

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 08/30/2013
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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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F000000	<p>This visit was for the Investigation of Complaint # IN00133702.</p> <p>Complaint # IN00133702-Substantiated. Federal/state deficiencies related to the allegations are cited at F279, F309, and F514.</p> <p>Survey dates: August 28, 29, & 30, 2013</p> <p>Facility number: 000191 Provider number: 155294 AIM number: N/A</p> <p>Survey team: Michelle Carter, RN- TC</p> <p>Census bed type: SNF- 62 Residential- 21 Total- 83</p> <p>Census Payor type: Medicare- 30 Other- 53 Total- 83</p> <p>Sample: 4</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>	F000000	<p>Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the alleged or conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with federal and/or state law.</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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	Quality Review was completed by Tammy Alley RN on September 4, 2013.			

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F000279 SS=D	<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, the facility failed to identify specific behaviors related to emotional stress for 1 of 1 behavior care plan reviewed in a sample of 4. (Resident B)</p> <p>Findings include:</p> <p>The record for Resident B was reviewed on 8/28/13 at 3:00 p.m.</p> <p>Diagnoses for Resident B included, but were not limited to, osteoarthritis, chronic pain, fatigue, weakness,</p>	F000279	<p>F279 In response to the cited findings R/T to F279, the following actions will be taken: A) There is no corrective action needed. Resident is deceased and Medical Record is closed. B) All residents in facility, with preference to those who have psych/behavioral needs, have the potential to be affected by this alleged deficient practice. Behavior care plans of current residents will be reviewed by Social Services Director/designee for appropriate interventions R/T psych needs in next 30 days. The physical/emotional characteristics of the identified</p>	09/29/2013			

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	<p>debility and walking difficulty secondary to osteoarthritis, high blood pressure, dementia, and psychosis.</p> <p>A care plan, titled "Behavior Patterns with Husband", with a review dated 6/11/13, indicated the following:</p> <p>"Problem- Resident has shown open conflict with spouse, as evidenced by spouse raising his voice with the resident. Resident appears to have increased emotional distress/sx [symptoms] after his visits."</p> <p>During an interview with the Executive Director (ED), the Administrator, and the Director of Nursing (DON) on 8/30/13 at 10:09 a.m., the DON indicated Resident B often displayed tearful and sorrowful behaviors. The ED and DON indicated the care plan should reflect the specific behaviors.</p> <p>This tag relates to the investigation of complaint IN00133702.</p> <p>3.1-35(a)</p>		<p>behavior (s) will be noted on the care plan with both pharmacological and non-pharmacological interventions. Newly admitted residents will be assessed by Social Services/designee within appropriate time frame and care plan completed R/T any behavior/mood indicators noted. Specific target behaviors will be a focus. C) Resident care plans R/T psych needs will be individualized and specific, with psych diagnoses and related behaviors noted. DON/ADON/designee will review behavior care plans during routine care conferences for specific behaviors R/T psych diagnosis. D) Specific behaviors R/T psych diagnoses will be identified in daily IDT clinical rounds (M-F) and CareTracker documentation (electronic). Monitoring will include daily electronic reports of observed/documented behaviors, bi-weekly Continuous Quality Improvement (CQI) meetings, and monthly behavior meetings E) Date of compliance with proposed actions: September 29, 2013</p>		

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F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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 record review and interview, the facility failed to ensure a nursing assessment was completed after notification that a resident "felt like she was going to die" and prior to contacting emergency medical services for 1 of 1 resident reviewed for nursing assessment in a sample of 4. (Resident B)</p> <p>Findings include:</p> <p>The record for Resident B was reviewed on 8/28/13 at 3:00 p.m.</p> <p>Diagnoses for Resident B included, but were not limited to, osteoarthritis, chronic pain, fatigue, weakness, debility and walking difficulty secondary to osteoarthritis, high blood pressure, dementia, and psychosis.</p> <p>1. During an interview with RN #1 on 8/29/13 at 2:15 p.m., she indicated she was working on the morning of 6/23/13, when Resident B passed.</p>	F000309	<p>F309 In response to the cited findings R/T to F309, the following actions will be taken: A) No corrective action needed. Resident is deceased and Medical Record is closed. B) All residents in facility have the potential to be affected by this alleged deficient practice. C) Licensed staff will be in-serviced re: documentation of nursing assessment with any significant resident change of condition, either observed or stated. D) DON/ADON/designee will review documentation R/T resident significant change in condition for appropriate assessment/documentation daily by nursing management. Residents with significant change in condition will be identified in daily clinical rounds. Clinical assessment/documentation expectations will be communicated to each unit and monitored for compliance by DON/ADON/designee. Monitoring of assessment/documentation R/T resident significant change in condition will be completed by</p>	09/29/2013			

