottom." No date nor time indicated for this interview. CNA #18, "not here on the date in question. When returned to work the			

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	next day the resident had open area on bottom. The patient stated the aide pulled her panties down and the patch stuck on it." No date nor time was indicated for this interview. CNA #19, "This employee was in the patients room watching and learning the patient. She stated the CNA #9 ripped her panties down and never said sorry till after she told another CNA #17." No date nor time indicated for this interview. An interview with the Social Services Director (SSD), on 11/19/13, (no time given) indicated the SSD asked to speak with Resident #18 regarding an incident that occurred the week of 10/21/13. Resident #18 stated on 10-22-13 or 10-23-13, she received care from an aide named [CNA #9] who was working a double shift. Resident #18 stated at that time she had a small wound on her left bottom that had a band-aid on it. Resident #18 reported that on second shift CNA #9 took her to the bathroom at one point in the evening, pulled down her pants and panties and her band-aid stayed intact. She indicated when CNA #9 took her to the restroom on third shift she pulled down her pants and " 'snatched her			

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	panties off' " which ripped her band aid off and opened the wound. She was upset the aide wasn't more careful the second time she took her to the bathroom. Resident #18 made no indication she [the resident] was uncomfortable continuing to receive care from CNA #9. "No tearfulness or distress noted during the interview." A review of CNA #9's time card indicated she had continued to work as assigned to Resident #18, after the reported allegation of mistreatment to Unit Manager, until ISDH was notified of the incident. Review of a facility policy, dated 8/20/2011, titled "Abuse Prevention," received on 11/18/13 at 11:59 a.m., from the DON, indicated the following: "...III. Preventing Resident Abuse:... 2. r. Reporting any allegation of abuse or neglect to the State licensing/certification agency responsible for surveying/licensing the facility immediately with a brief description of the alleged occurrence... IV. Identifying & recognizing signs and symptoms of abuse Policy statement: Our facility will not condone any form of resident abuse or neglect. To aid in abuse			

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	prevention, all personnel are to report any signs and symptoms of abuse/neglect to their supervisor immediately who will report to the administrator immediately. V. Abuse investigations: 1. Should an incident or suspected incident of resident abuse, neglect or injury of an unknown source be reported, the administrator, or his/her designee, will appoint a member of management to investigate the alleged incident. When an alleged or suspected case of mistreatment, neglect, injuries of an unknown source, or abuse is reported, the facility administrator, or his/her designee, will notify the following persons or agencies of such incident when applicable: The State licensing/certification agency responsible for surveying/licensing the facility immediately; The local/State Ombudsman; The Resident's Representative of Record; Adult Protective Services; Law Enforcement Officials; The resident's Attending Physician, and The facility Medical Director." 3.1-13(q)			

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F000520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. Based on record review and interview, the facility failed to ensure the Quality Assessment and Assurance (QAA) Committee had identified deficiencies and developed and implemented appropriate plans of action to correct the identified deficiencies. Findings include: During an interview on 11/22/13 at	F000520	F 520-QAA COMMITTEE-MEMBERS/MEET QUARTERLYI. It is the practice of Greenwood Health and Living to conduct routine and timely Quality Assurance meetings with the facility administrator, director of nursing, facility physician and at least three additional leaders of the community at a minimum of quarterly. Residents #6, #49, #111(no longer resides in the facility), #48 and #18 are free from allegations of abuse and their safety, wellbeing and quality	12/22/2013

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	1:30 p.m., the Administrator and the Director of nursing were asked if the following issues had been addressed in their QAA meetings: 1. Prevention, investigation, recognition, reporting, and following their policy on abuse. (Residents #6, #49, #111, #48 and #18) 2. Acting upon dietary grievances, which became apparent in Resident Council Meetings the past 11 months. 3. Providing palatable meals in a timely manner. (Residents #4, #23, #109, #85 and #18) The Administrator indicated, at that time, he didn't think the above issues had been addressed. The Administrator and DON indicated on 11/22/13 at 1:45 p.m., they would go through their QAA meeting notes to see if any of these deficiencies were addressed. No further information was provided by survey exit on 11/22/13 at 5:00 p.m. 3.1-52(b)(1)(2)		of care has been ensured. Resident council has met with the administrator, assistant administrator and corporate dietary consultant on December 18, 2013 to discuss all outstanding resident council grievances and to discuss with resident council the plan of correction for this alleged deficient practice of the past 11 months of dietary grievances. Residents #4, #23, #109, #85 and #18 have been met with by the administrator and dietary designee to ensure their concerns with meal service and quality have been addressed in a manner that satisfies the ISDH regulatory status and that which is acceptable for the residents affected. Quality Assurance meeting held on December 11, 2013. Abuse policy, grievance concerns, and providing palatable meals in timely manner reviewed and noted in meeting. II. Residents who reside at Greenwood Health and Living have the potential to be affected by the alleged deficient practice. The Quality Assurance members will identify any resident's concerns or grievances and monitor. Any concerns will be addressed. III. The systemic change will include:Quality Assurance meeting restructured and QAPI program integrated December 11, 2013.The QAPI program includes identification of deficiencies and development	

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			and implementation of appropriate plans of action to correct the identified concerns. Education has been provided to the Quality Assurance Committee Members regarding the systemic change. IV. Director of Medical Records or designee will monitor/review Quality Assurance participation, concerns for resolution, and minutes monthly x 3 months, then quarterly for a total of 12 months of monitoring. Any concerns will be addressed. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. The corporate nurse consultant and corporate director of operations will review the Quality Assurance meetings quarterly for the next 12 months to ensure compliance. V. Plan of Completion date is December 22, 2013.	