STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTHCARE	2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000				
		F0000		

This visit was for the Investigation of Complaint IN00102099.

Complaint IN00102099 - Substantiated. Federal / state deficiencies related to the allegations are cited at F280, F282, F323, F329.

Survey dates: January 18, and 19, 2012

Facility number : 004700
Provider number: 155741
AIM number: 100266630

Survey team:
Christine Fodrea, RN, TC
Barbara Hughes, RN

Census bed type:
SNF/NF: 45
Total: 45

Census payor type:
Medicare: 1
Medicaid: 40
Other: 4
Total: 45

Sample: 5

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on January 20, 2012 by Bev Faulkner, RN			

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F0280 SS=D	The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.			
	Based on interview and record review, the facility failed to ensure fall prevention care plans were updated with interventions and information to prevent falls for 1 of 3 residents reviewed for fall prevention care plans in a sample of 5 (Resident #R) Findings include: Resident #R's record was reviewed 1-19-2012 at 10:45 a.m. Resident #R's diagnoses included but were not limited to depression, anxiety, and dementia. Nurse's notes, dated 12-4-2011 at 5:45 a.m., indicated Resident #R fell attempting to self transfer while in the bathroom.	F0280	During Resident R's hospitalization in December 2011, we connected her pressure pad alarm to the call light system so that her call light would be activated in the event she tried to get out of bed, and we inserviced staff to watch for her call light and respond immediately whenever it comes on. RN #1 has been counseled regarding leaving Resident R alone in the bathroom, and Resident R's C.N.A. Care Guide has been updated to indicate she cannot be left alone in the bathroom. The fall inestigation report from Resident #R's fall has been located and will be available for review upon surveyor's revisit. Resident #R is currently hospitalized. Her care plans,	02/18/2012

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	A Fall investigation report, dated 12-4-2011, indicated Resident #R had been attempting to go to the bathroom when she fell. Resident #R was sent to the hospital with a fractured hip and no new intervention was initiated. A nurse's note, dated 12-13-2011 at 2 p.m., indicated Resident #R returned from the hospital. A review of a care plan titled potential for injuries from falls did not indicate new interventions to prevent falls on return from the hospital. A nurse's note, dated 1-5-2012 at 5 p.m., indicated Resident #R had fallen. In an interview 1-18-2012 at 1:40 p.m., the Director of Nursing indicated the investigation from the fall on 1-5-2012 could not be located. She further indicated Resident #R had been in the bathroom next to the dining room, was left alone and fell in the bathroom. The care plan did not indicate Resident #R was non complaint with safety measures to prevent falling. In an interview 1-18-2012 at 2 p.m., RN #1 indicated Resident #R should not have been left alone in the bathroom.		including interventions to prevent injuries related to falls, will be updated upon her return to the facility. Her care plan will also be updated to reflect her non-compliance upon her return. All residents who are at risk for falls are identified as having potential to be affected. Residents at risk for falls will have their care plans reviewed and updated by 2/18/12. An inservice for all licensed nurses is scheduled for Tuesday 2/07/12 to re-educate nurses about procedures that must be followed after a fall, as well as the importance of implementing interventions to prevent falls. We will also cover notification requirements at that inservice. Falls will be reviewed at morning meeting on a daily basis to ensure that appropriate interventions are added to the resident plan of care to prevent future falls or reduce risk for injuries. Falls will be discussed at our Quality Assurance meeting monthly X 3 months and then no less than quarterly thereafter on an ongoing basis as a method to monitor the effectiveness of our fall prevention interventions. The Administrator and Director of Nursing are responsible for compliance. Completion date 2/18/2012	

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	In an interview on 1-18-2012 at 2:30 p.m., LPN #2 indicated the care plan should have been updated with fall interventions and Resident #R's noncompliance. A policy titled Care plans procedure, dated 4-2010, indicated care plans were to be completed with in 7 days of Minimum Data Set completion. There was no provision for care plan updates or accuracy. This Federal tag relates to complaint number IN00102099. 3.1-35(d)(2)(B)			

