

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155292	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/08/2014
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NAME OF PROVIDER OR SUPPLIER  AMERICAN VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2026 E 54TH ST INDIANAPOLIS, IN 46220
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit included a State Residential Licensure Survey.</p> <p>Survey dates: December 2, 3, 4, 5, &amp; 8, 2014.</p> <p>Facility number: 000189 Provider number: 155292 AIM number: 100267330</p> <p>Survey team: Megan Burgess, RN, TC Lora Brettnacher, RN (December 3, 4, 5, 8, 2014) Tracina Moody, RN Kewanna Gordon, RN (December 3, 5, 8, 2014)</p> <p>Census bed type: SNF: 32 SNF/NF: 104 Residential: 67 Total: 203</p> <p>Census payor type: Medicare: 29 Medicaid: 88 Other: 19 Total: 136</p>	F000000	<p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p> <p>This provider respectfully requests that the 2567L Plan of Correction be considered the Letter of Credible Allegation and requests a Desk Review on or after January 7, 2015.</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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F000248 SS=E	<p>Sample: 9</p> <p>These deficiencies reflect state findings in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed 12/10/14 by Brenda Marshall, RN.</p> <p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, record review, and interview, the facility failed to ensure residents were provided with activities designed to meet their interest and their physical, mental, and psychosocial well being for 4 of 4 residents reviewed for activities (Residents #180, #139, #148, and #114).</p> <p>Findings include:</p> <p>1. Resident #180's record was reviewed on 12/08/2014 at 10:27 a.m. Resident #180 had diagnoses which included, but were not limited to, dementia and</p>	F000248	<p><b>F248 ACTIVITIES MEET INTERESTS/NEEDS OF EACH RESIDENT</b></p> <p>It is the practice of this provider to ensure that all alleged violations involving activities meet interests/needs of each resident are in accordance with State and Federal law.</p> <p><b>What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?</b></p> <p>The facility reviewed and updated</p>	12/30/2014			

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	<p>depression. A Minimum Data assessment tool (MDS) dated 11/30/14, indicated Resident #180 had severe cognitive impairment with a Brief Interview for Mental Status score (BIMS) of 3 out of 15.</p> <p>During observations on 12/04/2014 from 1:22 p.m. to 2:07 p.m., Resident #180 was observed. At 1:22 he was observed going through a trash can in resident room 112. The resident who resided in this room was observed seated in a recliner. At 2:07 p.m., Certified Nursing Assistant (CNA) #2 was observed entering room 112 and removing the trash can from Resident #180. CNA #2 was observed exiting room 112 without redirecting Resident #180 out of room 112. At 2:08 p.m., LPN #1 was observed looking into room 112 then walk away without redirecting Resident #180 out of resident room 112. At 2:13 p.m., Resident #180 was observed standing by a bed in room 112. He was observed pulling on the call light cords and attempting to pick up the bedside table which was knocked over leaning against the bed. At 2:28 p.m., CNA #2 entered room 112 and redirected Resident #180 back to his own room. The activity calendar indicated an activity titled "afternoon stroll" followed by an activity titled "reading buddies" was scheduled</p>		<p>resident # 180, #139, #148 and #114's activity care plans. The facility is providing activities to residents identified per their preference, interest and care plan.</p> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <p>All residents have the potential to be affected by this alleged deficient practice. Cottage staff has been educated on Re-directing wandering residents, activities schedules, and activity care plans by the Memory Care Facilitator or designee on or before 12/30/2014.</p> <p>All residents families on Cottage 3 were re-interviewed to ensure activity interest were accurate by Memory Care Facilitator or designee. Activity calendar was developed based on resident preference and interest by Memory Care Facilitator.</p> <p><b>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</b></p>		

