

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/02/2015
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NAME OF PROVIDER OR SUPPLIER  SENIOR SUITES AT THE LELAND, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 900 SOUTH A STREET RICHMOND, IN 47374
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R 0000  Bldg. 00	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: June 1 and 2, 2015</p> <p>Facility number: 012497 Provider number: 012497 AIM number: N/A</p> <p>Census bed type: Residential: 74 Total: 74</p> <p>Census payor type: Medicaid: 50 Other: 24 Total: 74</p> <p>Sample: 8</p> <p>These State findings are cited in accordance with 410 IAC 16.2-5.</p>	R 0000	<p>Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies rendered by the reviewing agency. The Plan of Correction is prepared and executed solely because it is required by the provisions of and state law. Senior Suites at the Leland maintains that the alleged deficiencies do not individually or collectively jeopardize the health and/or the safety of its residents nor are they of such character as to limit the provider's capacity to render adequate resident care. Furthermore, Senior Suites at the Leland asserts that it is in substantial compliance with regulations governing the operation of assisted living facilities, and this Plan of Correction in its entirety constitutes this provider's credible allegation of compliance and, thereby, we request resurvey to verify such as of June 30th , 2015 . Further, we request desk review (paper compliance) for compliance, if acceptable. Completion dates are provided for procedural processing purposes to comply with state regulations, and correlate with the most recent contemplated or accomplished</p>	

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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R 0117 Bldg. 00	<p>410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on interview and record review, the facility failed to provide a staff member on site at all times with a current CPR (cardiopulmonary resuscitation)</p>	R 0117	<p>corrective action. These do not necessarily chronologically correspond to the date that Senior Suites at the Leland is under the opinion that it was in compliance with the requirements of participation or that corrective action was necessary.</p> <p><u>1. What corrective action(s) will be accomplished for the resident(s) found to be affected by the alleged deficient practice?1.)</u> No residents were so</p>	06/22/2015

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	<p>certification. This had the potential to affect all 74 residents.</p> <p>Findings include:</p> <p>A review of the employee listing form on 6/2/15 at 2:50 p.m., indicated a total of 51 current employees. Of the 51, the Director of Nursing (DON) indicated she did not have staff members CPR certification. She indicated the facilities former pharmacy had the certifications and she would call and have them faxed to the facility.</p> <p>On 6/2/15 at 5:20 p.m., interview with DON indicated she could not provide CPR certification on any of the staff members.</p> <p>Interview on 6/2/15 at 5:45 p.m., with the DON indicated the facility does not have a policy or procedure on CPR.</p>		<p>identified. A review of 410 IAC 16.2-5-1.4 sections a – j (2013 updated) it should be noted that the personnel files are NOT required to have evidence of a current CPR certificate contained therein. Quoting the regulation “...<i>The personnel records for all employees shall include the following: (1) The name and address of the employee. (2) Social Security number. (3) Date of beginning employment. (4) Past employment, experience, and education, if applicable. (5) Professional licensure or registration number or dining assistant certificate or letter of completion, if applicable. (6) Position in the facility and job description. (7) Documentation of orientation to the facility, including residents' rights, and to the specific job skills. (8) Signed acknowledgement of orientation to residents' rights. (9) Performance evaluations in accordance with facility policy. (10) Date and reason for separation. (i) The employee personnel record shall be retained for at least three (3) years following termination or separation of the employee from employment.....” We ask for expungement of this citation as the basis of the citation is not a requirement. 2.) <u>How will the facility identify other residents having the potential to be affected by the same alleged deficient practice and what corrective</u></i></p>				

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R 0148  Bldg. 00	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows:				<p><u>action will betaken?</u> None were so identified. 3.) <u>What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur?</u> All staff with documentation of current skills demonstration in CPR have been asked to supply a copy of same to the business office to be placed into the employee file. As new personnel are hired the same request will be made of them and copies placed as well. While not required by regulation, it is acknowledged that such action would be beneficial for future reference. Further the policy of the facility has been changed to reflect this additional item in the personnel file. 4.) <u>How will the corrective actions be monitored to ensure that the deficient practice does not recur?</u> Employee file audit form will be completed by office staff monthly – any deficiencies found as a result of the audit will be corrected. Administrator will receive a report of audit findings for follow up action, as required. 5.) EDC – 06-22-2015</p>		

