

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155816	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/09/2015
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NAME OF PROVIDER OR SUPPLIER ARLINGTON PLACE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1635 N ARLINGTON AVE INDIANAPOLIS, IN 46218
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00187786.</p> <p>Complaint IN00187786-Substantiated. Federal/State deficiencies related to the allegations are cited at F309 and F323.</p> <p>Survey dates: December 8 and 9, 2015</p> <p>Facility number: 013005 Provider number: 155816 AIM number: 201256400</p> <p>Census bed type: SNF: 51 SNF/NF: 24 Residential: 13 Total: 88</p> <p>Census payor type: Medicare: 43 Medicaid: 23 Other: 9 Total: 75</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 30576 on December 11, 2015</p>	F 0000	<p>Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during a Complaint (IN00187786) Survey on December 9, 2015. Please accept this plan of correction as the provider's credible allegation of compliance.</p> <p>The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</p>	
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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 0309 SS=D Bldg. 00	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on interview and record review the facility failed to initiate their bowel protocol after 72 hours of no bowel movement, for a resident with a history of constipation for 1 of 3 residents reviewed for bowel movements. (Resident #A)</p> <p>Findings include:</p> <p>Resident #A's record was reviewed on 12/8/15 at 1:09 p.m. Her diagnoses documented on her December 2015 physician recapitulation orders included but were not limited to, constipation and impaction of the intestine.</p> <p>Resident #A's quarterly Minimum Data Set (MDS) assessment dated 11/20/15, indicated she was understood and had the ability to understand others. She was cognitively intact for her daily decision</p>	F 0309	<p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #A- if no recorded bowel movement in 72 hours, ensure the timely implementation of the bowel protocol for monitoring, assessment and intervention.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: DHS or designee will complete a ongoing review during daily clinical meeting (5 times per week) of all residents with no recorded bowel movement in 72 hours to ensure the timely implementation of the bowel protocol for monitoring,</p>	01/08/2016
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	<p>making skills. She required extensive assistance of 2 persons for bed mobility. She required total dependence of 2 persons for transfer. She did not walk. She required total dependence of 2 persons to toilet. She was continent of her bowel.</p> <p>A Vitals Report for Resident #A indicated she had not had a bowel movement on 10/30/15, 10/31/15, 11/1/15, and 11/2/15.</p> <p>An Ineffective Bowel Pattern Circumstance for Resident #A dated 11/3/15 at 9:42 a.m., indicated she had not had a bowel movement for 72 hours and the Bowel Management Program was initiated.</p> <p>Resident #A's bowel movement report indicated she had a small bowel movement on 11/3/15, and no bowel movement on 11/4/15.</p> <p>A Progress Note for Resident #A dated 11/5/15 at 9:30 p.m., indicated she had complained of being constipated.</p> <p>A Progress Note for Resident #A dated 11/6/15 at 3:53 a.m., indicated she was fixated on her bowel movements. She had asked for a suppository as soon as the shift started. A bowel suppository was</p>		<p>assessment and intervention.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Licensed Nurses and CNAs on the following campus guidelines: Guideline for Bowel Protocol.</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits for 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 2 months to ensure compliance: residents with no recorded bowel movement in 72 hours to ensure the timely implementation of the bowel protocol for monitoring, assessment and intervention.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 4 months then</p>	

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	<p>administered.</p> <p>A Progress Note for Resident #A dated 11/6/15 at 4:22 p.m., indicated she had repetitively requested bowel suppositories and pain medication. A bowel suppository and Milk Of Magnesia had been administered.</p> <p>A Progress Note for Resident #A dated 11/6/15 at 8:31 p.m., indicated she had a suppository on day shift with results. The nurse continued to re-direct Resident #A and informed her that her bowel's had moved.</p> <p>A Progress Note for Resident #A dated 11/11/15 at 10:48 p.m., indicated she had been sent to a local Emergency Room. Resident #A had refused Milk Of Magnesia stating it didn't work. A bowel suppository had been administered and Resident #A had voiced no relief. She was administered a bowel enema and had a bowel movement and then became nauseous and vomited.</p> <p>A local hospital note for Resident #A dated 11/11/15, indicated Resident #A had a distal colonic impaction.</p> <p>An interview with Resident #A on 12/8/15 at 1:45 p.m., indicated she had previously been sent to a local hospital</p>		randomly thereafter for further recommendation.	

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	<p>for constipation and she suffered with constipation.</p> <p>An interview with the Director of Health Services (DHS) on 12/9/15 at 11:19 a.m., indicated the facility initiated their bowel protocol for a resident after no bowel movement for 3 days.</p> <p>An interview with the DHS on 12/9/15 at 3:38 p.m., indicated no documentation was available for Resident #A regarding a bowel movement on 10/30/15, 10/31/15, 11/1/15, and 11/2/15. The bowel protocol was not initiated for Resident #A until 11/3/15.</p> <p>The Guidelines Bowel Protocol provided by the DHS on 12/9/15 at 12:45 p.m., indicated the following: "Purpose: To provide guidance for the use of bowel stimulants for residents with constipation... 5. The Bowel and Bladder Circumstance form or Ineffective Bowel Pattern form shall be initiated for any resident not having a BM with 72 hours (unless this has been determined to be a usual bowel pattern for the individual). a. The 72 Hour follow up on the B&B Circumstance form should be completed until the resident has a BM or the bowel pattern returns to normal for the resident. b. The Ineffective Bowel Pattern form should be completed each shift until the</p>			