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	<p>during this time.</p> <p>During observations on 12/05/2014 from 2:11 p.m. to 2:30 p.m., Resident #180 was observed wandering in the hallway looking into other residents' rooms. At 2:15 p.m., he was observed attempting to enter the activity/dining room at which time CNA #4 redirected him to a chair in the hallway. At 2:21 p.m., Activity Staff #10 asked Resident #180, "Where is your wheel chair you are going to fall? " Activity Staff #10 took Resident #10 to his room. At 2:25 p.m., Resident #180 was observed standing in the hallway turning the light switch off and on. Activity Staff #10 was observed walking down the hall way. She passed Resident #180 and did not stop to talk to him. At 2:28 p.m., Resident #180 was observed messing with the hand sanitizer dispenser in the hallway. At 2:29 p.m., Resident #180 was observed wandering into a female resident's room in room 100. Staff was not observed to encourage Resident #180 to participate in the scheduled activity.</p> <p>During an observation on 12/8/14 at 8:15 a.m., Resident #180 was observed seated in a wheel chair in the hall way positioned towards a wall. The activity calendar indicated an activity titled "music" was scheduled at this time.</p>		<p>Activities staff have been educated on activity preferences and following the residents activity care plan by the Memory Care Facilitator or designee on or before 12/30/2014.</p> <p>A daily/activity preferences form will be completed upon admission and quarterly updated with significant changes by the activities director. The residents care plan will then be updated with the current resident activity preferences by the activities director or IDT team. The activities director will utilize an activity attendance record to ensure residents are offered / participating in their activity preference based on the residents care plan.</p> <p><b>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?</b></p> <p>The Memory Care Facilitator/ designee will review activity calendar daily, to ensure activities are planned based on resident interests as identified in residents care plan. The attendance records will be monitored by the Memory Care</p>	

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	<p>During an observation on 12/8/14 at 10:05 a.m., Resident #180 was observed seated in a wheel chair in the hallway positioned towards a wall. A ball toss activity was provided at the other end of the unit.</p> <p>A comprehensive assessment Minimum Data Set basement tool(MDS), dated 1/22/14, indicated it was very important to Resident #180 to have books, newspapers, and magazines to read; somewhat important for him to listen to music he liked: and very important for him to do his favorite activities, go outside to get fresh air when the weather was good, and to participate in religious services This MDS indicated Resident #180 required extensive assistance from staff for transfers, bed mobility, and locomotion on the unit.</p> <p>An activity care plan, dated 1/24/14, indicated Resident #180 enjoyed: trivia, socials, games, music, listening programs, and movies. A goal indicted he would participate in three activities per week. Approaches included staff was to assist him to activities as necessary, observe his whereabouts at all times, encourage activity attendance, give verbal reminders as to time and place of activities.</p>		<p>Facilitator/ designee to ensure the records are accurate. TheMemory Care Facilitator will conduct rounds on Cottage 3 during the day toensure the resident who wished to participate in activities of choice areencouraged to participate.</p> <p>The Cottage Activity CQIaudit tool will be completed for six months with audits being completed onweekly for one month, and then monthly for 6 months by Memory Care Facilitatoror designee.</p> <p>The Cottage Activity CQIaudit tool will be reviewed monthly by the CQI Committee for six months after whichthe CQI team will re-evaluate the continued need for the audit. If a 95% threshold is notachieved an action plan will be developed. Deficiency in this practice willresult in re-education and training of the responsible employee.</p> <p><b>By what datethe systemic changes will be completed?</b> Date of Compliance 12/30/2014</p>		

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	<p>An activity attendance document for December 1-8, 2014, was reviewed on 12/8/13 at 2:30 p.m. This document indicated Resident #180 was not available for activities on 12/4/2014 from 2:00 through 4:00 p.m. and was actively participating in scheduled activities on 12/5/14 from 8:00 a.m. through 10:30 a.m.</p> <p>During an interview on 12/8/14 at 11:33 a.m., Activity Staff #8 indicated Resident #180 was "lonely" and enjoyed staff talking to him. Activity Staff #8 was queried regarding the discrepancies between observations made of Resident #180 and documentation recorded on the activity attendance document. She indicated the activity staff who documented his attendance was not available. She was queried as to why Resident #180 was marked as "other" on the document for December 4, 2014. She indicated if residents were in the hallway or unavailable due to care she "marks" them as "other" on the attendance record.</p> <p>2. Resident #139's record was reviewed on 12/05/2014 at 2:49 p.m. Resident #139 had diagnoses which included, but were not limited to, dementia, depressive disorder, and Alzheimer' s disease. A quarterly Minimum Data Set assessment</p>						

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	<p>tool (MDS), dated 9/30/14, indicated Resident #139 had severe cognitive impairment with a Brief Interview for Mental Status score (BIMS) of 3 out of 15.</p> <p>During observations on 12/4/14 from 2:13 p.m. to 2:32 p.m., Resident #139 was observed. At 2:13 p.m., Resident #139 wandered into and around room 112. At 2:15 p.m., Resident #139 sat on a bed in room 112. At 2:28 p.m., Certified Nursing Assistant (CNA) #2 entered room 112 to redirect another resident who had wandered into room 112. CNA #2 did not redirect Resident #139 out of the room. Resident #139 was observed to remain in room 112 until 2:32 p.m., at which time CNA #2 returned to room 112 and redirected him out of room 112. The activity calendar indicated an activity titled "reading buddies" was scheduled at this time.</p> <p>During observations on 12/05/2014 at 1:43 p.m. to 1:59 p.m. Resident #139 was observed. Resident #139 was seated in a chair pushed up to a table in the hallway. Staff was not present, music or television was not playing, and Resident #139 did not have anything on the table for cognitive stimulation. At 1:50 p.m., Resident #139 began shredding a paper napkin. At 1:51 p.m., CNA #4</p>				