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F0282 SS=D	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 interview and record review, the facility failed to ensure physician's orders were followed for obtaining lab results for 1 of 4 residents reviewed for labs (Resident #R). The facility further failed to ensure orders were clarified for suture removal for 1 of 1 residents reviewed requiring suture removal in a sample of 5 (Resident #R). Findings include: 1.a.) Resident #R's record was reviewed 1-19-2012 at 10:45 a.m. Resident #R's diagnoses included but were not limited to depression, anxiety, and dementia. A physician's order, dated 12-13-2011, indicated lab tests PT/INR were to be drawn every Monday and Thursday. A separate physician's order, dated 12-30-2011, indicated PT/ INR should be drawn every Monday and Thursday. A review of labs indicated the labs PT/INR should have been drawn on the following dates: 12-16, 12-20, 12-23, 12-26, 12-29, 1-2, 1-5, 1-9, 1-12, and 1-16. There were PT/INR results recorded for	F0282	The LPN who did the re-admission orders for Resident #R is no longer in the position of day shift charge nurse at the facility. The lab orders which had not been implemented upon Resident R's return from the hospital on 12/13/11 were implemented on 12/31/11. All residents in the facility are identified as having potential to be affected. All admission orders or re-admission orders will be reviewed by the Director of Nursing or her designee on the next business day after a resident is admitted or re-admitted. This review will determine if all orders, including lab orders, orders for staple removal, follow-up physician appointments, medication orders, etc. were handled appropriately to ensure that they are implementation as ordered. Any orders that had been missed by the admitting nurse will be corrected at the time of this review, and the admitting nurse will be counseled as needed if he/she failed to implement all physician's orders appropriately. See also Tag 280 for information related to fall prevention and care plans. An inservice for all licensed nurses is scheduled for Tuesday	02/18/2012

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	12-31, 1-5,1-9, 1-12 and 1-16. There were no PT/INR results recorded for 12-16, 12-20, 12-23, 12-26, 12-29, and 1-2. In an interview on 1-19-2012 at 1:40 p.m., the Director of Nursing indicated no further PT INR's could be located and she had discovered the PT INR's were not being drawn per order on 12-30-2011, so she called the physician and reordered the tests so the labs would be drawn. A policy titled lab orders, ensuring compliance and reporting dated indicated the nurse would be responsible to monitor for timely lab results to be received. b.) Nurse's notes, dated 12-4-2011 at 5:45 a.m., indicated Resident #R fell attempting to self transfer while in the bathroom. A Fall investigation report, dated 12-4-2011, indicated Resident #R was sent to the hospital with a fractured hip. A nurse's note, dated 12-13-2011 at 2 p.m., indicated Resident #R returned from the hospital. The hospital discharge orders, dated 12-13-2011, did not indicate when the staples in the surgical incision were to be		2/07/12 to re-educate nurses about the importance of admission orders and re-admission orders, as well as the review that will take place on the next business day. The DON or designee will report the results of the post-admission chart review to the Administrator. Admission and re-admission chart reviews will be discussed at our Quality Assurance meeting monthly X 3 months and then no less than quarterly thereafter on an ongoing basis as a method to monitor the effectiveness of this plan to make sure all physicians orders are followed. The Administrator and Director of Nursing are responsible for compliance. Completion date 2/18/2012	

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	removed. The follow up appointments with Resident #R's physician's were to be scheduled between 12-27 and 12-31-2011. Resident #R's family made an appointment with the physician on 12-28-2011. In a confidential interview with a family member on 1-19-2012 at 9:15 a.m., the family member indicated the physician's appointment had not been set up. The family member further indicated the appointment was set up by the family, and during the appointment the physician removed the sutures. According to the family member, the physician was unsure why the facility had not removed the sutures. The physician was unavailable for comment. A nurse's note, dated 12-28-2011, without a time indicated Resident #R's staples were intact. A nurse's note, dated 12-31-2011 at 4 a.m., indicated Resident #R had steri strips intact on the incision. A review of the physician's orders did not indicate an order to remove the staples. In an interview on 1-18-2012 at 1:40 p.m., the Director if Nursing indicated the family had taken Resident #R to the			

