STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155783	A. BUILDING 00 B. WING	09/17/2024

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: September 8, 9, 10, 11, 12, 13, 16 and 17, 2024. Facility number: 002661 Provider number: 155783 AIM number: 201056540 Census Bed Type: SNF/NF: 28 SNF: 30 Residential: 42 Total: 99 Census Payor Type: Medicare: 21 Medicaid: 27 Other: 10 Total: 58 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on 9/27/2024	F 0000		
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations Based on observation, interview, and record review, the facility failed to report a fall resulting in major injury to the Indiana Department of Health (IDOH) for a resident requiring hospitalization greater than 23 hours, for one of four residents reviewed for falls. (Resident 46)	F 0609	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident 46 was affected. Incident report was not submitted	10/17/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brittney Plantinga	ED	10/11/2024

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	Finding includes: A Nursing Progress Note, dated 8/22/2024 at 8:00 P.M., indicated Resident 46 was found on the floor in her room. She was lying on her right side with blood coming from her head. Emergency Personnel were called and the resident was sent to the emergency room. A Nursing Progress Note, dated 8/23/2024 at 4:52 A.M., indicated Resident 46 was admitted to the hospital for observation of a large hematoma. A Nursing Progress Note, dated 8/24/2024 at 4:45 P.M., indicated Resident 46 arrived back to the facility with a laceration to the back of her head. The wound had 10 staples and measured 4.5 centimeters (cm) long. A CT (Computed Tomography) scan of Resident 46's brain without contrast, completed at the hospital on 8/22/2024 at 8:50 P.M., indicated the resident had a small intraventricular hemorrhage of the occipital horn and a right posterior scalp hematoma. A record review was completed on 9/10/2024 at 10:00 A.M., for Resident 46. Diagnoses included, but were not limited to: traumatic hemorrhage of cerebrum unspecified with loss of consciousness status unknown, laceration without foreign body of scalp, unspecified fracture of left pubis, subsequent encounter for fracture with routine healing-chronic, unspecified dementia, severe, without behavioral disturbance, psychotic disturbances, mood disturbances and anxiety. During an interview on 9/10/2024 at 1:37 P.M., the Administrator indicated the facility reported a		to the Indiana State Department of Health post fall with laceration measuring 4.5cm and small intraventricular hemorrhage. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected. All falls with hospitalizations reviewed with no findings. Education with nurses to occur related to timely reporting of incidents to ED/DHS. Education to occur with the Executive Director (ED) and/or designee on reportable guidelines. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: As a measure of ongoing compliance, the ED or designee will audit falls and/or injuries of unknown origin weekly x4 weeks, then every other week x2 months, then monthly x3 months to ensure any findings have been reported according reporting guidelines. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: As a quality measure, the ED and/or designee will review any findings and corrective action monthly and ongoing until campus achieves one hundred percent	

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	laceration over 5 cm, fractures and subdural hematomas. The resident was not aware that she had an intraventricular hemorrhage and she also misunderstood the portion of the policy referring to phrase of unknown origin or requires hospitalization > 23 hours. On 9/10/2024 at 10:25 A.M., the Administrator provided a policy titled, "Reportable Event Guidelines," revised 10/24/2022, and indicated the policy was the one currently used by the facility. The policy indicated "...PURPOSE To provide guidelines to ensure reportable occurrences are recorded and monitored in accordance with state and federal guidelines. PROCEDURES 1. iii. Large lacerations or contusions (of unknown origin or requires hospitalization > 23 hrs....." 3.1-28(c)		compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	
F 0636 SS=D Bldg. 00	483.20(b)(1)(2)(i)(iii) Comprehensive Assessments & Timing Based on record review and interview, the facility failed to complete an Annual MDS (Minimum Data Set) assessment timely for 1 of 16 residents. Finding includes: Resident 46's record review was completed on 9/10/2024 at 10:00 A.M. Diagnoses included, but were not limited to dementia, psychotic disturbance, mood disturbance, anxiety, and type 2 diabetes. An Annual MDS assessment was initiated on 8/26/2024 but had not been completed as of 9/13/2024. During an interview on 9/13/2024 at 9:15 A.M., the	F 0636	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The MDS for resident 46 was affected. The Annual MDS for resident 46 was not completed timely per RAI guidelines. The Annual MDS for resident 46 has been completed. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:	10/17/2024