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	<p>approached Resident #139 and removed the shredded napkin. At 1:52 p.m., CNA #5 approached Resident #139 and asked, "Do you want to go to your room?" Without waiting for a response, CNA #5 walked away from Resident #139. At 1:59 p.m., Resident #139 began thumping his head with his hand. A housekeeping staff sprayed the table where Resident #139 was seated with cleaner, wiped the table with a cloth, and without communicating or interacting with Resident #139 walked away. The activity calendar indicated an activity titled "afternoon stroll " was scheduled at this time.</p> <p>During an observation on 12/05/2014 at 2:12 p.m., Resident #139 remained seated in the hallway at the same table without activities. The activity calendar indicated an activity titled "reading buddies" was scheduled at this time.</p> <p>During an observation on 12/5/14 at 2:21 p.m., Resident #139 remained seated in the hallway at a table without anything provided for cognitive stimulation. The activity calendar indicated an activity titled "reading buddies" was scheduled at this time.</p> <p>During an observation on 12/8/14 at 8:15 a.m., Resident #139 was observed seated</p>				

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	<p>at the side of his bed. No music or television provided. The activity calendar indicated a "music" activity was scheduled at this time.</p> <p>During an observation on 12/8/14 at 10:05 a.m., Resident #139 was observed seated at the edge of his bed with the bedside table in front of him without music, television, or activity. A balloon toss activity was being provided on the unit at this time.</p> <p>A comprehensive assessment MDS, dated 1/14/14, indicated Resident #139 indicated it was very important for him to: have books, newspapers, magazines, to read, listen to music he liked, be around animals, keep up with the news, do thing with groups, participate in his favorite activities, go outside when the weather was nice, and participate in religious services or practices. This MDS indicated Resident #139 needed extensive assistance from staff for bed mobility and transfers and limited assistance of staff for walking.</p> <p>A current activity care plan indicated as of 9/1/12, Resident #139 enjoyed activities with exercise, bus rides, trivia, walking, porch fun, socials, music programs, and listening to music. A goal indicated Resident #139 would</p>			

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	<p>participate in 2 to 3 activities week. Interventions to meet this goal included staff was to assist him to activities as necessary, provide verbal reminders as to time and place of activities, and encourage activity attendance.</p> <p>An activity attendance document for December 1-8, 2014, was reviewed on 12/8/13 at 2:30 p.m. This document indicated Resident #139 passively participated in activities on December 4th from 1:30 p.m. through 3:30 p.m.; he was unavailable for the 9:30 a.m. scheduled activities on December 5th, actively participated in the scheduled activities at 10:00, and 10:30 a.m., and passively participated in scheduled activities at 11:00 a.m., 11:30 a.m., 1:00 p.m., and 2:00 p.m.; and he was unavailable for activities on December 8th from 9:30 -11:30 a.m.</p> <p>During an interview on 12/8/14 at 11:33 a.m., Activity Staff #8 indicated Resident #139 was "lonely" and enjoyed it when they talked to him about his "friend." She indicated he wanted "more attention." Activity Staff #8 was queried regarding the discrepancies between observations made of Resident #139 and documentation on the activity attendance document. She indicated she did not work on December 5th and the</p>						

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	<p>activity staff who documented his attendance was not available. She did not have an explanation for December 4 or December 8, 2014.</p> <p>3. Resident #148's record was reviewed on 12/05/2014 at 3:07 p.m. A comprehensive full Minimum Data Set assessment tool (MDS), dated 6/3/14, indicated Resident #148 had severe cognitive impairment with a Brief Interview for Mental Status score of 0 out of 15.</p> <p>During an observation on 12/4/14 at 2:35 p.m., Resident #148 was observed seated in a recliner in his room alone with his eyes open, blinds closed, lights off, no television or music playing. The activity calendar indicated an activity titled "reading buddies" was scheduled at this time.</p> <p>During an observation on 12/5/14 at 1:43 p.m., Resident #148 was observed seated in his wheelchair in the hallway outside the dining/activity room with his eyes open and his head resting on his hand. Staff was not present, music or television was not playing, and Resident #148 did not have anything provided for cognitive stimulation. The activity calendar indicated an activity titled "afternoon stroll" was scheduled at this time.</p>			

