

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/06/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F0000	<p>This visit was for the post survey revisit to the Recertification and State Licensure Survey completed on 7/19/2012.</p> <p>Survey Date: 9/4/2012- 9/6/2012</p> <p>Facility number: 004700 Provider number: 155741 AIM number: 100266630</p> <p>Survey Team: Courtney Mujic, RN- TC Beth Walsh, RN Karina Gates</p> <p>Census Bed Type: SNF/NF: 47 Total: 47</p> <p>Census Payor Type: Medicaid: 41</p> <p>Medicare: 3 Private: 1 Other: 2 Total: 47</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 9/13/12</p>	F0000		
-------	---	-------	--	--

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/06/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Cathy Emswiler RN			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/06/2012
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F0248 SS=D	<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, interview and record review, the facility failed to provide an activity program to accommodate 1 of 3 residents reviewed for activities. (Resident #15)</p> <p>Findings include:</p> <p>The clinical record for Resident #15 was reviewed on 9/5/12 at 1:30 p.m.</p> <p>The diagnoses for Resident #15 included, but were not limited to: heart failure, hypertension, and diabetes.</p> <p>Review of Resident #15's activity log for the month of September, 2012 was provided by the Activity Assistant on 9/6/12 at 3:15 p.m. The log indicated Resident #15 did not participate in any activities thus far in the month of September, 2012.</p> <p>Resident #15's care plans were reviewed on 9/5/2012 at 1:45 p.m.</p>	F0248	<p>An activities care plan has been established for Resident # 15. Activities staff have been inviting Resident # 15 to activities regularly, and since the survey she has chosen not to participate in group activities. One on one activities are offered to her at least twice weekly.</p> <p>All residents in the facility have the potential to be affected. Activities staff (Activities Director and Activities Assistant) has been inserviced on inviting all residents who are not bedfast to group activities, and making 1 on 1 activities available for any resident who is bedfast or does not participate in group activities for any other reason.</p> <p>To monitor the effectiveness of our activity program, ten residents will be selected each month to be interviewed using the activity questions on the "Resident Interview and Observation," CMS form 20050. Additionally, residents will be asked to share their opinions of the activities program at Resident Council meetings monthly. The results of the resident interviews and feedback from Resident Council</p>	09/25/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/06/2012	
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>and no activity care plan could be found.</p> <p>Review of the 4/24/12 Admission MDS (minimum data set) assessment indicated it was somewhat important for Resident #15 to listen to music she liked and to do things with groups of people.</p> <p>Resident #15 was observed on 9/5/12 from 11:00 a.m. to 3:00 p.m. She did not participate in any activities during this time frame.</p> <p>On 9/6/12 from 10:40 a.m. to 11:08 a.m., Resident #15 was observed lying awake in bed. A sing-a-long was taking place at this same time in the dining room. No one was observed to ask Resident #15 if she would like to attend.</p> <p>The Executive Director was observed entering Resident #15's room on 9/6/12 at 10:47 a.m. to say hello. He did not ask her to go to the sing-a-long.</p> <p>During an interview with Resident #15 on 9/6/12 at 11:08 a.m., she indicated she would like to go to the sing-a-long in the dining room if someone would take her down there. She also indicated that no one asked her if she</p>				<p>meetings will be discussed at the QA meeting monthly X 3 months and then quarterly thereafter on an ongoing basis.</p> <p>The Activity Director and Administrator are responsible for compliance.</p> <p>Completion date 9/25/2012</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/06/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>would like to go.</p> <p>Review of the 7/23/12 Quarterly MDS indicated Resident #15 was an extensive 2 person assist for transfer and for locomotion off the unit (e.g. areas set aside for dining).</p> <p>During an interview with the Social Services Director on 9/6/12 at 11:17 a.m., she indicated the Activities Department usually asked residents if they would like to go to an activity.</p> <p>During an interview with the Activity Director at 11:19 a.m. on 9/6/12, she indicated Resident #15 usually refused to go to activities, so they didn't ask her. She indicated they went around twice and asked other residents if they would like to go to the sing-a-long. She indicated, "It's a new activity and we've been trying to get residents involved." She indicated she believed Resident #15 was sleeping when they went around and asked residents to attend the sing-a-long. She stated, "She's passive at activities." At this time, the Activity Director was informed Resident #15 would like to go to the sing-a-long. The Activity Director stated, "Are you serious? So, she's awake?"</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/06/2012