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	MDS Coordinator indicated the Annual MDS assessment for Resident 46 was not completed and there was still one section to be completed by the Life and Enrichment staff member. The Annual MDS assessment should have been completed on 9/8/2024. The MDS Coordinator indicated the facility did not have a policy regarding completing MDS assessments but they followed the Resident Assessment Instrument (RAI) manual. During an interview on 9/13/2024 at 9:17 A.M., the MDS Regional Support Specialist indicated Resident 46 should have had an Annual MDS Assessment completed within 14 days from the Assessment Reference Date. 3.1-31(d)(1)		All Health Center residents have the potential to be affected by alleged deficient practice. Assessment Support Nurse completed an initial audit of all in process MDS assessments with no delinquent findings. The MDS Coordinator, Director of Social Services, and Life Enrichment Director have been educated on MDS completion date per RAI guidelines. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: As a measure of ongoing compliance, the Assessment Support Nurse and/or Designee will conduct an audit of 3 assessments weekly for 4 weeks, then twice monthly for 2 months, then monthly for 3 months to ensure compliance with MDS completion date per RAI guidelines. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: As a measure of quality assurance, The Executive Director and/or Designee will review any findings and subsequent corrective actions monthly and ongoing in	

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			the campus Quality Assurance Performance Improvement meeting until one hundred percent compliance is achieved. The plan will be reviewed and updated as warranted.	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents Based on observation, record review and interview, the facility failed to provide ADL (Activities of Daily Living) services related to nail care and facial hair removal for 1 of 3 residents reviewed for ADL care. (Resident 46) Finding includes: During an observation on 9/8/2024 at 2:11 P.M., Resident 46 was in the common area and had facial hair on her chin and dirt under the fingernails. During an observation on 9/09/24 at 10:05 A.M., Resident 46 was seated at a table and had facial hair on her chin and a brown substance under her fingernails. During an observation on 9/10/24 at 9:40 A.M., Resident 46 had facial hair on her chin and a brown substance under her fingernails. During an observation on 9/10/24 at 2:29 P.M., Resident 46 had facial hair on her chin and a brown substance under her nails. During an observation on 9/12/24 at 9:51 A.M., Resident 46 had facial hair on her chin.	F 0677	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident 46 was affected. Resident 46 was observed on different days with substance under her nails and facial hair. Nail care and removal of facial hair completed. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected. All residents have been reviewed for the need for nail care and removal of facial hair. Nursing staff to be educated on nail care and facial hair removal. Education to nursing staff for documentation of refusal. 3. What measures will be put into place or what systemic changes	10/17/2024