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	<p>During an observation on 12/05/2014 at 1:52 a.m., staff took Resident #148 to his room, transferred him from his wheel chair to his recliner, and left the room. The blinds were closed, the lights were off, and television or radio was not on. The activity calendar indicated a activity titled "afternoon stroll" was scheduled at this time.</p> <p>During an observation on 12/05/2014 at 2:13 p.m., Resident #148 was observed seated in his recliner in his room alone with his eyes open, the blinds closed, the lights off, no television or music on. The activity calendar indicated an activity titled "reading buddies" was scheduled at this time.</p> <p>During an observation on 12/05/2014 at 2:22 p.m., Resident #148 was observed seated in his room alone, in the dark, with no television or music. The activity calendar indicated an activity titled "reading buddies" was scheduled at this time.</p> <p>During an observation on 12/8/14 at 8:15 a.m., Resident #148 was observed in his room. No music or television provided. The activity calendar indicated an activity titled "music" was scheduled at this time.</p>						

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	<p>During an observation on 12/8/14 at 10:05 a.m., Resident #148 was observed in bed. Music or television was not provided. A balloon toss activity was provided on the unit at this time. .</p> <p>A 6/3/14, Minimum Data Set assessment tool (MDS) indicated Resident #148 enjoyed listening to music, reading books, newspapers, or magazines, keeping up with the news, doing things with groups of people, participating in his favorite activities, spending time away from the nursing home, participating in religious activities or practices. This MDS indicated he required extensive assistance from staff for bed mobility, transfers, and locomotion on the unit</p> <p>A current activity care plan, dated 10/4/12, indicated Resident #148 enjoyed reading the bible, listening to spiritual music, church, exercise, working on "tables." A goal indicated he would participate in three spiritual music listening activities per week without falling asleep. Approaches to meet this goal included staff was to provide him with reading materials such as "newspaper and magazines," assist to activities as necessary, encourage activity attendance, give verbal reminders as to the time and place of activities.</p>			

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	<p>An activity attendance document for December 1-8, 2014, was reviewed on 12/8/13 at 2:30 p.m. This document indicated Resident #148 was unavailable or "other" for activities on December 1, 2, 3, 4, 5, and 8th with the exception of a group activity of Trivia on the 5th, music during lunch on the 5th, and snowy day read and trivia (both group activities) on December 8, 2014.</p> <p>During an interview on 12/08/2014 at 10:56 a.m., Activity Staff #8 indicated Resident #148 "liked his church music." She indicated he liked being talked to "as if he is okay." She indicated he would respond to you "depending on your approach." She indicated his wife had headphones for him to listen to music but she would not leave them at the facility because they were too expensive. She indicated the facility did not provide head phones for him to listen to music. Activity Staff #8 was queried regarding the discrepancies between observations made of Resident #139 and documentation of his "availability" on the activity attendance document. She did not have an explanation.</p> <p>4. Resident #114's record was reviewed on 12/4/14 at 12:51 p.m. Resident #114 had a diagnosis which included, but was not limited to, dementia. A Minimum</p>						

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	<p>Data Set assessment tool (MDS), dated 10/14/14, indicated Resident #114 had severe cognitive impairment with a Brief Interview for Mental Status score (BIMS) of 0 out of 15.</p> <p>During an observation on 12/3/14 at 11:40 p.m., Resident #114 was observed wandering in and out of residents' rooms. The activity calendar indicated an activity titled "music" was scheduled at this time.</p> <p>During observations made on 12/4/14 from 2:10 p.m. to 2:28 p.m., Resident #114 was observed seated at a table in the hallway outside of the dining/activity room. Resident #114 was seated in a chair scooted up to a table. Resident #114 had his eyes open and was mumbling out loud. Resident #114 did not have any type of entertainment, books, music, or stimulation available for him at the table. Staff or other residents were not present in the area. At 2:28 p.m. staff was observed putting Resident #114 into a chair in his room and leaving him there. The activity calendar indicated an activity titled "reading buddies" was scheduled at this time.</p> <p>During an observation on 12/05/2014 1:43 p.m., Resident #114 was observed seated in a chair pushed up to a table in the dining/activity room. One other</p>			

