

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155294	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/28/2016
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NAME OF PROVIDER OR SUPPLIER FORUM AT THE CROSSING	STREET ADDRESS, CITY, STATE, ZIP CODE 8505 WOODFIELD CROSSING BLVD INDIANAPOLIS, IN 46240
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey dates: January 20, 21, 22, 25, 26, 27 and 28, 2016</p> <p>Facility number: 000191 Provider number: 155294 AIM number: N/A</p> <p>Census bed type: SNF: 34 Residential: 29 Total: 63</p> <p>Census payor type: Medicare: 15 Other: 19 Total: 34</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed by 21662 on February 3, 2016.</p>	F 0000		

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 0241 SS=D Bldg. 00	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on interview and record review, the facility failed to ensure staff were treating residents with dignity and respect for 2 of 4 residents reviewed for dignity. (Residents #16 and #60)</p> <p>Findings include:</p> <p>1. On 1/25/16 at 2:05 p.m., the record review for Resident #16 was completed. Diagnoses included, but were not limited to, Kidney Disease Stage III, congestive heart failure with an ejection fraction of 12%, dementia, osteoporosis, and generalized weakness.</p> <p>During an interview on 1/21/16 at 2:23 p.m., Resident #16 indicated she had been left on the toilet on the overnight shift and the staff told her if she pushed her call light in the next 2 hours they would not answer. Another staff member on the night shift left the resident's brief on her lap and told her to put it on. The resident indicated she had told the staff she could not do that due to problems with her left arm. Resident #16</p>	F 0241	<p>F 241 Dignity and Respect of Individuality Forum personnel uphold dignity and respect for all residents. A complete investigation was initiated upon learning of this allegation from the Surveyor. The identified C.N.A.'s employment was terminated for failure to meet 5 Star Senior Living customer services expectations. All residents have the potential to be affected by the alleged deficiency. Residents were interviewed during the course of the investigation with no other concerns noted. Nursing Staff will be educated by 2/27/16 and periodically thereafter regarding resident dignity, respect of individuality and Five Star Senior Living Customer Service expectations. The Administrator and/or designee will conduct dignity, respect and customer services audits for 15 residents weekly for the next 30 days, then every 2 weeks for the following 30 days, then monthly for the subsequent 30 days, and then quarterly. Results will be reported to the Q.A. Committee. Recommendations for additional corrective actions, training or education will be implemented as</p>	02/27/2016

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	<p>indicated she was told by the CNA to use her other arm.</p> <p>2. On 1/25/16 at 12:01 p.m., the record review for Resident # 60 was completed. Diagnoses included, but were not limited to, Alzheimer's, osteoporosis, seizure disorder, atrial fibrillation, lumbar back compound fractures and kyphoplasty.</p> <p>During an interview on 1/20/16 at 2:21 p.m., Resident #60 indicated she had been sitting in her chair and waiting an hour to go to the bathroom. She indicated she pushed her call light, staff came in and turned off the call light and did not come back. She indicated when that happened in the past, she just urinated in her pants. She also indicated when the staff did help her they were rough when they turned her.</p> <p>On 1/21/6 at 2:45 p.m., the Executive Director and the Director of Nursing Services were informed of the residents allegations of staff being rough and rude. At that time, the Administrator indicated she expected the staff to treat the residents with more respect.</p> <p>On 1/26/16 at 2:22 p.m., the investigation regarding the concerns from Residents #16 and #60 were reviewed. The facility was concerned with a potential allegation</p>		indicated.	

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	<p>of abuse, so they did a full investigation.</p> <p>The review of the investigation indicated on 1/21/16, Resident #16 was interviewed by the Regional Clinical Director. The statement indicated she had interviewed the resident in her room and asked the resident if she had any concerns with anyone being mean or abusive and the resident stated she had a problem with a CNA that told her she would not answer her call light for 2 hours. The resident described the staff members she believed were rude to her. She also described the CNA that laid the brief on her legs and told her to change it.</p> <p>The review of the investigation indicated on 1/21/16, Resident #60 was interviewed by the Regional Clinical Director. The document indicated the interview was done in person and the resident was asked if anyone had been mean or abusive. She stated, "I don't want to get into this." The resident was told by the interviewer the interview was strictly between them. The resident described the staff member she felt had been rough putting her in bed. She did not think she did it intentionally. She thought it was because she was in a hurry. The Regional Clinical Director asked if she was abusive and the resident said no, just rough and rude. The</p>			

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F 0253 SS=D Bldg. 00	<p>example the resident provided was the CNA would get irritated if she did not move fast enough. The resident indicated she was not afraid.</p> <p>On 1/26/16 at 2:22 p.m., the Director of Nursing indicated the CNA who the resident indicated was rough during care was let go due to poor customer service.</p> <p>3.1-3(t)</p> <p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation and interview, the facility failed to keep the carpet clean in a resident's room to maintain a comfortable environment for 1 of 7 resident rooms observed for comfort. (Resident #16)</p> <p>Findings include:</p> <p>On 1/21/16 at 2:27 p.m., the carpet in Resident #16's room was observed to have dark gray to black colored stains by the resident's bed and by the bathroom door.</p> <p>During an interview on 1/21/16 at 2:29 p.m., Resident #16 indicated she did not like how dirty the carpet was and the</p>	F 0253	<p>F253 Housekeeping and Maintenance The Carpet in Resident #16's room has been cleaned and stains mitigated or removed. All residents have the potential to be affected by the alleged deficiency.</p> <p>Resident rooms have been inspected, cleaned and stains mitigated or removed as recommended. The weekly carpet cleaning schedule has been revised. Maintenance staff responsible for carpet cleaning have been educated relative to the revised cleaning schedule. The Administrator and/or designee will audit cleanliness and condition of carpets during the dignity, respect and customer services audits for 15 residents</p>	02/26/2016