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	physician to have the staples removed. She further indicated the staples removal should have been clarified with the physician when Resident #R was readmitted after surgery. In an interview on 1-19-2012 at 2 p.m., the Administrator indicated although there was no specific policy regarding following physician orders, it was understood the orders would be followed. This Federal tag relates to complaint number IN00102099. 3.1-35(g)(2)			

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F0323 SS=D	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to ensure fall interventions were developed after a fall to prevent further falls for 2 of 3 residents reviewed for fall interventions (Resident #R and Resident #S). The facility further failed to implement fall prevention interventions for 1 of 3 residents reviewed for fall prevention intervention initiation in a sample of 5 (Resident #R). Findings include: 1.a. Resident #R's record was reviewed 1-19-2012 at 10:45 a.m. Resident #R's diagnoses included but were not limited to depression, anxiety, and dementia. Nurse's notes, dated 12-4-2011 at 5:45 a.m., indicated Resident #R fell attempting to self transfer while in the bathroom. A Fall investigation report, dated 12-4-2011, indicated Resident #R had been attempting to go to the bathroom when she fell. Resident #R was sent to the hospital with a fractured hip and no new intervention was initiated.	F0323	For Resident #R, please refer to the plan of correction for tag 280. Resident #S has had her fall care plan reviewed and updated. All residents in the facility that are at risk for falls are identified as having potential to be affected. An inservice for all licensed nurses is scheduled for Tuesday 2/07/12 to re-educate nurses about procedures that must be followed after a fall, as well as the importance of implementing interventions to prevent falls. We will also cover notification requirements at that inservice. Falls will be reviewed at morning meeting on a daily basis to ensure that appropriate interventions are added to the resident plan of care to prevent future falls or reduce risk for injuries. Falls will be discussed at our Quality Assurance meeting monthly X 3 months and then no less than quarterly thereafter on an ongoing basis as a method to monitor the effectiveness of our fall prevention interventions. The Administrator and Director of Nursing are responsible for compliance. Completion date 2/18/2012	02/18/2012

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	A nurse's note, dated 12-13-2011 at 2 p.m., indicated Resident #R returned from the hospital. A review of a care plan titled potential for injuries from falls did not indicate new interventions to prevent falls on return from the hospital. A nurse's note, dated 1-5-2012 at 5 p.m., indicated Resident #R had fallen. In an interview 1-18-2012 at 1:40 p.m., the Director of Nursing indicated the investigation from the fall on 1-5-2012 could not be located. She further indicated Resident #R had been in the bathroom next to the dining room, was left alone and fell in the bathroom. There were no new interventions put into place to prevent Resident #R from falling. A nurse's note, dated 1-17-2012 at 4 p.m., indicated Resident #R had fallen by the bed. A review of Resident #R's care plan indicated no new intervention had been put into place to prevent further falls. b. Nurse's notes, dated 12-4-2011 at 5:45 a.m., indicated Resident #R fell attempting to self transfer while in the			

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	bathroom. A Fall investigation report, dated 12-4-2011, indicated Resident #R had been attempting to go to the bathroom when she fell. Resident #R was sent to the hospital with a fractured hip and no new intervention was initiated. A nurse's note, dated 1-5-2012 at 5 p.m., indicated Resident #R had fallen. In an interview 1-18-2012 at 1:40 p.m., the Director of Nursing indicated the investigation from the fall on 1-5-2012 could not be located. She further indicated Resident #R had been in the bathroom next to the dining room, was left alone and fell in the bathroom. In an interview on 1-18-2012 at 2 p.m., RN #1 indicated Resident #R should not have been left alone when in the bathroom. A policy titled fallen resident policy/ procedure, dated 6/2008, did not indicate staff were to follow interventions to prevent falls. 2. Resident #S record was reviewed 1-18-2012 at 2:45 p.m. Resident #S diagnoses included but were not limited to dementia, depression, and diabetes.			