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	<p>resident was observed sleeping in the dining room at this time. Staff was not present. Music was not playing, the television was not on, and Resident #114 did not have any form of cognitive simulation activity on the table. The activity calendar indicated an activity titled "afternoon stroll" scheduled at this time.</p> <p>During an observation on 12/05/2014 at 1:50 p.m., CNA #4 escorted Resident #114 from the dining room to his room. The activity calendar indicated an activity titled "afternoon stroll" was scheduled at this time.</p> <p>During an observation on 12/5/14 at 1:55 p.m., Resident #114 was observed seated in his recliner in his room looking out towards the hallway. Television or music was not turned on for him. The activity calendar indicated an activity titled "afternoon stroll" was scheduled at this time.</p> <p>During an observation on 12/5/14 at 2:23 p.m., Resident #114 was observed seated in his room in a chair looking out towards the hallway. The activity calendar indicated an activity titled "sensory stimulation" was scheduled at this time.</p>			

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	<p>During an observation on 12/8/14 at 8:15 a.m., Resident #114 was observed in his room. Television or music not on. The activity calendar indicated an activity titled "music" was scheduled at this time.</p> <p>During an observation on 12/8/14 a.m. at 9:30 a.m., Resident #114 was observed wandering up and down the hall. He entered room 102 and stood in the middle of the room CNA #6 was observed transporting a female resident out of room 102 at this time. CNA #6 left Resident #114 unattended in the room where a female resident was resting in her bed. CNA #6 did not redirect Resident #114 out of room 102. The activity calendar indicated a activity titled "morning sensory" was scheduled at this time.</p> <p>During an observation on 12/8/14 at 10:05 a.m., Resident #114 was observed wandering up and down the hall way. The activity calendar indicated a activity titled "balloon toss" was scheduled at this time.</p> <p>A comprehensive MDS, dated 7/20/14, indicated Resident #114 enjoyed being outdoors, participating in his favorite activities, music, keeping up with the news, and religious/spiritual activities. This MDS indicated Resident #114</p>			

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	<p>required assistance from staff for transfers.</p> <p>A current activity care plan which originated on 1/12/12, indicated Resident #114 had difficulty staying the duration of groups of his interest due to he got up and wandered out of groups. He needed "one on one" activities for stimulation. A goal indicated he would actively or passively participate in 1 one on one activity a day and smaller groups of his interest with others for 10-15 minutes a week. Approaches to meet this goal indicated staff would observe his whereabouts at all times when he was off the unit participating in groups of his interest and staff would encourage him to participate in ball toss, trivia, socials, bus rides, walks.</p> <p>An activity attendance document for December 1-8, 2014, was reviewed on 12/8/13 at 2:30 p.m. This document indicated Resident #114 was unavailable or "other" for activities all day on December 3, with the exception of an activity titled "afternoon stroll" which was scheduled at 1:30 p.m., and a music activity scheduled at 2:00 p.m. The record indicated he was unavailable or "other" for activities on December 4, with the exception of music played in the dining room at lunch and "after noon</p>			

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	<p>stroll" scheduled at 1:30 p.m. The record indicated he was unavailable or "other" on December 5th for activities from 8:30-10-30 a.m., passively participated in trivia scheduled at 11:00, music played at lunch, and "afternoon stroll" scheduled at 1:30 p.m., unavailable for activities at 2:00 p.m. The record indicated he was unavailable on December 8, for activities scheduled at 9:30 a.m., 10:00 a.m., and passively participated in an activity at 10:30 a.m.</p> <p>During an interview on 12/5/14 at 1:48 p.m., CNA #4 indicated, Resident #114 would not get up out of a chair on his own but once they assisted him up out of the chair he would walk all over.</p> <p>During an interview on 10/8/14 at 10:51 a.m., CNA #6 indicated Resident #114 enjoyed walking, music, singing, conversation, and being read to.</p> <p>During an interview on 12/08/2014 at 11:15 a.m., Activity Staff #8 indicated Resident #114 did not do well in group activities. She indicated he would come for the "juice and snacks" but his attention span was not long enough to sit through a large group activity. She indicted he "loved" music especially jazz music and he "loved" to walk with staff. She indicated he enjoyed having</p>			