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F 0278 SS=D Bldg. 00	<p>maintenance staff had cleaned the carpet, but the stains remained.</p> <p>During an interview on 1/26/15 at 11:45 a.m., the Maintenance Director (MD) and the Maintenance Manager (MM) indicated they cleaned the carpets weekly. They indicated they had no documentation regarding the cleaning of the carpets. The MD indicated he was not sure when the facility carpet would be replaced.</p> <p>3.1-19(f)</p> <p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual</p>		<p>weekly for the next 30 days, then every 2 weeks for the following 30 days, then monthly for the subsequent 30 days, and then quarterly. Results will be reported to the Q.A. Committee with additional corrective actions or education provided as recommended.</p>	

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	<p>who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on interview and record review, the facility failed to correctly identify and accurately assess the resident's status regarding Hospice for 2 of 2 residents reviewed for Hospice. (Residents #1 and #27)</p> <p>Findings include:</p> <p>1. Resident #1's record was reviewed on 1/26/16 at 4:00 p.m. Diagnoses included, but were not limited to, depression, Alzheimer/dementia with agitation, anxiety, and malnutrition.</p> <p>A "Hospice Physician Certification/Recertification of Terminal Illness" dated 10/20/15, with recertification dates from 10/29/15 to 12/27/15 indicated the resident was admitted to hospice for Alzheimer's Disease. The document indicated "Based on these findings, I certify that this individual's prognosis was for a life</p>	F 0278	<p>F278 Assessment Accuracy/coordination/certified</p> <p>The MDS assessments for resident #1 and #27 have been corrected. All residents receiving hospice services have the potential to be affected by this alleged deficient practice. An audit of current MDS assessments for residents receiving hospice services will be conducted and corrections made as needed. The MDS Coordinator and assistant have been educated to correctly populate the MDS Assessment relative to a resident's life expectancy prognosis of 6 months or less when a Hospice resident is identified. The Director of Nursing or designee will audit for accuracy. MDS Assessments for residents receiving Hospice Services, monthly x 3 months and then quarterly for 2 quarters. Random audits will be completed at least semi-annually. Results will be reported to the Q.A. Committee with additional</p>	02/26/2016

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	<p>expectancy of six months or less if the terminal illness runs its normal course." The form was electronically signed by (Physician) on 10/20/2015 at 3:17 p.m.</p> <p>An Annual MDS (Minimum Data Set) assessment dated 11/06/15, indicated Resident #1 was on Hospice care, but did not have a prognosis of six months or less.</p> <p>A current "Hospice Services Agreement" dated 6/20/14, provided by the Administrator on 1/28/16 at 1:06 p.m., indicated "... Hospice's Criteria For The Provision Of Hospice Services... 3. The terminal prognosis of six months or less if the disease follows its normal course must be confirmed by the Patient's physician...."</p> <p>2. Resident #27's record was reviewed on 1/26/16 at 9:18 a.m. Diagnoses included, but were not limited to, heart failure, chronic respiratory failure, chronic pain, malaise, shortness of breath, anxiety disorder, and transient cerebral ischemic attack.</p> <p>A "Physician Face-To-Face Encounter/Recertification of Terminal Illness" 60 day periods with a visit date 11/23/15, indicated the benefit period was 11/23/15</p>		corrective actions or education provided as recommended.	

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	<p>to 1/21/16 and the resident had an initial hospice diagnosis of CHF (Congestive Heart Failure). A recertification Statement indicated "I recertify that I have reviewed the clinical record prior to recertification for the above noted patient and that patient is still considered to be terminally ill and has a life expectancy of six (6) months or less, if the terminal illness runs it's normal course." The form was electronically signed by (Physician) on 11/23/2015 at 2:28 p.m.</p> <p>A Quarterly MDS assessment dated 11/29/15, indicated Resident #27 was on Hospice care, but did not have a prognosis of six months or less.</p> <p>A current "Hospice Services Agreement" dated 8/16/12, provided by the Administrator on 1/28/16 at 1:06 p.m., indicated "... Hospice Admission Criteria... 2. There is minimal chance of disease reversal and Resident's life expectancy is estimated to be (6) months or less if the disease process follows its normal course...."</p> <p>During an interview on 1/27/16 at 10:34 a.m., the MDS Coordinator, Regional Clinical Director and Administrator were in attendance, the MDS Coordinator indicated the answer to the prognosis of six months or less question</p>			

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F 0280 SS=D Bldg. 00	<p>on the MDS assessment was "always no" unless the physician had a note in the residents' record indicating the resident had a life expectancy of six months or less. She indicated most physicians would not give that statement to the facility to place in the residents' records. She indicated she always marked no to that question because she did not think the facility medical director would sign off that a resident had less than six months to live because not all hospice residents had less than six months to live. She also indicated a resident did not have to have less than 6 months to live to be on hospice because they can change and be put on and taken off hospice frequently. At that time, the Regional Clinical Director indicated the residents should have had an order or statement in their record indicating they had less than 6 months to live if their disease ran it's normal course and yes should have been checked on the MDS question for their prognosis of less than 6 months.</p> <p>3.1-31(d) 3.1-31(g)</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p>			