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	During an observation on 9/13/24 at 9:43 A.M., Resident 46 had facial hair on her chin and a brown substance under her nails. Resident 46's record review was completed on 9/10/2024 at 10:00 A.M. Her diagnoses included but were not limited to: traumatic hemorrhage of cerebrum unspecified with location, laceration without foreign body of scalp, fracture of left pubic, dementia, psychotic disturbance, mood disturbance, anxiety, and type 2 diabetes. A Quarterly Minimum Data Set (MDS) assessment, dated 5/31/2024, indicated Resident 46 had severe cognitive impairment and required substantial assistance for bathing and moderate assistance for personal hygiene. The current care plan for Resident 46, initiated on 10/11/2023, included a plan related to the resident's impairment of functional status problems. Interventions included: Offer facial shaving on shower days, as needed, and as requested and provide nail care on shower days and as needed. A review of the facility's Shower Book, completed on 9/10/2024 at 10:15 A.M., indicated Resident 46 had received a partial bed bath on 9/5/2024 and bed bath on 9/9/2024. Resident 46's record lacked documentation indicating she had refused to be shaved or have nail care performed by staff. During an interview with CNA 3, completed on 9/12/2024 at 11:39 A.M., she indicated she provided the following care for A.M Care (morning care routine): clean incontinent residents, change them into clean clothes, help		will be made to ensure that the deficient practice does not recur: As a measure of ongoing compliance, the DHS and/or designee will randomly audit needs for nail care and facial hair removal for 5 residents weekly for 4 weeks, then twice per month for 2 months, then monthly for 3 months. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: As a quality measure, the ED and/or designee will review any findings and corrective action monthly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	with oral care and personal hygiene, give a shower if it is the resident's shower day. CNA 3 indicated a shower would consist of the resident's body and hair being washed, then applying deodorant and dressing the resident. During an interview with CNA 7, completed on 9/12/2024 at 11:45 A.M., she indicated A.M Care included showering the resident if it were the resident's shower day. A shower included washing the residents body and hair, helping them apply deodorant, dressing the resident, assisting the resident during oral care, shaving the resident and cleaning the resident's nails. During an interview with CNA 8, completed on 9/12/2024 at 11:51 A.M., she indicated A.M Care included washing the resident's arm pits, perineal care, oral hygiene, changing the residents clothes, brushing their hair and making sure the resident was clean. If the resident was receiving a shower, the resident would be assisted with washing their body from top to bottom, hair washed, perineal care performed with a clean wash cloth, dried with a towel, dressed and nail care performed. During an interview with CNA 6, completed on 9/12/2024 at 11:55 A.M., she indicated A.M Care included oral care, brushing hair, providing drinks, positioning in bed, toileting the resident or check and changing the resident. During a shower, the resident would be washed from top to bottom, their hair would be washed, oral care would be provided, they would be assisted to dress and taken to breakfast. During an interview with the RCN (Regional Clinical Nurse), completed on 9/13/2024 at 10:00 A.M., she indicated shaving and nail care are performed during A.M and P.M Care (morning			

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	and nightly care routine) by the CNAs. Nail care could also be provided by the Activities Department when they painted resident's nails as a scheduled activity. Refusal for nail care and shaving should be documented on the shower sheet or in a Nurse's Progress Notes. A policy for ADL care was requested but the facility indicated they did not have a policy for providing ADL care. 3.1-38 (a)(3)			
F 0679 SS=D Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident Based on observation, interview and record review, the facility failed to provide activity programs in the evenings. This had the potential to affect 57 out of 57 residents residing in the facility. Finding includes: During an interview on 9/8/2024 at 10:27 A.M., Resident 7 indicated they have not had any evening activities and she would like to have attended them. A record review was completed on 9/9/2024 at 1:52 P.M., for Resident 7. Diagnoses included, but were not limited to: hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, facial weakness following cerebral infarction, unilateral primary osteoarthritis, left hip, low back pain, unspecified, and other chronic pain. An Annual Minimum Data Set (MDS) assessment, dated 11/30/2023, indicated that it was very important to the resident to invite her to group	F 0679	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #7 was affected. Resident reported that facility did not provide evening activities. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected. Life enrichment staff educated on providing evening activities consistently based on resident preferences. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:	10/17/2024