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>This federal tag was cited on 7/19/2012. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-33(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/06/2012
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F0280 SS=E	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <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>	F0280	<p>Resident # 4 has had his MD orders, care plan, and C.N.A. Care Guide reviewed and updated to include all pertinent interventions on each document. All residents in the facility have been identified as having potential to be affected. Physicians orders will be reviewed in morning meeting. After review, the green copies of the orders will be distributed to the appropriate department head (such as the DON or designee, or Dietary Manager), to be checked off for 1) transcription (such as to the MAR or TAR), 2) care plan update (including an update to the C.N.A. Assignment Sheets when appropriate), and 3)</p>	09/25/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/06/2012
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Based on interview and record review, the facility failed to revise care plans for pressure ulcer prevention/skin care for 1 of 3 residents reviewed for care plan revision. (Resident #4)</p> <p>Findings include:</p> <p>The clinical record for Resident #4 was reviewed on 9/5/12 at 12:30 p.m. The diagnoses for Resident #4 included, but were not limited to: diabetes mellitus, hypertension, and history of ischium and coccyx decubitus ulcers.</p> <p>A Physician's Order, dated 8/24/12, indicated resident was to be up (symbol for up) in chair (wheelchair) 1-2 hour (symbol for hour) at (symbol for at) a time, turn every (symbol for every) 2 hour (symbol for hour), and</p>		<p>implementation by observing at least one instance of the order being followed before disposal of the green copy of the order. The Quality Assurance Team will review the care planning process monthly X 3 months and then quarterly thereafter on an ongoing basis to maximize its effectiveness. The DON, MDS Coordinator, and Administrator are responsible for compliance. Completion Date 9/25/2012.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/06/2012
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>waffle boot at (symbol for at) all times.</p> <p>The (name of wound clinic) Physician Orders/Patient Instructions sheet, dated 8/24/12, indicated Resident #4 was to be up in chair for 1 to 2 hours at (symbol for at) time [sic] turn every (symbol for every) 2 hour (symbol for hour). Waffle boot at (symbol for at) all times.</p> <p>The following care plans did not have an intervention, nor had been revised, for Resident #4 to wear a waffle boot at all times: resident is in bed more than half of time (symbol for time) due to every (symbol for every) 2 [sic] schedule [sic] for decreases [sic] skin issues, dated 4/19/12; risk for skin breakdown due to total dependence on staff for bed mobility, dated 4/19/12; risk for contractures and skin breakdown due to paraplegia, dated 4/19/12; resident has a long history of pressure ulcers, currently has pressure ulcers on his coccyx, back of thigh and right heel, dated 4/19/12.</p> <p>In an interview, at 1:10 p.m. on 9/5/12, the Assistant Administrator/MDS Coordinator indicated when new orders were written, the orders were reviewed the next day in morning meeting and then it was determined if the new orders</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/06/2012
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>should have been added to the care plan. The Assistant Administrator/MDS Coordinator indicated care plans were typically revised within a day or two of a new order. He also indicated if an order for Resident #4 to wear a waffle boot at all times was written, then it should've been added to a pressure ulcer risk/skin care plan. The Assistant Administrator/MDS Coordinator indicated the waffle boot order was probably missed because there were a lot of other orders on the Physician's Order.</p> <p>This Federal Tag was cited on 7/19/2012. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-35(d)(2)(B)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/06/2012	