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	<p>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.</p> <p>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.</p> <p>Based on interview and record review, the facility failed to ensure Care Plans were revised with appropriate interventions for hospice care for 2 of 15 residents reviewed for care plans. (Residents #1 and #27)</p> <p>1. Resident #1's record was reviewed on 1/26/16 at 4:00 p.m. Diagnoses included, but were not limited to, depression, Alzheimer/dementia with agitation, anxiety, and malnutrition.</p> <p>An Annual MDS (Minimum Data Set) assessment dated 11/06/15, indicated Resident #1 was on Hospice care.</p> <p>The resident had a Care Plan dated 12/4/15, which addressed the problem</p>	F 0280	<p>F280 Right to participate Planning Care Revise CP Hospice Care Plans for residents #1 and #27 have been revised and updated as needed in collaboration with hospice providers. All residents receiving hospice services have the potential to be affected by this alleged deficient practice. An audit of Care Plans for residents receiving hospice services will be conducted and updated to reflect collaborative services and responsible parties. Policy revisions ensure a facility-generated hospice care plan includes responsibilities of the community and the Hospice provider as a collaborative effort between the two entities. MDS and Social Service staff members have been instructed by the</p>	02/26/2016

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	<p>she was receiving medical care/support through Hospice. Plan of action/approaches included "12/4/15-SSD [Social Service Director] will invite Resident's Hospice care team to all Care Plan Meetings, SSD will serve as liaison to Hospice care support, Comfort measures are in place such as comfort meds supportive care visits, anticipatory grief counseling." The resident's hospice care plan did not indicate what care the facility was responsible to provide or what care the Hospice was responsible to provide.</p> <p>2. Resident #27's record was reviewed on 1/26/16 9:18 a.m. Diagnoses included, but were not limited to, heart failure, chronic respiratory failure, chronic pain, malaise, shortness of breath, anxiety disorder, and transient cerebral ischemic attack.</p> <p>A Quarterly MDS assessment dated 11/29/15, indicated Resident #27 was on Hospice care, but did not have a prognosis of six months or less.</p> <p>The resident had a Care Plan dated 11/24/15, which addressed the problem she was receiving medical care/support through hospice. The Plan of action/approaches included "11/29/15-SSD [Social Service Director] will invite</p>		<p>Regional Clinical Director. An ongoing log of efforts to invite hospice representatives to care plan meetings will be developed and maintained by The Social Service Director or designee. The Director of Nursing or designee will audit care plans for residents receiving hospice services for the inclusion of a facility-generated collaborative hospice care plan. This shall identify responsibilities and services to be provided by the facility and the hospice provider. The Administrator or designee will audit the care plan invitation log to ensure that invitations to hospice representatives are issued and responses are recorded. Reviews will be monthly x 3 months then quarterly for 2 quarters. Random audits will be completed with the care plan meetings. Results will be reported to the Q.A.Committee with additional corrective actions or education provided as recommended.</p>	

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	<p>Resident's Hospice care team to all Care Plan Meetings, SSD will serve as liaison to Hospice care support." The resident's hospice care plan did not indicate what care the facility was responsible to provide or what care the Hospice was responsible to provide.</p> <p>During an interview on 1/27/16 at 10:58 a.m., the SSD indicated she and the Nursing department did the Hospice care plans.</p> <p>During an interview on 1/27/16 at 11:38 a.m., LPN #9 indicated there was only one care plan in the chart for the residents' Hospice care plan and that was the care plan nursing was to use as the residents' care plan.</p> <p>During an interview on 1/27/16 at 11:55 a.m., the SSD indicated Resident #27's palliative/comfort and hospice Care Plans were thinned out of her record, so they were not available for the nursing staff to refer to when caring for the resident.</p> <p>During and interview on 1/27/16 at 12:45 p.m., the Regional Clinical Director indicated there was no other documentation for the nursing staff to refer to besides the residents' record to find information on what care the facility and hospice was responsible for to</p>			

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	<p>collaborate the two services to provide care for the resident.</p> <p>A current policy titled "Process For Care Plan Development and Communication" dated 11/15/12 and revised 9/25/14, provided by the Director of Nursing Services on 1/28/16 at 10:10 a.m., indicated "...3.0 Fundamental Information: Each facility shall follow a care planning process to ensure timely development and updating of the residents' plan of care. The facility must develop a plan of care specific to each resident which helps to attain or maintain the residents' highest practical level of function. The residents' plan of care is an interdisciplinary document to be used as a communication tool for all staff providing care... The plan of care shall be available and understandable for all levels of staff caring for the resident. The RN is responsible to review all aspects of the plan of care... Direct care staff (e.g., nursing assistants) must be directly involved in the care planning process... Direct care staff must be informed about the residents' care needs to improve, maintain or minimize decline in the residents' condition and well being... 5.0 The direct care nurse will update the residents' care plan as the residents' needs change...."</p>			

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F 0309 SS=D Bldg. 00	<p>3.1-35(d)(2)(B)</p> <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. Based on interview and record review, the facility failed to collaborate resident care between the hospice company and the facility for 2 of 2 residents reviewed for hospice. (Residents #1 and #27)</p> <p>Findings include:</p> <p>1. Resident #1's record was reviewed on 1/26/16 at 4:00 p.m. Diagnoses included, but were not limited to, depression, Alzheimer/dementia with agitation, anxiety, and malnutrition.</p> <p>An Annual MDS (Minimum Data Set) assessment dated 11/06/15, indicated Resident #1 was on Hospice care.</p> <p>The resident had a Care Plan dated 12/4/15, which addressed the problem she was receiving medical care/support through Hospice. The resident's hospice</p>			F 0309	<p>F309 Provide Care/Services for the Highest well being Care Plans for residents #1 and #27 have been revised and updated as needed. All residents receiving hospice services have the potential to be affected by this alleged deficient practice. An audit of care plans for residents receiving hospice services will be conducted and updated as needed in collaboration with the hospice provider. Policy revisions ensure a facility-generated hospice care plans includes responsibilities of the community and the hospice provider as a collaborative effort between the two entities. An ongoing log of efforts to invite hospice representatives to care plan meetings will be developed and maintained by The Social Service Director or designee. The Director of Nursing or designee will audit care plans for residents receiving hospice</p>		02/26/2016

