STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155070	A. BUILDING _____ B. WING _____	**03/10/2020**

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a staff member followed a resident's (Resident D) plan of care for behaviors for 1 of 3 residents reviewed for care plans. Finding includes: The clinical record for Resident D was reviewed on 3/5/20 at 4:29 p.m. [DIAGNOSES REDACTED]. The incident report, dated 2/11/20 at 5:50 a.m., indicated the resident had bruising and slight [MEDICAL CONDITION] to the left side of her lip and lower cheek area below the lip. The care plan, dated 10/23/18, indicated the resident was physically resistive to care and, if unable to calm, staff were to walk away calmly and approach later. The Nurse Practitioner's note, dated 2/11/20, indicated the resident had bruising, purple/blue in color to the left lip, face, and cheek due to an unknown accident. During an interview on 3/6/20 at 6:20 a.m., CNA (Certified Nursing Assistant) 5 indicated on the morning of 2/11/20 at 5:36 a.m., Resident D was in bed and was his last resident to get up. Resident D became combative, screamed, cursed and called him names. CNA 5 continued to do his work and asked her to please calm down. CNA 5 was dressing the resident and when he tried to get her up, Resident D grabbed CNA 5's hand, opened her mouth and tried to bite him. CNA 5 yanked his hand away and Resident D hit herself in the face with her own force. Resident D continued to be combative with care and when CNA 5 turned her to the side to pull her pants up, CNA 5 heard Resident D hit something, possibly the side rail. CNA 5 continued to provide care while Resident D was combative. During an interview on 3/8/20 at 7:10 p.m., CNA 7 indicated when a resident was combative with care, stop care, and re-approach at a later time. On 3/9/20 at 1:30 p.m., the Administrator provided a current copy of the document titled Care Planning and Interventions dated 7/23/2009. It included, but was not limited to, The interdisciplinary team meets on a scheduled basis and develops an individualized care plan .to provide the greatest benefit to the resident .The Care Plan addresses .The resident's goals and choices .Interventions for preventing avoidable declines .Resident-specific interventions .Standards of current professional practice This Federal tag relates to Complaint IN 641
F 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident's (Resident E) plan of care was updated for 1 of 3 residents reviewed for care plan revisions. Finding includes: The clinical record for Resident E was reviewed on 3/6/20 at 10:19 a.m. [DIAGNOSES REDACTED]. On 3/9/20 at 2:37 p.m., Resident E was observed without a code alert bracelet in place. The care plan, dated 12/5/18, indicated the resident was at risk for elopement with an intervention of a code alert bracelet and to check placement and function every shift. The care plan was last revised on 2/26/20. The significant change elopement risk evaluation, dated 11/19/19 at 3:18 p.m., indicated the resident was not an elopement risk. The progress note, dated 11/19/19 at 3:19 p.m., indicated to discontinue the code alert bracelet due to the resident was not an elopement risk, exhibited no exit seeking behaviors, and was propelled by staff in the wheel chair. During an interview on 3/9/20 at 2:56 p.m., the Administrator indicated the elopement care plan should have been removed from the plan of care. On 3/9/20 at 1:30 p.m., the Administrator provided a current copy of the document titled Care Planning and Interventions dated 7/23/2009. It included, but was not limited to, The interdisciplinary team meets on a scheduled basis .The care plan is updated as needed, but no less than quarterly as .Interventions are determined to be ineffective or need to be revised This Federal tag relates to Complaint IN 252 3.1-35(d)(2)(B)
F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure adequate supervision was in place when two residents with dementia, with security bracelets in place, exited the locked unit and facility without supervision and ambulated .03 miles to a subdivision next to the facility without staff awareness for 2 of 3 residents reviewed for accidents/supervision (Resident B and Resident C); and failed to ensure staff immediately notified the nurse when a resident (Resident D) was combative with care struck herself and, when turned, struck the side rail on the bed, which resulted in a split lip, bruising, and [MEDICAL CONDITION] to the left side of the mouth and cheek for 1 of 3 residents reviewed for accidents. This deficient practice resulted in an Immediate Jeopardy. The Immediate Jeopardy began on 3/1/2020 when two cognitively impaired residents with security bracelets exited the locked unit and the facility, without staff awareness, and were found by an off duty staff member 0.3 miles away from the facility in a subdivision next to the facility which was located 0.25 miles from a heavily traveled thoroughfare with a speed limit of 35 miles per hours. The interstate was located directly behind the facility with a speed limit of 65 miles per hour. The Administrator, Director of Nursing, and Regional Nurse were notified of the Immediate Jeopardy on 3/6/20 at 11:30 a.m. Findings include: 1. The incident report, dated 3/1/20 at 12:20 p.m., indicated Resident B and Resident C were found to be outside walking. During an interview on 3/5/20 at 12:45 p.m., the Administrator indicated she had not completed the investigation yet, but thought the residents walked off the unit with church members through the main 400 hall doors. They brought in musical equipment for church and upon leaving the 400 hall, the door may have been opened too long which would cause the alarm sound. The church members may have turned the alarm off since they knew the code. If a resident with a security bracelet would exit through the doors while the alarm was sounding, it would not make a different alarm sound. The church members were notified and did not recall any residents following them out. The facility was unsure as to how the residents exited the building. During an interview on 3/5/20 at 1:00 p.m., Staff Member 4 indicated she was off work at 11:20 a.m. on 3/1/20. She had an appointment at 12:15 p.m., to look at a house in the subdivision next to the facility. At 12:22 p.m., she looked out the window of the house she was viewing and Resident B and Resident C were observed walking on the sidewalk across the street. Staff Member 4 called the facility to let them know the residents were observed in a subdivision. The facility was unaware that the residents were out of the building. She walked the residents back to the facility where a staff member met them in the parking lot. Review of the facility investigation indicated Resident B and Resident C were last seen on the unit at 11:55 a.m. On 3/1/20, the residents were found outside of the facility at 12:22 p.m., and then brought back into the building at 12:33 p.m. The temperature outside was sunny and 60 degrees. On 3/5/20 at 3:28 p.m., the facility video from 3/1/20 was reviewed and the two church members were observed to exit through the main front doors alone. No residents were