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F0282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <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, interview, and record review, the facility failed to follow physician's orders for wound treatment for 1 of 3 residents reviewed for pressure ulcers and failed to provide a nutritional supplement as ordered for 1 of 3 residents reviewed for nutrition. (Resident #4) (Resident #26)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #26 was reviewed on 9/5/12 at 11:00 a.m.</p> <p>The diagnoses for Resident #26 included, but were not limited to: anemia and weight loss.</p> <p>The 7/8/12 weight loss care plan indicated the goal was, "Res (resident) will have slow steady wgt (weight) gain over next 90 d (days) to achieve acceptable BMI (body mass index). An intervention was, "Mighty Shakes (symbol for with) meals".</p>	F0282	<p>Resident # 26 receives his supplements with meals as ordered. Additionally, he receives Ensure and Prostat. His current weight is 128.5 lbs, up from 122 lbs in August.</p> <p>Dietary staff will be inserviced on Monday 9/24/12 following dietary cards carefully and ordering sufficient quantities to avoid running out of ordered supplements.</p> <p>Resident #4 has had his treatment orders clarified and corrected on the TAR.</p> <p>All residents in the facility have been identified as having potential to be affected.</p> <p>A meeting for all licensed nurses in the facility was held on 9/18/12. At this meeting, nurses were instructed to review paperwork that comes back from resident appointments and write orders as needed, also updating the MAR or TAR as appropriate. The nurses were instructed that the Wound Care Nurse may write the order if the resident returns while he is still on duty, but if the resident returns with a new order after the Wound Care Nurse leaves for the day, it is the charge nurse's responsibility to write the order, order any medications or</p>	09/25/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/06/2012
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>The 8/20/12 physician order indicated Mighty Shake with meals due to weight loss.</p> <p>During an observation of lunch on 9/6/12 at 12:26 p.m. no mighty shake was observed with Resident #26's meal. The meal ticket for Resident #26 was on the table in front of him and indicated, "Mighty Shake".</p> <p>During an interview with Resident #26 during lunch on 9/6/12 at 12:39 p.m. he indicated, he was not served a Mighty Shake. He indicated they tasted all right and that he would drink it if it was given to him.</p> <p>Resident #26 was observed leaving the dining room on 9/6/12 at 12:54 p.m. and still had not been served the Mighty Shake.</p> <p>2. The clinical record for Resident #4 was reviewed on 9/5/12 at 12:30 p.m.</p>		<p>supplies, and change the order on the TAR.</p> <p>Physicians orders will be reviewed in morning meeting. After review, the green copies of the orders will be distributed to the appropriate department head (such as the DON or designee, or Dietary Manager), to be checked off for 1) transcription (such as to the MAR or TAR), 2) care plan update (including an update to the C.N.A. Assignment Sheets when appropriate), and 3) implementation by observing at least one instance of the order being followed before disposal of the green copy of the order. Day shift staffing for the nursing department will be changed in such a way to allow for an Assistant Director of Nursing position. The ADON will assist with checking to make sure orders are written and transcribed accurately, and MAR and TAR are updated.</p> <p>The QA Committee will discuss the effectiveness of the facility's process of following physician orders monthly on an ongoing basis.</p> <p>The Director of Nursing and Administrator are responsible for compliance.</p> <p>Completion date September 25, 2012.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/06/2012	
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>The diagnoses for Resident #4 included, but were not limited to: diabetes mellitus, hypertension, and history of ischium and coccyx decubitus ulcers.</p> <p>A (name of wound clinic) Physician Orders/Patient Instructions sheet for Resident #4, dated 8/24/12, indicated the right (symbol for right) heel, right (symbol for right) buttocks, and coccyx should have santyl (wound medication), calcium alginate (wound medication), ABD (dressing pad), and cover roll (type of adhesive) applied once daily in the a.m. (checkmark in a.m. column).</p> <p>A Physician's Order, dated 8/24/12 10:00 a.m., indicated Resident #4 may shower/clean following areas: rt (right) heel, coccyx, rt (right) buttock, apply santyl, calcium alginate, ABD, et coverall [sic] bid (twice a day) and (symbol for and) prn (as needed).