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	Nurse's notes, dated 9-7-2011 at 8:30 a.m., indicated Resident #S fell in the bathroom. Resident #S denied hitting her head and there was no obvious injury. Neurological checks were initiated. Fall investigation report, dated 9-7-2011, did not indicate any interventions were initiated to prevent further falls. In an interview on 1-19-2012 at 10:30 a.m., the Director of Nursing indicated interventions should have been attempted to prevent further falls. A care plan titled risk for falls, dated 7-1-2011, did not indicate any new interventions were initiated after the fall on 9-7-2011. A policy titled fallen resident policy/ procedure, dated 6/2008, did not indicate interventions were to be initiated to prevent further falls. This Federal tag relates to complaint number IN00102099. 3.1-45(a)(2)			

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F0329 SS=D	Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			
	Based on interview and record review, the facility failed to monitor medication side effects per physician's order for 1 of 3 residents reviewed with Coumadin monitoring orders in a sample of 5 (Resident #R). Findings include: Resident #R's record was reviewed 1-19-2012 at 10:45 a.m. Resident #R's diagnoses included but were not limited to depression, anxiety, and dementia. A physicians order, dated 10-24-2011,	F0329	The LPN who did the re-admission orders for Resident #R is no longer in the position of day shift charge nurse at the facility. The lab orders which had not been implemented upon Resident R's return from the hospital on 12/13/11 were implemented on 12/31/11. All residents in the facility are identified as having potential to be affected. All admission orders or re-admission orders will be reviewed by the Director of Nursing or her designee on the next business day after a resident is admitted or re-admitted. This review will determine if all orders,	02/18/2012

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NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203	

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	indicated Coumadin was to be given 4 mg on Sunday and Thursday and 3 mg Monday, Tuesday, Wednesday, Friday and Saturday. PT/INR monitoring was to be completed every Monday. A current physician's order, dated 12-13-2011, indicated Resident #R was to receive Coumadin 3 milligrams (mg) daily with monitoring lab tests PT/INR to be drawn every Monday and Thursday. A review of labs indicated the labs PT/INR should have been drawn on the following dates: 12-16, 12-20, 12-23, 12-26, 12-29, 1-2, 1-5, 1-9, 1-12, and 1-16. There were PT/INR results recorded for 12-31, 1-5 ,1-9, 1-12 and 1-16. There were no PT/INR results recorded for 12-16, 12-20, 12-23, 12-26, 12-29, and 1-2. PT/INR results for 11-28-2011 were PT- 34.2 and INR-2.5. Results for 12-31-2011 were PT 26.8 and INR 2.0. In an interview on 1-19-2012 at 1:40 p.m., the Director of Nursing indicated no further PT INR's could be located and she had discovered the PT/INR's were not being drawn per order on 12-30-2011, so she called the physician and reordered the tests so the labs would be drawn. A policy titled medication monitoring		including lab orders, orders for staple removal, follow-up physician appointments, medication orders, etc. were handled appropriately to ensure that they are implementation as ordered. Any orders that had been missed by the admitting nurse will be corrected at the time of this review, and the admitting nurse will be counseled as needed if he/she failed to implement all physician's orders appropriately. An inservice for all licensed nurses is scheduled for Tuesday 2/07/12 to re-educate nurses about the importance of admission orders and re-admission orders, as well as the review that will take place on the next business day. The DON or designee will report the results of the post-admission chart review to the Administrator. Admission and re-admission chart reviews will be discussed at our Quality Assurance meeting monthly X 3 months and then no less than quarterly thereafter on an ongoing basis as a method to monitor the effectiveness of this plan to make sure all physicians orders are followed. The Administrator and Director of Nursing are responsible for compliance. Completion date 2/18/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/19/2012
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	,dated January 2007, indicated the facility staff would be responsible to monitor for possible medication related adverse consequences. This Federal tag relates to complaint number IN00102099. 3.1-48(a)(3)			