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	activities. A current Care Plan, titled Activities, initiated on 8/30/2019, indicated that it was important to her to be with groups of people and to invite to activities. The January 2024 Activity schedule provided to the Residents had no activities listed in the evening hours for the month. The August 2024 Activity schedule provided to the Residents only had one special themed dinner listed for the month on 8/22/2024, no other group activity scheduled for the evening hours. The September 2024 Activity calendar provided to the Residents had no evening activities scheduled. During an interview on 9/10/2024 at 9:56 A.M., the Life Enrichment Director indicated the last activity for the day started at 3:00 P.M., then the residents got ready for dinner. He currently did not have anyone working evenings, so he stopped providing activities in the evenings for the past couple of months. He indicated there should have been at least two activities scheduled a week in the evenings. On 9/10/2024 at 10:41 A.M., the Life Enrichment Director, provided a policy titled, "Program Components/Standards," dated 6/3/2017, and indicated the policy is the one currently used by the facility. The policy indicated "...The Life Enrichment Department designs programs which are meaningful, diverse, stimulating, and consistent with the needs, preferences, and abilities of each individual resident/patient....."		As a measure of ongoing compliance, the LES or designee will audit Activities calendar for consistent evening activities scheduled. Audit will be conducted monthly x6 months. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: As a quality measure, the ED and/or designee will review any findings and corrective action monthly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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F 0689 SS=D Bldg. 00	3.1-33(c) 483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on observation, interview and record review, the facility failed to ensure the environment was free from accidents and hazards related to medication left unattended on 1 or 2 halls. (200 hall, Resident 7) Finding includes: During an observation on 9/8/2024 at 11:30 A.M., Resident 7 had a tube of Voltaren gel and Biofreeze pain relief cream on her nightstand, and an opened bag of Hall's cough drops on the bedside table. During an observation on 9/9/2024 at 9:19 A.M., Resident 7 had a tube of Voltaren gel and Biofreeze on her nightstand, and an opened bag of Hall's cough drops on the bedside table. A record review was completed on 9/9/24 at 1:52 P.M., for Resident 7. Diagnoses included, but were not limited to: hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, facial weakness following cerebral infarction, unilateral primary osteoarthritis, left hip, low back pain, unspecified, and other chronic pain. A review of the Physician Orders, dated September 2024, indicated Resident 7 did not have an order for Voltaren gel, Biofreeze or Hall's cough drops. A review of clinical record assessments indicated there was no self-administration assessment	F 0689	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident 7 was affected. Medications were removed from bedside and family was educated on bringing in medications from the outside. No adverse effects noted. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: Residents who are wandering have the potential to be affected. All residents who currently self-administer medication were reviewed to ensure proper storage maintained and facility sweep of rooms for bedside medications. Education will be provided to staff on self-administration guidelines and not leaving medications at the bedside. 3. As a measure of ongoing compliance, the Director of Health Services (DHS) and/or designee with complete the following audits:	10/17/2024

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	completed for Resident 7. During an interview on 9/9/2024 at 2:13 P.M., RN 11 indicated the facility kept medicated creams in a cart in the medication room. RN 11 indicated the Voltaren gel, Biofreeze, and cough drops should not have been in Resident 7's room and she should have had an order for use of the medication as well as for self-administration of the medications. RN 11 indiated Resident 7 did not self-administer her own medications. In addition, RN 11 indicated there were two cognitively impaired Resident's (43 and 46) housed on the unit that wandered into other residents rooms. On 9/9/2024 at 2:00 P.M., the DON provided a policy titled, "Guidelines for Self Administration of Medications," dated 12/31/2023, and indicated the policy was the one currently used by the facility. The policy indicated "...Procedures: 1. Residents requesting to self-medicate or self-medications as a part of their plan of care shall be assessed using the observation Trilogy-Self Administration of Medication within the electronic health record. Results of the assessment will be presented to the physician for evaluation and an order for self medication. 3. The medication will be kept in a locked drawer in the residents' room. The resident will maintain the key, as well as, a key will be maintained by the licensed nurse and or QMA. 8. The assessment will be documented in the EHR....." 3.1-45(a)1		Room rounding to ensure no medications are left at bedside daily for 5 days per week x4 weeks, then twice weekly every other week x2 months, then once monthly for 3 months. DHS and/or designee will review 5 residents for appropriate self-administration assessments, as available, weekly x4 weeks, then biweekly x2 months, then monthly x3 months. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: As a quality measure, the ED and/or designee will review any findings and corrective action monthly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on observation, record review, and interview the facility failed to ensure oxygen	F 0695	1. What corrective action(s) will be accomplished for those residents	10/17/2024