</p> <p>A clarification of the above orders was requested on 9/5/12 at 2:50 p.m.</p> <p>On 9/6/12 at 10:45 a.m., the following orders, dated 9/5/12, were received from the wound nurse: 1) DC (discontinue) TX (treatment) to right (symbol for right) heel, right (symbol for right) buttocks [sic] and coccyx. 2)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/06/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>New order clarification: cleans [sic] right (symbol for right) heel with (symbol for with) NS (normal saline), pat dry, apply santyl [sic] and calcium alginate [sic] cover with (symbol for with) Kerlix [sic] secure with (symbol for with) coverall [sic] QD (every day). 3) N.O. (new order) cleans [sic] OA (open area) to right (symbol for right) buttocks with (symbol for with) NS [sic] pat dry [sic] apply santyl and calcium alginate, cover with (symbol for with) ABD pad and secure with (symbol for with) coverall [sic] QD clarification! 4) Clarification: N.O. cleans [sic] coccyx OA with (symbol for with) NS. apply santyl and pack with (symbol for with) calcium alginate and cover with (symbol for with) ABD pad. secure with (symbol for with) coverall [sic] QD.</p> <p>The August TAR indicated the above wound treatments were done twice a day on 8/25/12, 8/26/12, 8/27/12, 8/28/12, 8/29/12, 8/30/12, and 8/31/12.</p> <p>In an interview with the Wound Nurse on 9/6/12, at 12:05 p.m., he indicated he personally did not do the wound treatments twice a day, but a review of the August TAR would indicate the wound treatments were done twice a day.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/06/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>This federal tag was cited on 7/19/2012. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-35(g)(2)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/06/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review, the facility failed to discontinue medications after the medications were ordered to be discontinued for 1 of 3 residents reviewed for unnecessary medications. (Resident #67)</p> <p>Findings include:</p> <p>The clinical record for Resident #67 was reviewed on 9/5/12 at 11:00 a.m. The diagnoses for Resident #67</p>	F0329	<p>The discontinued medications for Resident # 67 have been removed from the medication cart, and the MAR has been corrected. The order to discontinue those medications was written after the September physician's orders and MARs were reviewed.</p> <p>All residents in the facility have potential to be affected.</p> <p>On 9/17/2012, a meeting was held for all licensed nurses. At this meeting, they were instructed that if a physician's order is written after the rewrite has been</p>	09/25/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/06/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>included, but were not limited to: bladder cancer, acute renal failure, and hypertension.</p> <p>A review of a Physician Order, dated 8/30/12 at 5:15 p.m., indicated to DC (discontinue) Lasix (fluid retention/hypertension medication) and to DC potassium. No dosage was indicated for either medication.</p> <p>The August MAR (medication administration record) indicated furosemide tab 20 milligram (generic for Lasix) and K-Effervesce (potassium supplement) 25 milliequivalents tab was not given on 8/31/12, since there were no initials in the 8/31/12 dated slot and there was a handwritten note, "DC 8/30/12."</p> <p>On the September MAR (medication administration record), it indicated furosemide tab 20 mg (generic for Lasix) and K-Effervesce 25 milliequivalents tab was given on 9/1/12, 9/2/12, and 9/3/12, by the initials in the dated slots for the medications. There was a handwritten note, "DC 9/4/12" with a nurse's signature (name of nurse) on the lines for the furosemide and the K-Effervesce.</p> <p>The DoN (Director of Nursing)</p>		<p>checked for the following month, the nurse transcribing the order must make the appropriate order changes on both the current month's MAR and next month's MAR.</p> <p>Day shift staffing for the nursing department will be changed in such a way to allow for an Assistant Director of Nursing position. The ADON will assist with checking to make sure orders are written and transcribed accurately, and MAR and TAR are updated.</p> <p>The QA Committee will discuss the effectiveness of the facility's process of following physician orders monthly on an ongoing basis.</p> <p>The Director of Nursing and Administrator are responsible for compliance.</p> <p>Completion date September 25, 2012.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/06/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>indicated on 9/6/12 at 11:10 a.m., a nursing expectation was to not administer a medication after the date the medication was discontinued by a physician.