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	<p>care plan did not indicate what care the facility was responsible to provide or what care the hospice company was responsible to provide for the resident.</p> <p>The "Care Plan Conference Summary" notes dated 2/10/15, 5/26/15, and 8/5/15 did not indicate the resident remained on hospice care, the hospice team members were present for the care plan conference or they were invited to the care plan conference and declined to attend the care plan conferences.</p> <p>2. Resident #27's record was reviewed on 1/26/16 at 9:18 a.m. Diagnoses included, but were not limited to, heart failure, chronic respiratory failure, chronic pain, malaise, shortness of breath, anxiety disorder, and transient cerebral ischemic attack.</p> <p>A Quarterly MDS assessment dated 11/29/15, indicated Resident #27 was on Hospice care.</p> <p>The resident had a Care Plan dated 11/24/15, which addressed the problem she was receiving medical care/support through hospice. The resident's hospice care plan did not indicate what care the facility would provide for the resident and what care hospice was responsible to provide for the resident.</p>		<p>services for the inclusion of a facility-generated collaborative hospice care plan. This shall identify responsibilities and services to be provided by the facility and the hospice company.</p> <p>The Administrator or designee will audit the care plan invitation log to ensure that invitations to hospice representatives are issued and responses are recorded. Reviews will be monthly x 3 months then quarterly for 2 quarters. Random audits with care plan meetings will be ongoing. Results will be reported to the Q.A. Committee with additional corrective actions or education provided as recommended.</p>	

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	<p>The "Care Plan Conference Summary" notes dated 3/5/15, 6/2/15, 8/26/15, and 12/1/15 indicated the resident continued to receive hospice services. The only summary signed by a hospice member to indicate that person attended a care conference was the 6/2/15, conference. No indication written on the other conference summaries indicated the hospice team member was invited or declined to come.</p> <p>During an interview on 1/27/16 at 10:58 a.m., the SSD (Social Service Director) indicated there was a Hospice Collaborative agreement, which was signed by each hospice company and the facility. She indicated that agreement indicated what care the facility and the Hospice company was responsible for when caring for the resident. She indicated she received the care plan conference list for the following week from the MDS girls, then she generated the list and gave the list of care plan conference meetings to be scheduled for the following week to the Receptionist who called the residents' family members and the Hospice companies. She indicated the Receptionist kept a log of who she called to invite to the care plan meetings and she would have her get the log. She indicated Resident #1's Hospice</p>			

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	<p>nurse never came to the care plan conference meetings. She indicated Resident #27's Hospice nurse usually came, but she had been sick the month of December and could not make it.</p> <p>At the end of the exit conference on 1/28/16 at 4:32 p.m., there was no further information provided regarding the Hospice companies being invited to the Care plan conferences or they had declined to attend the meeting invitations for Residents #1 and #27.</p> <p>During an interview on 1/27/16 at 11:55 a.m., the SSD indicated the "Hospice Collaborative Agreement" was thinned from the residents' records by LPN #9, so they were not available to the nursing staff in the residents' records when providing care to in order to collaborate their care with hospice . She indicated the Collaborative agreement was the record, which told the nursing staff members what care they were responsible for the resident and what care the Hospice staff members were responsible for the resident. She indicated the resident's palliative/comfort and hospice Care Plan was thinned out of Resident #27's record and was not available for the nursing staff to refer to when caring for the resident. The SSD indicated the Receptionist would look for</p>			

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F 0371 SS=F Bldg. 00	<p>documentation to indicate she had invited the hospice companies to the care plan meetings and they declined to come.</p> <p>During an interview on 1/27/16 at 12:45 p.m., the Regional Clinical Director indicated there was no other documentation for the nursing staff to refer to besides the residents' records to find information on what care the facility and Hospice were responsible for, to collaborate the care for the residents.</p> <p>3.1-37(a)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to ensure proper food handling and storage of sliced beef livers for 22 of 33 residents who ordered beef livers for the dinner meal service on 1/20/16, failed to ensure proper handwashing for kitchen staff and failed to ensure sanitary kitchen practices during dishwashing procedure. These</p>	F 0371	F-371 The still-frozen sliced Beef Livers were discarded as a precaution. No residents were adversely affected. All residents in the facility who participate in community meals have potential to be affected by the alleged deficient practices. The Policy & Procedure for Food Safety, Food Safety in Receiving & Storage, Dress Code, & Hand washing were immediately	02/27/2016

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	<p>deficient practices had the potential to affect 34 of 34 residents receiving food from the kitchen.</p> <p>Findings include:</p> <p>The kitchen tour was completed on 1/20/2016 at 10:15 a.m., with the Executive Chef in attendance.</p> <p>1. Two boxes of sliced beef livers were observed on a cart outside the walk in cooler and walk in freezer. During an interview on 01/20/2016 at 10:20 a.m., the Executive Chef indicated they had "just" received the food delivery and it was being put away.</p> <p>On a second visit to the kitchen on 1/20/2016 at 11:55 a.m., two, ten pound boxes of sliced beef livers were observed on a cart outside the walk in cooler and walk in freezer. At that time, the Executive Chef directed Dietary Aide #1 to put the sliced beef livers away. At that time, Dietary Aide #1 indicated the food delivery truck had arrived at 8:00 a.m., that day.</p> <p>On a third visit into the kitchen on 1/20/2016 at 1:05 p.m., two, ten pound boxes of sliced beef livers were observed sitting on a second shelf in the walk in cooler. The labeling on the boxes indicated to "keep frozen, store at zero</p>		<p>re-enforced by the Dietary Manager. Kitchen and Dietary staff will be fully Re-educated on 2/27/16 with policies related to food safety regarding proper thawing procedure, food safety in receiving & storage, dress code, Eating while on duty in the Kitchen, & Proper Hand washing. The Dietary Manager or her Designee will be responsible for observing compliance with policies. Observations will occur twice weekly for 30 days, Weekly for 90 days, then monthly thereafter. The Dietary Manager or her Designee will be responsible to audit for compliance during daily QA rounds and will address deficits as identified with management personnel. Ongoing success and/or challenges will be reported to the Quality Assurance Committee on a quarterly basis for additional direction as required.</p>	