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) observed following them out of the building. a. The clinical record for Resident B was reviewed on 3/5/20 at 12:30 p.m. [DIAGNOSES REDACTED]. The quarterly MDS (Minimum Data Set) assessment, dated 2/26/20, indicated the resident's cognition was severely impaired. The care plan, dated 11/23/18, indicated the resident was a risk for elopement with interventions of a code alert bracelet (security bracelet) and staff were to monitor the resident frequently. The physician's orders [REDACTED]. The elopement risk evaluation, dated 5/20/19, indicated Resident B was cognitively impaired, ambulated independently, had a history of [REDACTED]. The progress note, dated 3/1/20 at 1:00 p.m., indicated the resident was observed in the parking lot by a staff member and then escorted back into the building. On 3/5/20 at 3:05 p.m., Resident B was observed with a security bracelet to his left ankle. b. The clinical record for Resident C was reviewed on 3/5/20 at 12:14 p.m. [DIAGNOSES REDACTED]. The admission MDS assessment, dated 2/19/20, indicated the resident's cognition was severely impaired. The care plan, dated 2/10/20, indicated the resident was an elopement risk with interventions of a code alert bracelet, provide for safe wandering, and encourage to participate in activities to divert from exit seeking behavior. The physician's orders [REDACTED]. The elopement risk evaluation, dated 2/10/20, indicated the resident was cognitively impaired, ambulated independently, and had a history of [REDACTED]. The resident was exit seeking and became more agitated with interventions. The progress note, dated 3/1/20 at 1:00 p.m., indicated the resident was observed in the parking by a staff member and escorted back into the building. On 3/5/20 at 3:07 p.m., Resident C was observed with a security bracelet to her left ankle. During an observation on 3/5/20 at 3:00 p.m., LPN (Licensed Practical Nurse) 3 put in the code on the main 400 hall door and held the door open. After 7 seconds the alarm sounded and RN 2 went through with a security bracelet and there was no change to the tone of the sound of the alarm. On 3/6/20 at 9:50 a.m., the Administrator provided a current copy of the document titled Elopement Policy dated February 2009. It included, but was not limited to, Residents have the right to live at ease in a safe and secure environment. The facility is responsible for ensuring that effective policies and procedures are developed and implemented to reduce the risk of elopement by residents .Definition of Elopement .An incident in which a resident leaves the facility grounds without staff knowledge; the resident has impaired decision making abilities and is unaware of his/her own safety needs 2. The clinical record for Resident D was reviewed on 3/5/20 at 4:29 p.m. [DIAGNOSES REDACTED]. The incident report, dated 2/11/20 at 5:50 a.m., indicated the resident had bruising and slight [MEDICAL CONDITION] to the left side of her lip and lower cheek area below the lip. The progress note, dated 2/11/20 at 6:05 p.m., indicated the resident was observed to have [MEDICAL CONDITION] to left cheek and lip and complained the area was sore. The Nurse Practitioner's note, dated 2/11/20, indicated the resident had bruising, purple/blue in color to the left lip, face, and cheek due to an unknown accident. The physician's orders [REDACTED]. The radiology report, dated 2/12/20 at 12:28 a.m., indicated the resident's bony orbits and mandible were intact. The skin assessment, dated 2/12/20, indicated Resident D's left cheek, at the crease by the side of the mouth, had a purple discoloration which measured 1.5 cm (centimeters) by 1.0 cm and the left lip had [MEDICAL CONDITION] with a slight amount of bleeding. During a telephone interview on 3/5/20 at 4:51 p.m., Resident D's NP (Nurse Practitioner) indicated she was told the resident may have hit her face on the side rail, but the investigation was still ongoing at the time. The resident had tried to bite a CNA (Certified Nursing Assistant) who had provided care and when the CNA pulled his had away, Resident D hit herself in the face. The bruising seemed too extensive for Resident D to have just hit herself in the face. During an interview on 3/6/20 at 6:20 a.m., CNA 5 indicated on the morning of 2/11/20 at 5:36 a.m., Resident D was in bed and was his last resident to get up. Resident D became combative, screamed, cursed and called him names. CNA 5 continued to do his work and asked her to please calm down. CNA 5 was dressing the resident and when he tried to get her up, Resident D grabbed CNA 5's hand, opened her mouth and tried to bite him. CNA 5 yanked his hand away and Resident D hit herself in the face with her own force. Resident D continued to be combative with care and when CNA 5 turned her to the side to pull her pants up, CNA 5 heard Resident D hit something, possibly the side rail. CNA 5 did not report either incident to the nurse because he did not see any injury to the resident. During an interview on 3/8/20 at 7:10 p.m., CNA 7 indicated the nurse should be notified immediately when any incident which could cause injury has occurred. The Immediate Jeopardy that began on 3/1/2020 was removed on 3/9/2020 when the facility completed staff education on the elopement policy, procedures for elopement follow-up, door locks checked for proper functioning, wanderguard system checked for proper functioning, door codes changed, staff education related to security measures of the secure unit door codes as well as placement of signage on the entrance/exit doors of the secure unit, elopement book reviewed and updated, elopement risk assessments updated, and care plans reviewed and updated. The Immediate Jeopardy was removed on 3/9/20 but non compliance remained at the lower scope and severity of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy because not all care plans were updated. This Federal tag relates to Complaint IN 252 and IN 641 3.1-45(a)(2)