STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155070	A. BUILDING _____ B. WING _____	C 06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN VALLEY CARE CENTER	3118 GREEN VALLEY RD NEW ALBANY, IN 47150

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F 000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00408975, IN00411234, and IN00411765. Complaint IN00408975 - No deficiencies related to the allegations were cited. Complaint IN00411234 - No deficiencies related to the allegations were cited. Complaint IN00411765 - No deficiencies related to the allegations were cited. Unrelated deficiency cited. Survey dates: June 27, 28 and 29, 2023 Facility number: 000028 Provider number: 155070 AIM number: 100275370 Census Bed Type: SNF/NF: 121 Total: 121 Census Payor Type: Medicare: 15 Medicaid: 81 Other: 25 Total: 121 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on July 6, 2023.	F 000		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		

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

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F 677	Continued From page 1 §483.24(a)(2) 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; This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a resident received the necessary treatment care and services to maintain current level of function related to transfers and personal hygiene for 1 of 3 residents reviewed for Activities of Daily Living. (Resident F) Findings include: The record for Resident F was reviewed on 6/18/23 at 8:58 a.m. The diagnoses included, but were not limited to, the need for assistance with personal care, type 2 diabetes mellitus, history of a transient ischemic attack, cerebral infarction, difficulty walking, and a fracture of the shaft of the left femur. The MDS (Minimum Data Set) assessment, dated 5/15/23, indicated the resident was moderately cognitively impaired. He required extensive assistance with 2 staff with all Activities of Daily Living (ADLs). The physician's order, dated 5/18/23, indicated the resident required the assistance of 2 staff members with transfers using the sit-to-stand lift and a size large sling on every shift. The physician's order, dated 5/7/23, indicated to encourage the resident to shift his weight from side to side every 2 hours while up in his wheelchair, to prevent skin breakdown every shift for prevention.	F 677	Past noncompliance: no plan of correction required.	

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F 677	Continued From page 2	F 677		

The care plan, initiated on 2/6/23, indicated the resident had an ADL self-care performance deficit related to the need for hands on assistance and weight bearing staff assistance with ADLs and mobility. The interventions included, but were not limited to, the resident required hands on and weight bearing staff assistance to turn and reposition while in bed and to get to a sitting position on edge of bed, allow sufficient time for dressing and undressing, assist the resident to choose simple comfortable clothing, and make sure his shoes were comfortable and not slippery. Resident F required hands on and weight bearing staff assistance for toileting, incontinence care, and catheter care, and required hands on and weight bearing staff assistance to move between surfaces.

The Incident Report, dated 6/11/23 at 9:50 a.m., indicated on 6/12/23 the resident was found in the morning sleeping in his chair. A head-to-toe assessment and a pain assessment was completed.

The Incident Report, dated 6/11/23, indicated RN 2 had last observed the resident at 8:15 p.m., on 6/10/23 when she walked past his room. He was sitting up in his wheelchair at that time. She indicated she did not check on the resident throughout the night. His door was closed, and she assumed he was sleeping.

The Incident Report, dated 6/11/23, indicated CNA (Certified Nursing Aide) 3 was the CNA on the 200 Hall on 6/10/23 from 6 p.m. to 6 a.m. She thought the QMA (Qualified Medication Aide) put the resident to the bed before she left. The CNA indicated she and the QMA split halls, and the

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F 677	Continued From page 3	F 677		

QMA was supposed to help the residents on the long 200 Hall get in bed for the night. The last time she saw the resident was about 7:30 p.m. He was in his room up in the wheelchair visiting with family. She did not check on the resident throughout the night and the resident's door was closed.

The Incident Report, dated 6/11/23, indicated QMA 4 did not lay the resident down. The last time she observed the resident was around shift change and he had company visiting. She did not know what time he got laid down. She changed the rest of her residents and went to another hall to provide assistance before leaving.

The Incident Report, dated 6/11/23, indicated CNA 5 went into the resident's room around 7:00 a.m., to get him up for the day. The resident was sitting in his wheelchair by the window asleep. He was fully dressed. She asked the nurse if she was aware of anything with the resident as the CNA from the night shift had already left without giving a walk-through report. She hadn't been notified of any issues but assumed the night shift had already gotten him up. Shortly after his family member walked in, she complained about the resident still being in his chair and having on dirty clothes. The resident had on the same clothes he was wearing the day before. He had food in his lap and his catheter bag was filled to the top and had blood in his urine. Staff immediately changed the resident's clothes and drained his catheter bag. The family member did not want the resident assisted back to bed but wanted the cushion in the wheelchair changed.

During an interview on 6/28/23 at 12:42 p.m., Resident F's family member indicated on 6/11/23

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F 677	Continued From page 4	F 677		

the resident was left sitting in his wheelchair all night. She arrived at the facility around 8:00 a.m. and found him with the same clothes he had on from the day before. He had food debris in his lap and his shoes were left on. His catheter bag was full of urine and the bag had 2000 cc (cubic centimeters) of urine and it had not been emptied. She questioned the nurse and CNA, and they didn't know anything about it. The nurse indicated maybe therapy got the resident up. She knew that wasn't correct because physical therapy did not dress the resident. She talked to the physical therapist, and she indicated the resident had his therapy at 7:30 a.m. and she returned the resident to his room around 8:00 a.m. The resident had been dressed when she went to get him for his therapy. The resident wanted to go to the church services at the facility at 11:00 a.m. She had informed the staff and they did not come and change his clothes until 10:40 a.m. She indicated there was no reason to leave her family member up in his wheelchair all night.

During an interview on 6/28/23 at 1:10 p.m., CNA 6 indicated the residents should be checked and changed every 2 hours. There would be no reason not to check on a resident.

During an interview on 6/28/23 at 1:15 p.m., QMA 4 indicated on 6/11/23 she had worked the day shift as a QMA and after her shift she stayed over as a CNA to provide assistance with putting residents to bed on the 200 Hall. When she started her resident care, she started at the end of the 200 Hall. Resident F had family members visiting so she went on to the next resident. She had seen the resident around 7:00 p.m. When she was done, she went to the 100 Hall to provide assistance. She left at 9:00 p.m. She did not let

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F 677	Continued From page 5	F 677		

anyone know she skipped Resident F, but she let staff know which residents she had assisted to bed. The residents should be checked and changed every 2 hours, 24 hours a day. The resident required 2 staff members assistance with his ADLs.

During an interview on 6/28/23 at 1:30 p.m., LPN (Licensed Practical Nurse) 7 indicated she came in for her shift on 6/12/23. She did not receive anything in report about the resident. He went to therapy early and came back and ate his breakfast. The resident's family member came in and indicated the resident had the same clothes on that he had on yesterday. She did not observe his catheter being full, but the CNA would have emptied it and documented it. Typically, the resident would be checked and repositioned every 2 hours. She would have checked the resident at least that and more often if needed.

The Policy and Procedure titled Activities of Daily Living, dated 12/11/18, provided on 6/28/23 at 2:28 p.m., by the DON (Director of Nursing), included, but was not limited to, "...The resident will receive assistance as needed to complete activities of daily living (ADL's). Any change in the ability to perform ADL's will be documented and reported to the licensed nurse... 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..."

The deficiency cited was past non-compliance when the facility completed staff education related to ADL's, residents skin assessments, validated routine rounding was occurring and employee job descriptions were given to staff

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F 677	Continued From page 6 members prior to the entrance of the survey. 3.1-38(a)(2)(A) 3.1-38(a)(2)(B)	F 677		