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	<p>degrees or lower." The livers were soft and cool to the touch in the package. At that time, the Executive Chef indicated he should have recognized the sliced beef livers remained out of the cooler. He indicated frozen and cold food items should be stored in the freezer or cooler within two hours of receipt.</p> <p>During an interview on 01/20/2016 at 1:45 p.m., the Executive Chef indicated the residents were going to have beef livers for dinner that evening. He further indicated the beef liver issue bothered him and indicated he "told the guy to put it away and he didn't."</p> <p>During an interview on 01/20/2016 at 2:00 p.m., the Dietary Manager (DM) indicated upon food delivery, she expected the staff to inspect, date and place the food in the proper storage areas. She indicated the food received should be put away in a timely manner and it should not take four hours to do so. She indicated the sliced beef livers had been at room temperature for "too long and should not be served." The DM indicated she expected the Executive Chef to discard the sliced beef livers, which had been at room temperature too long. She indicated not discarding the beef livers would not be following the facility policy regarding food safety.</p>			

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	<p>During an interview on 01/20/2016 at 4:15 p.m., the DM indicated that 22 of 34 residents had ordered liver for that evening meal.</p> <p>2. During an observation on 01/20/2016 at 10:25 a.m., the Executive Chef performed hand washing for 3 seconds, then dried his hands with two paper towels, then shut off the water with wet paper towels.</p> <p>During an interview on 01/20/2016 at 10:30 a.m., the Executive Chef indicated he expected the staff to wash their hands for twenty seconds or "sing the birthday song." He pointed to a sign located over the hand wash sink that indicated to wash hands for 20 seconds</p> <p>During an observation on 01/20/2016 at 11:54 a.m., the Executive Chef performed hand washing for 12 seconds, then turned off the water with wet hands and dried his hands with paper towels.</p> <p>3. On 1/20/2016 at 12:35 p.m., Dishwasher #3 was observed to eat a breadstick in the kitchen during dishwashing procedures.</p> <p>During an interview on 1/20/2016 at 2:00 p.m., the DM indicated eating in the</p>			

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	<p>kitchen was unacceptable.</p> <p>A current policy titled " FOOD SAFETY ", dated 8/6/2012, provided by the DM on 1/20/2016 at 1:55 p.m., indicated "...1.0 POLICY: During the food production process, food is handled by methods to minimize contamination and bacterial growth. 2.0 PRACTICE GUIDELINES...5. Frozen foods to be thawed, under refrigeration (preferred method) by immersion under running potable water, or in the microwave if the food will be moved immediately to conventional cooking equipment, with no interruption in the process...."</p> <p>A current policy titled " FOOD SAFETY IN RECEIVING AND STORAGE " dated 8/6/2012, provided by the DM on 1/20/2016 at 1:55 p.m., indicated "...1.0 PURPOSE AND POLICY Food is received and stored by methods to minimize contamination and bacterial growth. 2.0 PROCEDURE...Receiving Guidelines 1. Food will be inspected by dietary personnel when it is delivered to the facility and prior to storage for signs of contamination. Examples of contamination include the following: b. Frozen foods that are partially thawed. Foods that have been thawed and then refrozen may be contaminated; check for large ice crystals, solid areas of ice,</p>			

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F 0463 SS=D Bldg. 00	<p>discolored or dried-out food, or misshapen items...4. Items will be put away quickly, especially potentially hazardous foods that need to be stored under refrigeration or frozen."</p> <p>A current policy titled "Dress Code" dated 1/1/14, provided by the DM on 1/28/16 at 11:44 p.m., indicated "...Eating, smoking or chewing gum while on duty is prohibited...."</p> <p>3.1-21(i)(3)</p> <p>483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. Based on observation, interview and record review the facility failed to ensure a system was in place to allow 2 of 20 residents on the 500 hallway to alert the staff of their needs. (Residents #44 and #135)</p> <p>Findings include:</p> <p>1. During an observation on 1/21/16 at 11:40 a.m., Resident #44's call light dome outside of the resident's room did not illuminate when the call light button was pushed. The resident indicated the</p>	F 0463	<p>F 463 Resident Call System-Rooms/Toilet/Bath The call lights for the Residents #44 and #135 have been replaced. All residents have the potential to be affected by this alleged deficient practice. A room to room inspection of the call system has been conducted with no evidence of call system failure. LPN #7 has been reeducated regarding use of pagers. Nursing staff will be re-educated regarding use of pagers. Monthly Preventive Maintenance Inspection rounds will continue. The Administrator</p>	02/26/2016

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	<p>only way she could notify staff when she needed help was to wheel her wheelchair to the bathroom and pull the emergency call light, as the other one had not been working for some time.</p> <p>2. On 1/21/16 at 12:07 p.m., Resident #135 indicated she had waited 3 hours to go to restroom when she first came here a few weeks ago. She indicated she was given hand bells and a desk bell to call the staff. She indicated at one time she had thrown the hand bells against door to call the staff and they had not heard it. She indicated she was told that her room was a communication problem room. She indicated she often had to go to the door in her wheelchair to summon for help and had waited up to 30 minutes for assistance when call light was turned on.</p> <p>On 1/27/16 at 9:25 a.m., CNA #4 indicated the call lights go to a pager. She indicated every CNA should have a pager. If the call light was not answered, the pager would continue to vibrate until the light was reset. She indicated the staff tried to answer the lights right away. If the CNA's were with another resident it might take just a couple of minutes to get to the resident who turned his or her call light on.</p> <p>On 1/27/16 at 12:11 p.m., an</p>		<p>and/or designee will audit call light function and response times during the dignity, respect and customer services audits for 15 residents weekly for the next 30 days, then every 2weeks for the following 30 days, then monthly for the subsequent 30 days, and then quarterly. Results will be reported to the Q.A. Committee with additional corrective actions or education provided as needed</p>	