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	tubing and humidifiers were maintained per standards appropriately for 2 of 3 residents observed for respiratory care. (Residents 259 & 36) Findings include: 1. During an observation, on 9/8/2024 at 10:38 A.M., Resident 259's oxygen tubing and humidifier lacked a date to ietntify when they were last changed. During an observation, on 9/9/2024 at 10:11 A.M., the oxygen tubing for Resident 259 had a date of 9/7/2024 and the humidifier still lacked a date. On 9/9/2024 at 2:28 P.M., a record review was completed for Resident 259. Diagnoses included, but were not limited to respiratory failure and bronchitis. A Physician's order, dated 8/26/2024, indicated to change the oxygen tubing monthly, once per day, on the first day of the month. During an observation, on 9/12/2024 at 10:54 A.M., the oxygen humidifier now had a date of 9/12/2024.2. During an observation on 9/8/2024 at 10:07 A.M., Resident 36 was asleep in her wheelchair wearing oxygen. The respiratory equipment storage bag and oxygen tubing were dated 8/29/2024. The BIPAP tubing was undated and laying on top of the machine uncovered. During an observation on 9/9/2024 at 9:24 A.M., Resident 7 was up in her wheelchair wearing oxygen and the respiratory storage bag and tubing were now dated 9/7 and the BIPAP tubing was undated and laying on top of the machine uncovered.		found to have been affected by the deficient practice: Residents #259 and #36 were affected. Both residents' respiratory supplies were not properly dated and stored. Both residents respiratory supplies were replaced, dated, and placed in a bag for sanitary storage between use. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents receiving respiratory therapies have the potential to be affected. All residents receiving respiratory therapies have been reviewed to ensure that equipment is properly stored between uses and dated. The DHS and/or designee to educate nursing staff on proper sanitary storage of respiratory equipment and dating. 3. As a measure of ongoing compliance, the Director of Health Services (DHS) and/or designee with complete the following audits: As a measure of ongoing compliance, The DHS and/or designee will complete rounding audit on 5 residents receiving	

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	155783	A. BUILDING 00 B. WING	09/17/2024