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	<p>(1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility.</p> <p>(2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes.</p> <p>(3) All plumbing shall function properly and comply with state plumbing codes.</p> <p>(4) At least yearly, heating and ventilating systems shall be inspected.</p> <p>Based on observation, interview and record review, the facility failed to transport a resident in a safe manner resulting in injury, for 1 of 1 resident reviewed for facility transportation. This deficient practice could potentially affect any resident transported by the facility. (Resident #6)</p> <p>Findings include:</p> <p>Resident #6's record was reviewed on 6/2/15 at 11:39 a.m. Diagnoses included but were not limited to, atrial fibrillation, hypertension, diabetes mellitus, and renal insufficiency.</p> <p>A local hospital note for Resident #6 dated 6/1/15 at 1:58 p.m., indicated the following: "IMPRESSION: 1. Head injury on Coumadin. 2. A 6 cm (centimeter) scalp laceration with 3 cm repair. PLAN: The patient was observed</p>	R 0148	<p><u>1. What corrective action(s) will be accomplished for the resident(s) found to be affected by the alleged deficient practice?</u>The resident received treatment at the local hospital as noted in the survey. The bus driver failed to follow policy regarding securing resident in bus and received disciplinary action in the form of termination, as there was injury to a resident involved.</p> <p><u>2. How will the facility identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken?</u>None were so identified.</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur? All residents are advised at admission that motorized carts cannot be used as a seat in the bus. Residents who use a motorized cart (scooter) will receive a notice</p>	06/22/2015

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	<p>here for a period of about 2-1/2 hours. He had no headache or altered mental status. I am going to recommend continued head injury precautions for the next 24 hours. Tylenol for headache. Staples out 1 week. wound care instructions provided."</p> <p>On 6/1/15 at 2:10 p.m., the Director of Nursing (DON) provided an "Accident or Incident Report" for Resident #6. The report indicated the following: "Detailed Description of accident/incident: Was riding on bus to see wife at (name of Long Term Care Facility) traveling on (name of local street). Upon coming around the first curve residents chair tipped over w (with)/ him in it. Cut to the back of head bleeding. Driver (name of driver) took resident to ER."</p> <p>An interview with the Facility's Bus Driver on 6/2/15 at 9:06 a.m., indicated she was transporting Resident #6 to a local Long Term Care facility. While driving, she heard a noise and saw through her rear view mirror, Resident #6 and his electric motorized wheelchair lying on the floor, in the back of the bus. After pulling the bus over, she pulled the wheelchair off of Resident #6 and sat it back up on its wheels. She indicated Resident #6 was too large for her to help stand, so she helped him sit up in the</p>		<p>reiterating that policy. All approved drivers of the facility van will be in-serviced on the correct procedure to secure wheelchairs and residents in the van. Return demonstration will be required. <u>4. How will the corrective actions be monitored to ensure that the deficient practice does not recur?</u> Supervisor will at least weekly spot check the drivers to be sure that the residents and wheelchairs are properly secured before the bus moves. If not, immediate 1 on 1 in-servicing will occur to allow for learning. After the 3 re-educations, disciplinary action will be commenced up to and including discharge. Expected date of completion – 06.22.2015</p>				

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	<p>back of the bus on the floor. Resident #6 was bleeding from the right side of his head. She provided Resident #6 with a paper towel to hold on his head and drove him to a local emergency room. There was one other resident fastened securely in a seat on the bus. She indicated she had never secured electric motorized wheelchairs or standard wheelchair to the floor and never placed any type of seat belt to residents seated on their electric motorized wheelchairs. Metal cleats were observed attached to the floor in the back of the bus and a pile of miscellaneous straps with hooks attached, lying in the back of bus on the floor. The Bus Driver indicated Maintenance Staff was going to train her that day on how to secure electric motorized wheelchairs and standard wheelchairs to the floor of the bus.</p> <p>An interview with the Maintenance Supervisor on 6/2/15 at 10:55 a.m., indicated the Facility Bus was equipped with straps to secure electric motorized wheelchairs and standard wheelchairs to the floor of the bus and also seatbelts to go around the residents in those wheelchairs. The straps hooked into the metal cleats on the floor of the bus. The previous Bus Driver no longer employed at the facility had trained the facility's current Bus Driver. No documentation</p>			