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	<p>environmental tour was completed. The call light domes outside of rooms 504 and 509 did not illuminate when the call light buttons were pushed from the bedside of Residents #44 and #135. At that time, the MM (Maintenance Manager) indicated the lights were to go to a pager system to notify staff when a call light was pressed.</p> <p>On 1/27/16 at 12:12 p.m., LPN #7 on the 500 hallway indicated the CNA was on lunch break and had her pager with her. LPN #7 indicated she did not have a pager and she looked for the lights above the outside of the residents' doors to see if a resident needed assistance.</p> <p>On 1/27/16 at 12:20 p.m., CNA #5 indicated the nurses and the CNA's usually had a pager to know if a resident had a need.</p> <p>On 1/27/16 at 12:30 p.m., the Maintenance Director (MD) indicated all of the staff entered all work orders via the computer system and email. The orders in the computer system were reviewed at that time for rooms 509 and 504. The documentation indicated: 11/5/15 -the call light for room 509 on the outside of the residents room was not working and was fixed within the same date.</p>			

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	<p>1/14/16 - the call light in room 504 bathroom call light was not working. The facility indicated they had fixed the call light at that time.</p> <p>During an interview on 1/28/16 at 11:45 a.m., the Administrator indicated the facility had discussed with their corporate office some plans to remodel both the 400 and 500 hallways, which included the call light system and total carpet replacement. The Administrator indicated there was no documentation or emails regarding this correspondence, and she did not know when the projects would be completed.</p> <p>During an interview on 1/28/16 at 3:40 p.m., the Director of Nursing Services indicated the nurses were to have their pagers on their medication carts at all times as they were usually by the medication carts. She indicated the nurses did not carry them with them as the facility did not want them to accidentally take them home. She indicated they do not have a way to print information from the pagers regarding call response times.</p> <p>A request was made at that time for any call light response time documentation or call light audits.</p>			

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F 0465 SS=D Bldg. 00	<p>On 1/28/16 the Administrator provided documentation indicating when the call light system had been checked. The document was titled, "Logbook Documentation...Nurse call checks...Room 504 10/1/15: Pass 10/20/15: N/A (not applicable) 10/21/15: N/A 10/22/15: N/A 10/23/15: N/A...Room 509: 10/1/15: Pass 10/20/15: N/A (not applicable) 10/21/15: N/A 10/22/15: N/A 10/23/15: N/A...."</p> <p>She indicated this was all of the documentation they could provide.</p> <p>3.1-19(u)(1)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview and record review, the facility failed to ensure resident rooms were well maintained for 1 of 7 rooms reviewed for maintenance needs. (Room 405)</p> <p>Findings include:</p> <p>During an environmental tour on 1/21/16 at 10:51 a.m., the Maintenance Manager indicated he had no individual rooms he was working on at that time. The tour of Room 405 was completed. There was</p>	F 0465	<p>F465 Safe/Functional/Sanitary/Comfortable Environment The ceiling in Room 405 has been repaired. All residents have the potential to be affected by unsightly surfaces. Resident rooms have been inspected and repaired as recommended. The resident room inspection/ Preventive Maintenance schedule has been revised. Maintenance/Housekeeping/Nursing staff have been retained to report environmental concerns. The Administrator</p>	02/26/2016

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	<p>ripped drywall near the bathroom, nail and screw holes in the wall, and the ceiling above one of the resident's beds was cracked and sagging in the middle. At that time, the Maintenance Manager indicated he was not aware of the items needing repaired in Room 405. He indicated the staff had a computer operated system to communicate when there was anything needing repaired.</p> <p>During an interview on 1/27/16 at 12:11 p.m., the Maintenance Manger indicated he was not aware of the cracked and sagging ceiling. The Maintenance Director (MD) joined the environmental tour at that time. The MM indicated to the MD there was a potential water leak in Room 405 that he was not aware of. A request was made at that time for any documentation of any work orders to be fixed.</p> <p>The computer documentation was reviewed on 1/27/16 at 12:30 p.m. and no documentation was found regarding concerns in room 405.</p> <p>On 1/28/16 at 3:50 p.m., the Administrator provided a document titled, "Health Center Room PM Inspection Report" dated 11/25/15. The document indicated the room had been inspected and there were no concerns at</p>		and/or designee will audit the condition and appearance of resident rooms during the dignity, respect and customer services audits for 15 residents weekly for the next 30 days, then every 2weeks for the following 30 days, then monthly for the subsequent 30 days, and then quarterly. Results will be reported to the Q.A. Committee with additional corrective actions or education provided as needed.	