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	A record review completed on 9/9/2024 at 2:41 P.M., for Resident 36. Diagnoses included, but were not limited to: chronic respiratory failure with hypoxia, acute and chronic respiratory failure with hypercapnia, chronic respiratory failure with hypercapnia, respiratory failure, unspecified with hypercapnia, other disorders of lung note: restrictive lung disease, and chronic obstructive pulmonary disease, unspecified. A Physician Order for Resident 36, dated 5/15/2024, indicated BIPAP 12.5 with 2 liters of oxygen at bedtime and as needed. A Physician Order for Resident 36, dated 5/26/2024, indicated to change oxygen tubing monthly on the 27 th of the month. A Physician Order for Resident 36, dated 4/25/2024, continuous oxygen at 2 liters per nasal cannula. During an interview on 9/12/2024 at 10:48 A.M., LPN 5 indicated the BIPAP tubing should be stored in a bag when not in use. The tubing and mask should be cleaned weekly, and the tubing should be changed out monthly. She could not tell when the BIPAP was cleaned or changed last because she did not have an order for either and the tubing was undated. On 9/10/2024 at 2:53 P.M., the Administrator provided a policy titled. " Administration of Oxygen, " reviewed 12/31/2023, and indicated the policy was the one currently used by the facility. The policy indicated ..." SOP DETAILS 14. Date the tubing for the date it was initiated. a. Tubing should be changed monthly and PRN....."		treatments weekly x 4 to ensure proper sanitary storage and dating, then every other week for 2 months, then monthly for 3 months. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: As a quality measure, the ED and/or designee will review any findings and corrective action monthly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	On 9/12/2024 at 11:40 A.M., the Administrator indicated they did not have a policy for the use and storage of CPAP or BIPAP equipment. 3.1-47(a)(6)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use Based on record review and interview, the facility failed to discontinue or obtain a new order for a PRN (as needed) psychotropic medication after 14 days, for 1 of 5 residents whose medications were reviewed. (Resident 44) Finding includes: Resident 44's record review was completed on 9/12/2024 at 2:04 P.M. Her diagnoses included, but were not limited to: bipolar disorder, depression, anxiety disorder. A current Physician's order dated, 8/8/2024, indicated Resident 44 could have 0.5 milligrams of Alprazolam twice a day if needed. Resident 44's record lacked the documentation providing a reason why a PRN psychotropic was used longer than 14 days. During an interview on 9/13/2024 1:57 P.M., the Director of Nursing indicated the facility should have stopped the Alprazolam after 14 days and notified the Nurse Practioner. On 9/13/2024 at 2:25 P.M. the Director of Nursing provided an undated policy titled, "Psychotropic Medication Usage and Gradual Dose Reduction", and identified it as the policy currently used by the facility. The policy indicated, "...8. PRN order	F 0758	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident 44 was affected by the alleged deficient practice. No adverse events noted. Resident was reviewed by NP for need of medication and DC order entered. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: Any resident taking medications that require a 14-day stop date have the potential to be affected. All residents on psychotropic medications as needed have been reviewed with no findings. The Social Service Director and nurses have been educated on requirements for psychotropics as needed. 3. As a measure of ongoing compliance, the Director of Health	10/17/2024

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	for psychotropic drugs are limited to 14 days. Except as provided if the attending physician or prescriber believes that it is appropriate for PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. 9. PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication." 3.1-48 (a)(2)		Services (DHS) and/or designee with complete the following audits: Director of Social Services (SSD) and/or designee will complete audit on 3 residents that take psychotropic medications as needed weekly for 4 weeks, every other week for 2 months and monthly x 3 months. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: As a quality measure, the ED and/or designee will review any findings and corrective action monthly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	
F 0773 SS=D Bldg. 00	483.50(a)(2)(i)(ii) Lab Srvcs Physician Order/Notify of Results Based on observation, interview, and record review, the facility failed to promptly notify the ordering physician of laboratory results requiring medical treatment according to policies and procedures for notification and the medical order for 1 of 3 reviewed for antibiotics. (Resident 7) Finding includes:	F 0773	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident 7 was affected by the alleged deficient practice with no adverse reactions. UA results	10/17/2024

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	During an interview on 9/8/2024 at 10:34 A.M., Resident 7 indicated she gets frequent urinary tract infections (UTI) but does not recall when she had the last one. A Nursing Progress Note, dated 4/21/2024 at 6:41 A.M., indicated the spouse requested a laboratory test for an UTI due her head being shaky. A physician's order was received. A Physician's Order, dated 4/21/2024, indicated to collect a urinalysis (UA) with culture. A Nursing Progress Note, dated 4/22/2024 at 7:02 P.M., indicated the urine was collected. A laboratory result, with a collection date of 4/22/2024, received date of 4/24/2024 and report date of 4/25/2024 indicated bacterial pathogen detected was Escherichia coli 99.998%. A Nursing Progress Note, dated 5/1/2024 at 4:30 P.M., indicated the urine culture results were reviewed by the Nurse Practitioner and orders were received for Nitrofurantoin, an antibiotic. A Physician Order, dated 5/1/2024, indicated Nitrofurantoin, an antibiotic, 100 mg twice a day for 7 days. A Care Plan, dated 8/30/2023, indicated the had the potential for UTI due to diagnoses of overactive bladder and history of UTI's and incontinence. Interventions included labs as ordered and report abnormal values to the Medical Director. A record review was completed on 9/9/24 at 1:52 P.M., for Resident 7. Diagnoses included, but		were not communicated to the attending physician timely. Interventions were added as appropriate. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents had the potential to be affected by this practice. Residents lab orders reviewed to ensure results obtained and communicated to physician timely. Education to nurses on reviewing ancillary orders daily for results and communication timeframes. 3. As a measure of ongoing compliance, the Director of Health Services (DHS) and/or designee with complete the following audits: The Director of Health Services and/or designee will review lab results 5 times a week x6 months to ensure labs are communicated timely to physicians. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: As a quality measure, the ED	