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	<p>RN #1 indicated after breakfast, Resident B wanted to lay down in bed. RN #1 and CNA #2 assisted Resident B into bed. RN #1 left the room. A few moments passed and CNA #2 communicated with RN #1 that Resident B said she didn't feel good and "felt like she was going to die." RN #1 indicated she went to Resident B's room and tried to comfort, reassure, and redirect Resident B. She indicated she did not do a formal assessment.</p> <p>Record documentation did not reflect a nursing assessment was completed after RN #1 was knowledgeable that Resident B indicated "she felt like she was going to die."</p> <p>2. Nursing notes, dated 6/23/13, at 11:15 a.m., indicated the following: "...This writer rushed in the room and found resident's eyes shut, mouth wide open and breathing hard, both hands up in chest area very tensed (sic) or stiff, crossed feet.CNA also present and this writer shouted call for help, get other nurses. This writer quickly called 911."</p> <p>Nursing notes did not indicate an assessment. During an interview with RN#1 on 8/29/13, at 2:15 p.m., she indicated</p>		Medical Records no less than weekly. E) Date of compliance with proposed actions: September 29, 2013				

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	<p>she did not do an assessment because there was not enough time.</p> <p>This tag relates to the investigation of complaint IN00133702.</p> <p>3.1-37(a)</p>			

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F000514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to ensure documentation was accurate and included assessments for 1 of 4 residents reviewed for accurate and complete documentation in a sample of 4. (Resident B)</p> <p>Findings include:</p> <p>The record for Resident B was reviewed on 8/28/13 at 3:00 p.m.</p> <p>Diagnoses for Resident B included, but were not limited to, osteoarthritis, chronic pain, fatigue, weakness, debility and walking difficulty secondary to osteoarthritis, high blood pressure, dementia, and psychosis.</p>	F000514	F514 In response to the cited findings R/T to F514, the following actions will be taken: A) No corrective action needed. Resident is deceased and Medical Record is closed. B) All residents in facility have the potential to be affected by this alleged deficient practice. C) DON/ADON/designee will review documentation R/T resident significant change in condition for appropriate assessment/documentation to ensure Medical Record is complete/accurate.. D) Monitoring of assessment/documentation R/T resident significant change in condition will be completed by Medical Records no less than weekly. E) Date of compliance with proposed actions: September 29, 2013	09/29/2013			

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	<p>1. During an interview with the DON on 8/30/13 at 10:09 a.m., she indicated the facility nursing staff was expected to chart by exception only. She would expect documentation only if there was a resident related negative outcome. She indicated death was a negative outcome.</p> <p>2. During an interview with RN #1 on 8/29/13, at 2:15 p.m., she indicated she was working on the morning of 6/23/13, when Resident B passed. RN #1 indicated after breakfast, Resident B wanted to lay down in bed. RN #1 and CNA #2 assisted Resident B into bed. RN #1 left the room. A few moments passed and CNA #2 communicated with RN #1 that Resident B said she didn't feel good and "felt like she was going to die." RN #1 indicated she went to Resident B's room and tried to comfort, reassure, and redirect Resident B. She indicated she did not do a formal assessment.</p> <p>Record documentation did not reflect a nursing assessment was completed after RN #1 was knowledgeable that Resident B indicated "she felt like she was going to die."</p> <p>3. Nursing notes, dated 6/23/13, at 11:15 a.m., indicated the following:</p>						

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	<p>"...This writer rushed in the room and found resident's eyes shut, mouth wide open and breathing hard, both hands up in chest area very tensed (sic) or stiff, crossed feet. ...CNA also present and this writer shouted call for help, get other nurses. This writer quickly called 911."</p> <p>Nursing notes did not indicate an assessment. During an interview with RN#1 on 8/29/13, at 2:15 p.m., she indicated she did not do an assessment because there was not enough time.</p> <p>This tag relates to the investigation of complaint IN00133702.</p> <p>3.1-50(a)(2) 3.1-50(f)(2)</p>				