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F 0323 SS=D Bldg. 00	<p>resident has a BM or bowel pattern has returned to "normal" for the resident. c. The assessment of the abdomen shall be completed each shift that includes abdominal distention, pain and bowel sounds. 6. Nursing staff shall assess the effectiveness within 24 hours of the first step before proceeding to the next level. 7. If at any time there are indications of a bowel blockage the physician should be notified to receive instruction to proceed with the protocol or to intervene with further testing...."</p> <p>This federal tag relates to Complaint IN00187786.</p> <p>3.1-37(a)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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 ensure a resident was safely transferred with the use of a mechanical lift for 1 of 4 residents reviewed for transfer. (Resident #A)</p> <p>Findings include:</p> <p>Resident #A's record was reviewed on</p>	F 0323	<p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #A was observed to ensure safe transfer with use of mechanical lift.</p>	01/08/2016

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	<p>12/8/15 at 1:09 p.m. Her diagnoses documented on her December 2015 physician recapitulation orders indicated but were not limited to, spinal stenosis, hand contracture, hemiplegia and hemiparesis affecting her right dominant side, and chronic pain syndrome.</p> <p>Resident #A's quarterly Minimum Data Set (MDS) assessment dated 11/20/15, indicated she was understood and had the ability to understand others. She was cognitively intact for her daily decision making skills. She required extensive assistance of 2 persons for bed mobility. She required total dependence of 2 persons for transfer. She did not walk.</p> <p>A Resident Lift/Transfer Assessment for Resident #A dated 8/10/15, indicated she required extensive assistance with a Stand-Up Lift.</p> <p>A Fall Circumstance for Resident #A dated 11/20/15, indicated she had a witnessed fall from a Stand-Up Lift and complained of right hip pain. Immediate measures taken indicated she would be transferred with a Stand-Up Lift or (name brand of mechanical lift) with assistance of 2 persons.</p> <p>A Resident/Staff Investigation Statement for Resident #A dated 11/20/15,</p>		<p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: DHS or designee will observe all residents who utilize a mechanical lift to ensure safe transfer.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the nursing staff on the following guideline: SWAT - We've Got Your Back Program</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 2 months to ensure compliance: Observe residents requiring the use of a mechanical lift to ensure safe transfer.</p> <p>The results of the audit observations will be reported,</p>	

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	<p>indicated Certified Resident Care Assistant (CRCA) #1 had assisted Resident #A out of bed with the use of mechanical lift by herself. CRCA #1 had felt the mechanical lift sling was secured. Resident #A had begun to slide because she had not been holding on tightly. Resident #A had voiced to CRCA #1 during the transfer the mechanical lift sling wasn't fitting properly. CRCA #1 had thought she could make the transfer, but Resident #A slid out of the mechanical lift sling onto the floor.</p> <p>A Resident/Staff Investigation Statement from Resident #A dated 11/20/15, indicated CRCA #1 was assisting her to the bathroom. Resident #A had requested CRCA #1 get someone else to assist her with the mechanical lift. Resident #A had stated that her chair was no where around her, her leg was in the wrong position, and she repeatedly told CRCA #1 to put her down because she was in pain.</p> <p>A Fall Care Plan for Resident #A dated 11/23/15, indicated she had a history of falls related to her need for assistance with transfers. Her Care Plan approaches to prevent falls included but were not limited to "re-education on 2 person staff assistance with use of transfer lift."</p>		<p>reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 4 months then randomly thereafter for further recommendation.</p>		

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	<p>An interview with Resident #A on 12/8/15 at 1:15 p.m., indicated she had previously been transferred with the assistance of CRCA #1 and the use of a Stand-Up Lift. Resident #A had fell out of the lift and had hit the floor. She had requested for CRCA #1 to get help transferring her, but CRCA #1 had told her "no I've got this." Resident #A indicated she had fell on her hip and it had hurt but her hip had not been fractured.</p> <p>An interview with the Director of Health Services on 12/9/15 at 11:19 a.m., indicated Resident #A had fallen from a Stand-Up Lift on 11/20/15. CRCA #1 had been operating the Stand-Up Lift by herself. CRCA #1 had informed the DHS, Resident #A had let go of the lift with her left hand and fell to the floor. Resident #A had complained of right hip pain. It was standard procedure to have 2 staff assisting with a mechanical lift transfer.</p> <p>The Guidelines for "SWAT-We've Got Your Back" Program provided by Unit Manager #2, indicated the following: "Purpose: To ensure the safety of residents and staff when performing mobility/transfer task... 6. Staff should seek the assistance of a second person for those residents' care planned for</p>			

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	<p>assistance of two with the lifting device or as needed for safe handling..."</p> <p>This federal tag relates to Complaint IN00187786.</p> <p>3.1-45(a)(2)</p>				