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	<p>someone talk to him and read to him. She indicated if he "walked from the dining room down the hall to his room" she counted it as participating in "afternoon stroll." Activity Staff #8 was queried regarding the discrepancies between observations made of Resident #114 and documentation of his "availability" and/or attendance on the activity attendance document. She did not have an explanation.</p> <p>During an interview on 12/8/14 at 11:33 a.m., Activity Staff #8 was queried regarding the content of the activities scheduled on Cottage 3. She indicated the following:</p> <p>Music- soft music played on the radio during meals.</p> <p>Morning Sensory Connections- telling the residents good morning and inquiring about their breakfast.</p> <p>Staying fit- limb stretches for resident who could not walk.</p> <p>Snowy Day Read- a group activity where winter theme ideas were read.</p> <p>Book Worm Trivia- a group activity were nursery rhymes were read.</p> <p>Afternoon Stroll- it was supposed to happen every day but "if the residents were in bed or unavailable it doesn't get done." Walking to their rooms after lunch or if "there is time" walking off</p>			

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	<p>the unit.</p> <p>Movie-takes place in the activity room.</p> <p>Juice and snack served.</p> <p>Sensory stimulation-table toys or sensory things like magazines.</p> <p>Big Band Music- music played while residents waited for dinner.</p> <p>Enchanted Evening- staff going to residents room and telling them "good night" helping them "wind down" for bed.</p> <p>Catch ball-tossing inflated ball in a group setting.</p> <p>Armchairs Travels-a geographic movie.</p> <p>Snacks and juice served.</p> <p>Reading Buddies-reading to residents in their rooms.</p> <p>Table games-puzzles, crayons, hand held sensory toys.</p> <p>Pretty Hands Makeover- nail care.</p> <p>Piano Melodies- a CD of soft piano music played while residents waited for dinner.</p> <p>Inspirational Listening-music played while residents waited for dinner.</p> <p>Bounce House- a firmer ball bounced back and forth with residents.</p> <p>During an interview on 12/8/14 at 11:25 a.m., The Medical Director indicated the Cottage was not physically designed to meet the psychosocial activity needs of the residents who resided there. She indicated she was aware of the lack of</p>			
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	<p>activity programming for dementia residents. She indicated it has been a problem for a long time. She indicated the facility had been in need of a better activity program especially for male residents and residents with dementia.</p> <p>During an interview on 12/08/2014 at 12:01 p.m., Activity Staff #8 indicated the lack of space available for activities limited the activity programming for the Cottage. She indicated activities could be more personalized and better meet the needs of the residents if she had more sensory type equipment, better videos, more staff involvement, and a personalized music program for residents who could not participate in group activities.</p> <p>During an interview on 12/08/2014 at 12:11 p.m., the Social Service Director indicated staff was to redirect residents who wandered into other residents' rooms and provide them with meaningful activities to reduce the wandering behaviors.</p> <p>During an interview on 12/08/2014 12:24 p.m., the Director of Nursing (DON) stated, "We are aware of the need for meaningful activities for the Cottage. We just haven't done anything yet."</p>			

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F000279 SS=D	<p>A policy titled "Activities" identified as current by the Social Service Director on 12/8/14 at 1:20 P.M., indicated, " It is the policy of this facility to provide for an ongoing program of activities designed to need the interests and the physical, mental, and psychosocial well-being of each resident in accordance with the comprehensive assessment...."</p> <p>3.1-33(a) 3.1-33(c)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview,</p>	F000279	F 279DEVELOP	12/23/2014			

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	<p>the facility failed to ensure a comprehensive care plan was developed for 1 of 5 residents reviewed for care plans related to unnecessary medications (Resident #222).</p> <p>Findings include:</p> <p>Resident #222's record was reviewed on 12/4/14 at 3:00 p.m. Her diagnosis included, but was not limited to, uncontrolled Diabetes Mellitus Type 2 with complications. The Minimum Data Set assessment tool (MDS), dated 11/10/14, indicated Resident #222 received insulin injections; however this was not reflected in the plan of care for the resident.</p> <p>A review of Resident #222's medications indicated she received accu checks (blood sugar monitoring) four times daily, Lantus (insulin glargine) 20 units subcutaneous (fat layer of tissue below the skin) at bedtime, and Novolog (insulin aspart) 13 units subcutaneous three times a day.</p> <p>During an interview, on 12/5/14 at 1:15 p.m., the MDS Coordinator indicated a care plan related to the diagnosis of Diabetes Mellitus and insulin administration should have been initiated for Resident #222 but this had not been</p>		<p>COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>Resident #222 care plan has been updated to include Diabetes Mellitus by MDS. <b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <p>All residents have the potential for the alleged deficient practice. All residents with diagnosis of diabetes mellitus care plans were reviewed by DNS/ Designee to ensure care plan was updated to address diabetes.</p> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b></p> <p>Upon admission nurses</p>		