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R 0383 Bldg. 00	<p>was available the facility's current Bus Driver had been trained how to secure wheelchairs to the floor of the bus. The facility's current Bus Driver was the only Bus Driver employed by the facility.</p> <p>On 6/2/15 at 2:40 p.m., Resident #6 was observed with 6 staples in the back of his head, a small dime size scab near his right temple, and a bandage wrapped around his right elbow. He indicated he sustained his injures when himself and his wheelchair tipped over in the Facility's bus on 6/1/15. An electric motorized wheelchair was observed in his room. He indicated it was the wheelchair that had tipped over in the Facility's bus. He indicated the Facility's Bus driver had assisted him to sit up after the accident and drove him to a local hospital.</p> <p>410 IAC 16.2-5-11.1(g)(1-2) Mental Health Screening - Deficiency (g) The residential care facility, in cooperation with the mental health service providers, shall develop the comprehensive careplan for the resident that includes the following: (1) Psychosocial rehabilitation services that are to be provided within the community. (2) A comprehensive range of activities to meet multiple levels of need, including the following: (A) Recreational and socialization activities.</p>			

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	<p>(B) Social skills. (C) Training, occupational, and work programs. (D) Opportunities for progression into less restrictive and more independent living arrangements.</p> <p>Based on interview and record review the facility failed to implement a comprehensive care plan in cooperation with an mental health facility for 2 of 2 residents with a diagnosis of a major mental illness (Resident #4 &amp; #5).</p> <p>Findings include:</p> <p>1.) Review of the record of Resident #4 on 6/1/15 at 12:20 p.m.. indicated the resident's diagnoses included, but was not limited to, latent schizophrenia, personality disorder and bipolar.</p> <p>Resident #4's record did not have a comprehensive care plan in conjunction with the local mental health facility.</p> <p>Interview with the Director Of Nursing (DON) on 6/1/15 indicated Resident #4 did not have a comprehensive careplan in conjunction with the local mental health facility because the facility was not required to have a care plan addressing a major mental illness.</p> <p>2.) Review of the record of Resident #5 on 6/2/15 at 11:40 a.m., indicated the</p>	R 0383	<p><u>1. What corrective action(s) will be accomplished for the resident(s) found to be affected by the alleged deficient practice?</u> The residents have a comprehensive care plan in place. <u>2.How will the facility identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken?</u> Those residents with the propensity to be affected by the same alleged deficient practice would be identified as those with a major mental illness. 5 were so identified. Comprehensive Care plans are in place. <u>3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur?</u> All such residents will have the care plan reviewed at least quarterly and updated as necessary. <u>4. How will the corrective actions be monitored to ensure that the deficient practice does not recur?</u> The Nursing Supervisor will monitor the residents with a major mental illness (Schizophrenia, Schizoaffective disorder, Mood (bipolar and major depressive type) disorder, Paranoid or delusional disorder, Panic or</p>	06/22/2015

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	<p>resident's diagnosis included, but were not limited to, bipolar disorder.</p> <p>Resident #5's record did not have a comprehensive care plan addressing a major mental illness in conjunction with the local mental health facility.</p> <p>Interview with the DON on 6/2/15 at 12:30 p.m., indicated Resident #5 did not have a careplan in conjunction with the local mental health facility addressing the resident's major mental illness.</p> <p>Interview with the DON on 6/2/15 at 1:40 p.m., indicated a local agency kept track of resident's with mental illness and formulated a careplan for the resident and the facility therefore did not have a careplan.</p>		<p>other severe anxiety disorder, Somatoform or paranoid disorder, Personality disorder, Atypical psychosis or other psychotic disorder(not otherwise specified)) and assure that upon admission such care plan is developed. Monthly the administrator will complete a review of the residents so affected. 5. Expected date of completion – 06.22.2015</p>		