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R 0000 Bldg. 00	that time. The Administrator indicated that was all of the documentation they could provide. 3.1-19(f) This visit was for a State Residential Licensure Survey. Residential Census: 29 Sample: 7 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-5.	R 0000		
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be			

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	<p>held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms.</p> <p>(2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present.</p> <p>Based on interview and record review, the facility failed to attempt a fire and disaster drill at least every 6 months in conjunction with the local fire department. This deficient practice had the potential to affect 29 of 29 residents residing in the facility.</p> <p>Findings include:</p> <p>The record review for fire drills was completed on 1/27/16 at 4:20 p.m. Documentation regarding attempted fire and disaster drills in conjunction with the local fire department could not be located.</p> <p>During an interview on 1/27/16 at 4:40 p.m., the Director of Engineering indicated fire and disaster drills had not been attempted with the local fire department and he was not aware that it was a requirement.</p>	R 0092	<p>During the survey, the community's newly-appointed Director of Engineering was advised of the regulation. A request was made to the local fire station for joint practice and education as indicated on February 9, 2016. All residents in the facility have the potential to be affected by this alleged deficient practice. The Executive Director, Director of Engineering or designee will endeavor to coordinate joint exercises with the Indianapolis Fire Department. Such activities will include the residential portion of the community and other portions of the physical plant as agreeable to the agency. The Safety Committee will record joint exercise as a part of fire drill documentation. The Executive Director, Director of Engineering or designee will ensure records are maintained on a quarterly basis as a Quality Assurance/Environmental standard. Compliance data will be referred to the Quality Assurance Committee for review and recommendations.</p>	02/09/2016

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R 0121 Bldg. 00	<p>410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance</p> <p>(f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following:</p> <p>(1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.</p> <p>(2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.</p> <p>(3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings.</p> <p>(4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out.</p>			
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	<p>Based on interview and record review, the facility failed to ensure a physical exam and a second step tuberculin test were completed in a timely manner for 1 of 2 new employees being reviewed for new employee records. (CNA #10)</p> <p>Findings include:</p> <p>The employee records were reviewed on 1/28/16 at 10:00 a.m. CNA #10's physical exam and second step Tuberculin test were not located in her new employee paper work.</p> <p>CNA #10's hire date was 3/18/15.</p> <p>During an interview on 1/28/16 at 12:50 p.m., the Bridge to Rediscovery (BTR) Director indicated she would find the physical exam and the second step Tuberculin test.</p> <p>During an interview on 1/28/16 at 4:02 p.m., the BTR Director indicated CNA #10 did not have her second step Tuberculin test results here at the facility and she did not have a physical exam at the facility. She indicated CNA #10 worked at another facility and had the second step test completed there, but had not brought the test results into this facility as of yet.</p>	R 0121	<p>R121 Community records indicated 2ndstep tuberculin skin tests were performed on identified employees, but source documents could not be immediately found. All residents in the facility have the potential to be affected by this alleged deficient practice. The HumanResources Coordinator is responsible to ensure current health records are maintained for all personnel. She established a revised protocol in December, 2015 prior to the survey. All new staff members have PPDs administered and/or documented prior to employment with necessary 2ndstep tests scheduled electronically with nursing management personnel. Established employees are scheduled for annual testing in December of each year. The HRC monitors for compliance as new employee files are created and updated. The QA Committee audits for compliance. The Executive Director will ensure records are maintained on a quarterly basis as a Quality Assurance/Personnel standard. Compliance data will be referred to the Quality Assurance Committee for review and recommendations.</p>	02/20/2016			

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R 0123 Bldg. 00	<p>410 IAC 16.2-5-1.4(h)(1-10) Personnel - Nonconformance (h) The facility shall maintain current and accurate personnel records for all employees. 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.</p> <p>Based on interview and record review, the facility failed to ensure job specific orientation was completed for 1 of 2 new employees being reviewed for new employee records. (LPN #11)</p> <p>Findings include:</p> <p>The employee records were reviewed on 1/28/16 at 10:00 a.m. LPN #11's job specific orientation checklist was not located in her new employee paper work.</p> <p>LPN #11's hire date was 6/19/15.</p>	R 0123	<p>R123 Community nurses are oriented to job-specific functions when they are employed, then periodically thereafter. Related documentation is maintained in personnel files. All residents in the facility have the potential to be affected by this alleged deficient practice. The BTR(Memory Care Unit) manager will review all personnel files of nurses assigned to the unit. Those found to be without job-specific orientation will have them completed. Both the Human ResourcesCoordinator and the BTR Unit Manager will be responsible toensure orientation/training records are</p>	02/20/2016

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R 0217 Bldg. 00	<p>During an interview on 1/28/16 at 12:50 p.m., the Bridge to Rediscovery (BTR) Director indicated she would find LPN #11's job specific orientation checklist.</p> <p>During an interview on 1/28/16 at 3:45 p.m., the Administrator indicated if the BTR Director had not provided the job specific orientation checklist by this time, she was unable to provide it.</p> <p>During an interview on 1/28/16 at 4:02 p.m., the BTR Director indicated she did not have a job specific orientation checklist for LPN #11. She indicated she did not have job specific orientation checklists for nurses.</p>				<p>maintained for professional nurses. The QA Committee audits for compliance. The Executive Director will ensure records are maintained on a quarterly basis as a Quality Assurance/Personnel standard. Compliance data will be referred to the Quality Assurance Committee for review and recommendations.</p>		
	<p>410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual</p>						

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	<p>resident shall be appropriate to the:</p> <p>(A) scope; (B) frequency; (C) need; and (D) preference; of the resident.</p> <p>(2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review.</p> <p>(3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request.</p> <p>(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.</p> <p>(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.</p> <p>Based on interview and record review, the facility failed to provide physician ordered psychological services in a timely manner for 1 of 7 residents reviewed for service plan accuracy. (Resident #632).</p> <p>Findings include:</p> <p>The record of Resident #632 was reviewed on 01/28/16 at 10:30 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, dementia, and depression.</p>	R 0217	R217 The cited resident was seen by the consulting psychologist in November, 2015. Community nurses have been re-oriented to forward orders for psychological evaluations directly to related clinicians. Currently one psychologist attends residents on a regular basis. All residents with orders allowing psychological evaluations have the potential to be affected by this alleged deficient practice. The BTR(Memory Care Unit) manager instructed nurses to contact clinicians upon receipt of a physician's order. The BTR Unit Manager will be responsible to	02/20/2016			