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F000282 SS=E	<p>done.</p> <p>A policy titled "IDT (interdisciplinary) Care Plan Review", identified as current by the Assistant Director of Nursing (ADON) on 12/5/14 at 3:20 p.m., indicated "... The care plan will include measurable goals and resident specific interventions based on resident needs and preferences to promote the highest level of functioning including medical, nursing, mental and psychosocial needs... Care plan problems, goals and interventions will be updated based on changes in resident assessment/condition, resident preferences or family input...."</p> <p>3.1-35(b)(1)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p>		<p>will initiate residents care plan. Licensed Nurses to be in-serviced by Director of Nursing or designee on initial care plans (12/23/14). RAI specialist will provide in-service to MDS staff and IDT team in utilizing IDT care plan review guide and IDR quarterly resident review tool. DNS / designee will review the IDT resident review tool to ensure resident with Diabetes Mellitus have an accurate care plan.</p> <p><b>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?</b></p> <p>A Care Plan Updating/Review CQI tool will be utilized by MDS or designee weekly X4, monthly X2 and quarterly thereafter; if expected threshold is not achieved, an action plan will be developed.</p> <p><b>By what date the systemic changes will be completed?</b> Date of Compliance: 12/23/ 2014</p>	

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	<p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review, and interview, the facility failed to ensure behavioral interventions were implemented to prevent residents for wandering into other residents' room for 3 of 3 residents reviewed for behaviors (Residents #180, #139, and #114).</p> <p>Findings include:</p> <p>1. Resident #180's record was reviewed on 12/08/2014 at 10:27 a.m. Resident #180 had diagnoses which included, but were not limited to, dementia and depression. A Minimum Data assessment tool (MDS) dated 11/30/14, indicated Resident #180 had severe cognitive impairment with a Brief Interview for Mental Status score (BIMS) of 3 out of 15.</p> <p>During on 12/04/2014 from 1:22 p.m. to 2:07 p.m. Resident #180 was observed. At 1:22 p.m. Resident #180 was observed going through a trash can in resident room 112. The resident who resided in this room was seated in his recliner. At 2:07 p.m., Certified Nursing Assistant (CNA) #2 was observed entering room 112 and removing the trash can from Resident #180. CNA #2 was observed</p>	F000282	<p><b>F282 SERVICESBY QUALIFIED PERSONS/ PER CARE PLAN</b></p> <p>The services provided or arranged by the facility mustbe provided by qualified person in accordance with each resident's written planof care.</p> <p><b>Whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice?</b> Resident #180, #139, and # 114 care plans have beenupdated for appropriateness specific to the residents wandering behaviors. Cottage staff will be educatedon Redirecting wanderingresidents, activities schedules, and activity care plans by the Memory CareFacilitator or designee on or before 12/30/2014. <b>How will you identify other residents having thepotential to be affected by the same deficient practice and what correctiveaction will be taken?</b></p> <p>All residents have thepotential for the alleged deficient practice. Residents exhibiting wandering behavior on cottage 3, care planswere reviewed by Memory Care Facilitator to ensure residents wanderingbehaviors were addressed and interventions were applicable. <b>What measures will be put into place or what systemicchanges you</b></p>	12/30/2014			

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	<p>exiting room 112 without redirecting Resident #180 out of room 112. At 2:08 p.m., LPN #1 was observed looking into room 112 then walk away without redirecting Resident #180 out of resident room 112. At 2:28 p.m., CNA #2 entered room 112 and redirected Resident #180 to his own room. The activity calendar indicated an activity titled "afternoon stroll" followed by an activity titled "reading buddies" was scheduled during this time.</p> <p>During observations on 12/05/2014 from 2:11 p.m. to 2:30 p.m., Resident #180 was observed wandering in the hallway looking into other residents' rooms. At 2:29 p.m., Resident #180 was observed wandering into a female resident's room in room 100. Staff was not observed to redirect him out of her room.</p> <p>A care plan, dated 1/27/14, indicated Resident #180 wandered through out the unit in and out of others rooms. A goal indicated he would be free from injury related to wandering. An approach to meet this goal included staff was to "observe resident for going into other residents rooms" and behind the nurse's station and to have him attend activities of choice.</p> <p>2. Resident #139's record was reviewed</p>		<p><b>will make to ensure that the deficient practice does not recur?</b> Memory Care Facilitator will monitor daily, and do 1:1 education with staff relating to behaviors and redirecting. Memory Care Facilitator or designee will ensure that behavior interventions are addressed. Cottage staff will be educated on Redirecting wandering residents, activities schedules, and activity care plans by the Memory Care Facilitator or designee on or before 12/30/2014. Nursing staff will assist activities staff in the attendance of residents in the scheduled activities. The Memory Care Facilitator will conduct rounds to ensure residents are invited and encouraged to participate in activities if residents decline 1:1 independent activities will be provided per resident preferences. <b>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?</b> A Cottage Activity CQI tool will be utilized weekly X4, monthly X2 and quarterly thereafter; if expected threshold is not achieved, an action plan will be developed. <b>By what date the systemic changes will be completed?</b> Date of Compliance 12/30/2014</p>		