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	were not limited to: hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, overactive bladder and type 2 diabetes. During an interview, on 9/12/2024 at 9:35 A.M., the Infection Preventionist indicated the lab was notified of the order when it was entered and then the laboratory sends the results back to the facility electronically under the diagnostics section. The nurse was expected to check the EMR each shift after the culture was ordered. She would have expected the nurse to respond within 4 hours after the results were received. May 1, 2024 was the date the laboratory results were followed up on when the follow up should have occurred on 4/25/2024. The NP indicated delay in treating the infection could have resulted in the resident's condition worsening. On 9/12/2024 at 10:59 A.M., the Administrator provided a policy "Physician Provider Notification Guidelines," review date 12/31/2023, and indicated the policy was the one currently used by the facility. The policy indicated "...PURPOSE: To ensure the resident's physician or practitioner (may include NP, PA, or clinical nurse specialist) is aware of all diagnostic testing results or change in condition in a timely manner to evaluate conation for need of provision of appropriate interventions for care. 1. Resident assessments for change in condition, suspect injury, event of unknown origin or ordered lab and/or other diagnostic tests should be completed in a timely manner. 11. Attempts to notify the physician/provider and their response should be documented in the resident electronic health record....." 3.1-49(a)(f)(2)		and/or designee will review any findings and corrective action monthly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, record review and interview, the facility failed to store food under sanitary conditions related to foods not tightly sealed, outdated foods and dirty kitchen equipment. In addition, the facility failed to prepare and serve food related to staff members not wearing hair nets as required for 2 of 2 kitchens observed. (Main and Activities kitchen) This issue had the potential to affect 57 of 57 residents who resided in the facility and received food from this dietary kitchen. Finding includes: On 9/8/24 at 10:09 A.M., a kitchen tour was conducted with the Assistant Director of Food Services. The following was observed in the walk in fridge: - A bag of salad mix not sealed properly. - A container of salad dressing with a use by date of 9/6/2024. The following was observed in the walk in freezer: - A bag of potatoes not sealed appropriately. The following was observed in the milk fridge: - A bottle of cinnamon yogurt flavoring with no use by date. - A bag of colby jack cheese with a use by date of 9/5/2024. The following was observed in the juice fridge: - Two bottles of prune juice with use by dates of 9/4/2024 and 9/6/2024. The following was observed in the dry storage: - A box of pancake mix with a use by date of	F 0812	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: All residents have the potential to be affected. All items were labeled/disposed of if expired, food storage safety ensured, hairs nets on while in kitchen, and sanitation ensured for all areas. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected. All items audited to ensure label in place and are discarded if expired. Education with culinary team related to labeling items and discarding expired items, proper storage of food items, need for hairnet or hat, and sanitation of kitchen areas. 3. As a measure of ongoing compliance, the Director of Health Services (DHS) and/or designee with complete the following audits: As a measure of ongoing compliance, the Direct of Food Services (DFS) will round for	10/17/2024