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	<p>A nursing progress note, dated 8/26/15, indicated, "...[resident] has been extremely irritable, cursing, yelling... [Nurse Practitioner] here ordered UA/C&S [urinalysis/culture and sensitivity]...."</p> <p>A nursing progress note, dated 8/28/15, indicated, "...Resident ambulating throughout unit hallways shouting, yelling, screaming at staff et [and] peers to get out of her house...Resident doesn't have PRN [as needed medication] for agitation/anxiety...[physician] paged...."</p> <p>A nursing progress note, dated 8/28/15, indicated "[physician] responded...new orders 1) Lorazepam 0.5 mg IM [intramuscular] injection q [every] 8 hours PRN x 5 days...."</p> <p>A Physician's Progress Note (signed by Nurse Practitioner), dated 8/31/15, indicated, "...Resident continues to exhibit irritability, refusing assessment today. Resident seen 8/26/15, urinalysis and labs are clinically stable. Resident's Zoloft [anti-depressant] was decreased to 25 mg every day on 8/18/15, unsure if this is the etiology of the behaviors...increase Zoloft to 50 mg daily, add Depakote [mood stabilizer] 125 mg BID [twice daily]...Have psych services consult...."</p>		<p>audit referrals for timely implementation. Nurses found to be out of compliance with this practice will be reprimanded. The QA Committee audits for compliance. Recommendations for changes in protocols will be made as indicated.</p>	

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	<p>A Physician's Order, dated 8/31/15, indicated, "...may consult in-house psych services if family agrees...."</p> <p>A nursing progress note, dated 8/31/15, indicated "...Resident seen by [Nurse Practitioner] with new orders written...3) May consult in house psych services if fam [family] agrees. Res dtr [daughter] informed of orders and agree...."</p> <p>No documentation regarding a psychological evaluation during this time frame was available.</p> <p>No nursing progress notes were available from 9/1/15 through 10/4/15.</p> <p>On 10/05/15, nursing progress notes indicated Resident #632 refused evening medications. Progress notes throughout October 2015 and November 2015 indicated Resident #632 consistently refused medications, care and lab draws.</p> <p>A Physician's Progress Note, dated 10/26/15, indicated "...Resident irritable per usual, difficult to assess...Plan: 1. Dementia with behaviors: ...unsure if Psych Services consulted. May require IM injection for mood stability...."</p> <p>A physician order, dated 11/5/15, indicated, "...please ask [name of</p>			

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R 0273 Bldg. 00	<p>psychologist] to see for: dementia [with] increased behaviors...."</p> <p>An initial Psychological Evaluation, dated 11/13/15, indicated Resident #632 was seen for a psychological evaluation and treatment secondary to a physician order due to combative and resistive behaviors and refusal of almost all medications over the past two months.</p> <p>During an interview on 01/28/16 at 3:10 p.m., the Bridge to Rediscovery Director indicated Resident #632 was not seen by the psychologist after the 8/31/15, physician order because her behaviors decreased. She indicated there were no nurse's notes or behavior tracking sheets to show the decrease in Resident #632's behavior. She also indicated there were no documented physician communications discussing the needs of Resident #632 or the decision to delay Resident #632's psychological evaluation that was ordered in August 2015.</p> <p>410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview and</p>	R 0273	The Policy & Procedure for Food	02/27/2016

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	<p>record review, failed to ensure proper handwashing and glove use for kitchen staff during meal service and failed to ensure sanitary kitchen practices during dishwashing procedure. These deficient practices had the potential to affect 29 of 29 residents receiving food from the kitchen.</p> <p>Findings include:</p> <p>1. During an observation on 01/20/2016 at 10:25 a.m., the Executive Chef performed hand washing for 3 seconds, then dried his hands with two paper towels, then shut off the water with wet paper towels.</p> <p>During an interview on 01/20/2016 at 10:30 a.m., the Executive Chef indicated he expected the staff to wash their hands for twenty seconds or "sing the birthday song." He pointed to a sign located over the hand wash sink that indicated to wash hands for 20 seconds</p> <p>During an observation on 01/20/2016 at 11:54 a.m., the Executive Chef performed hand washing for 12 seconds, then turned off the water with wet hands and dried his hands with paper towels.</p> <p>2. On 1/20/2016 at 12:35 p.m., Dishwasher #3 was observed to eat a</p>		<p>Safety, Food Safety in Receiving & Storage, Dress Code, & Hand washing were immediately re-enforced by the Dietary Manager. All residents in the facility who participate in community meals have potential to be affected by the alleged deficient practices. Kitchen and Dietary staff will be fully Re-educated on 2/27/16 with policies related to food safety regarding proper thawing procedure, food safety in receiving & storage, dress code, Eating while on duty in the Kitchen, & Proper Hand washing. The Dietary Manager or her Designee will be responsible for observing compliance with policies. Observations will occur twice weekly for 30 days, Weekly for 90 days, then monthly thereafter. The Dietary Manager or her Designee will be responsible to audit for compliance during daily QA rounds and will address deficits as identified with management personnel. Ongoing success and/or challenges will be reported to the Quality Assurance Committee on a quarterly basis for additional direction as required.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155294	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/28/2016
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NAME OF PROVIDER OR SUPPLIER FORUM AT THE CROSSING	STREET ADDRESS, CITY, STATE, ZIP CODE 8505 WOODFIELD CROSSING BLVD INDIANAPOLIS, IN 46240
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	<p>breadstick in the kitchen during dishwashing procedures.</p> <p>During an interview on 1/20/2016 at 2:00 p.m., the DM indicated eating in the kitchen was unacceptable.</p> <p>A current policy titled "Dress Code" dated 1/1/14, provided by the DM on 1/28/16 at 11:44 p.m., indicated "...Eating, smoking or chewing gum while on duty is prohibited...."</p>			