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	<p>on 12/05/2014 at 2:49 p.m. Resident #139 had diagnoses which included, but were not limited to, dementia, depressive disorder, and Alzheimer's disease. A quarterly Minimum Data Set assessment tool (MDS), dated 9/30/14, indicated Resident #139 had severe cognitive impairment with a Brief Interview for Mental Status score (BIMS) of 3 out of 15.</p> <p>During observations on 12/4/14 from 2:13 p.m. to 2:32 p.m., Resident #139 was observed. At 2:13 p.m., Resident #139 wandered into and around room 112. At 2:15 p.m., Resident #139 sat on a bed in room 112. At 2:28 p.m., Certified Nursing Assistant (CNA) #2 entered room 112 to redirect another resident who had wandered into room 112. CNA #2 did not redirect Resident #139 out of the room. Resident #139 was observed to remain in room 112 until 2:32 p.m., at which time CNA #2 returned to room 112 and redirected him out of room 112. The activity calendar indicated an activity titled "reading buddies" was scheduled at this time.</p> <p>A current care plan which originated on 5/17/12, indicated Resident #139 had a problem with wandering. A goal for him indicated he would not leave the facility unattended. Approaches to meet this</p>			

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	<p>goal included staff to provide diversion activity if resident was exit seeking and in and out of other rooms.</p> <p>3. Resident #114's record was reviewed on 12/4/14 at 12:51 p.m. Resident #114 had a diagnosis which included, but was not limited to, dementia. A Minimum Data Set assessment tool (MDS), dated 10/14/14, indicated Resident #114 had severe cognitive impairment with a Brief Interview for Mental Status score (BIMS) of 0 out of 15.</p> <p>During an observation on 12/8/14 a.m. at 9:30 a.m., Resident #114 was observed wandering up and down the hall. He entered room 102 and stood in the middle of the room CNA #6 was observed transporting a female resident out of room 102 at this time. CNA #6 left Resident #114 unattended in the room where a female resident was resting in her bed. CNA #6 did not redirect Resident #114 out of room 102.</p> <p>A current care plan which originated on 10/21/11, indicated Resident #114 had problems with intrusive wandering due to increased confusion. Approaches indicated staff would keep him occupied and observe for his location.</p> <p>During an interview on 12/3/14 at 12:04</p>			

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	<p>p.m., Licensed Practical Nurse (LPN) #1 indicated Resident #114 wandered "everywhere." She stated, "No that isn't his room. We wouldn't put a male in with a female."</p> <p>During an interview on 12/5/14 at 2:30 p.m., Licensed Practical Nurse (LPN) #9 stated, "It's not okay for them to go into other people's rooms. The wanderers need redirected." She indicated if staff see residents wandering into other residents rooms they are expected to redirect them and not to leave them alone.</p> <p>During an interview on 12/8/14 at 10:02 a.m., CNA #6 indicated she should have redirected Resident #114 out of room 102 but she "was too busy" with another resident.</p> <p>During an interview on 12/08/2014 at 12:11 p.m., the Social Service Director indicated staff was to redirect residents who wandered into other residents' rooms and provide them with meaningful activities to reduce the wandering behaviors.</p> <p>A policy titled "IDT (interdisciplinary) Care Plan Review", identified as current by the Assistant Director of Nursing (ADON) on 12/5/14 at 3:20 p.m.,</p>						

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R000000	<p>indicated "... The care plan will include measurable goals and resident specific interventions based on resident needs and preferences to promote the highest level of functioning including medical, nursing, mental and psychosocial needs... Care plan problems, goals and interventions will be updated based on changes in resident assessment/condition, resident preferences or family input...."</p> <p>3.1-35(g)(2)</p> <p>American Village Assisted Living was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.</p> <p>Quality review completed 12/10/14 by Brenda Marshall, RN.</p>	R000000	<p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p> <p>This provider respectfully requests that the 2567L Plan of Correction be considered the Letter of Credible Allegation and requests a Desk Review on or after January 7, 2015.</p>		