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	8/30/2024. During an interview, on 9/8/2024 at 10:36 A.M., the Assistant Director of Food Services indicated the foods should have been sealed appropriately and expired foods should have been thrown in the trash. During an observation and interview, on 9/8/2024 at 10:06 A.M., Cook 4 was not wearing a hair net. She indicated she should have had one on. On 9/10/2024 at 11:07 A.M., a tour of the activities kitchen was conducted with the Activities Director. The following was observed: - A microwave with dried food on the glass plate, the roof, and all sides. During an interview, on 9/10/2024 at 11:09 A.M., the Activities Director indicated the microwave should have been cleaned. On 9/10/2024 at 10:42 A.M., the Administrator provided the policies titled, " Food Safety and Handling," " Food Labeling and Dating Policy," and "Hair Restraint," dated 3/18/2019 and indicated the policies were the ones currently used by the facility. The policies indicated...." Prepared leftover food items must be discarded within 3 days. Any food product removed from its original container, has a broken seal, has been processed in any way must have a label that contains the following: 1. Item Name. 2. Date and time the food was labeled. 3. Use by date. 4. Initials of the person labeling the item. 5. Securely cover the food item. All Dining Service employees will be required to wear hair restraints as required by the 2009 Federal Food Code. Food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing		completion of labeling/dating/disposal of expired items, proper food storage, hairnet use, and sanitation weekly x4 weeks, then every other week x2 months, then monthly x3 months. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: As a quality measure, the ED and/or designee will review any findings and corrective action monthly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food...." 3.1-21(h)(3)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation and interview, failed to ensure infection control practices were in place for 1 of 1 resident observed during catheter care. (Resident 259) Findings include: On 9/12/2024 at 1:23 P.M., Resident 259 was observed for catheter care. CNA 3 entered the resident's room. Once in the room, CNA 3 washed her hands prior to putting on a gown and gloves. She removed a disposable wipe from the package and began cleansing the catheter tubing, starting at the insertion site and going down the tube. CNA 3 disposed of the wipe and removed another one from the package and repeated the process. CNA 3 grabbed the residents bed sheets and covered her up, pulled the residents shirt down to cover her abdomen, placed a new bag in the trash, and grabbed the resident's bedside table to move it closer to the. CNA 3 then removed her gown and gloves and washed her hands. On 9/9/2024 at 2:28 P.M., a record review was completed for Resident 259. Diagnoses included, but were not limited to retention of urine. During an interview, on 9/12/2024 at 1:36 P.M., CNA 3 indicated she should have removed her gloves and washed her hands before touching anything else in the room.	F 0880	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident 259 affected by alleged practice with no adverse effects noted. Room cleaned and sanitized post alleged practice. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents with catheters had the potential to be affected by this practice. Nursing staff educated on proper infection control practices during catheter care and hand washing guidelines. 3. As a measure of ongoing compliance, the Director of Health Services (DHS) and/or designee with complete the following audits: To assure ongoing compliance, the Director of Health Services	10/17/2024

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	A current Care Plan, dated 8/27/2024 indicated Resident 259 required enhanced barrier precautions (EBP) during high-contact care related to presence of: an indwelling catheter, infection or colonization of MDRO (Multi drug resistant organism). Interventions included to perform hand hygiene before and after care, per policy, and as required. Utilize gown and gloves per EBP policy during indwelling device care, central lines and urinary catheter care. On 9/12/2024 at 2:08 P.M., the Administrator provided the policy titled, "Urinary Catheter Care,"undated, and indicated it was the policy currently being used by the facility. The policy indicated, "21. After completion of the procedure: b. Discard disposable items into designated containers. Remove gloves and discard into designated container. Wash hands and dry thoroughly. c. Reposition bed covers. Make the resident comfortable. e. Return the over bed table to its proper position. f. Wash and dry hands thoroughly." 3.1-19(l)		and/or designee will audit 2 random residents with catheters for proper catheter care and infection control practices weekly for 3 months and biweekly for 6 months. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: As a quality measure, the ED and/or designee will review any findings and corrective action monthly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: September 8, 9, 10, 11, 12, 13, 16 and 17, 2024 Facility number: 002661 Residential Census: 42	R 0000		

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	Greenleaf Health Campus was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.			