</p> <p>During an interview, on 9/6/12 at 3:28 p.m., LPN #1 indicated when she looked at the September MAR of Resident #67, it indicated the above medications on the above dates were given, since there were initials in the dated slots for the medications.</p> <p>This Federal Tag was cited on 7/19/2012. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-48(a)(4)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/06/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE</p> <p>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>	F0514	<p>Resident #4 has had his treatment orders clarified and corrected on the TAR.</p> <p>All residents in the facility have been identified as having potential to be affected.</p> <p>A meeting for all licensed nurses in the facility was held on 9/18/12. At this meeting, nurses were instructed to review paperwork that comes back from resident appointments and write orders as needed, also updating the MAR or TAR as appropriate. The nurses were instructed that the Wound Care Nurse may write the order if the resident returns while he is still on duty, but if the resident returns with a new order after the Wound Care Nurse leaves for the day, it is the charge nurse's responsibility to write the order, order any medications or supplies, and change the order on the TAR.</p>	09/25/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/06/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Based on interview and record review, the facility failed to accurately document physician's orders for wound care, for 1 of 3 residents reviewed for documentation. (Resident #4)		Physicians orders will be reviewed in morning meeting. After review, the green copies of the orders will be distributed to the appropriate department head (such as the DON or designee, or Dietary Manager), to be checked off for 1) transcription (such as to the MAR or TAR), 2) care plan update (including an update to the C.N.A. Assignment Sheets when appropriate), and 3) implementation by observing at least one instance of the order being followed before disposal of the green copy of the order. Day shift staffing for the nursing department will be changed in such a way to allow for an Assistant Director of Nursing position. The ADON will assist with checking to make sure orders are written and transcribed accurately, and MAR and TAR are updated. The QA Committee will discuss the effectiveness of the facility's process of following physician orders monthly on an ongoing basis. The Director of Nursing and Administrator are responsible for compliance. Completion date September 25, 2012.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/06/2012	
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Findings include:</p> <p>The clinical record for Resident #4 was reviewed on 9/5/12 at 12:30 p.m. The diagnoses for Resident #4 included, but were not limited to: diabetes mellitus, hypertension, and history of ischium and coccyx decubitus ulcers.</p> <p>A (name of wound clinic) Physician Orders/Patient Instructions sheet, dated 8/24/12, indicated the right (symbol for right) heel, right (symbol for right) buttocks, and coccyx should have santyl (wound medication), calcium alginate (wound medication), ABD (dressing pad), and cover roll (type of adhesive) applied once daily in the a.m. (checkmark in a.m. column).</p> <p>A Physician's Order, dated 8/24/12 10:00 a.m., indicated Resident #4 may shower/clean following areas: rt (right) heel, coccyx, rt (right) buttock, apply santyl, calcium alginate, ABD, et coverall [sic] bid (twice a day) and (symbol for and) prn (as needed).</p> <p>A clarification of the above orders was requested on 9/5/12 at 2:50 p.m.</p> <p>On 9/6/12 at 10:45 a.m., the following</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/06/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>orders, dated 9/5/12, were received from the wound nurse: 1) DC (discontinue) TX (treatment) to right (symbol for right) heel, right (symbol for right) buttocks [sic] and coccyx. 2) New order clarification: cleans [sic] right (symbol for right) heel with (symbol for with) NS (normal saline), pat dry, apply santyl [sic] and calcium alginate [sic] cover with (symbol for with) Kerlix [sic] secure with (symbol for with) coverall [sic] QD (every day). 3) N.O. (new order) cleans [sic] OA (open area) to right (symbol for right) buttocks with (symbol for with) NS [sic] pat dry [sic] apply santyl and calcium alginate, cover with (symbol for with) ABD pad and secure with (symbol for with) coverall [sic] QD clarification! 4) Clarification: N.O. cleans [sic] coccyx OA with (symbol for with) NS. apply santyl and pack with (symbol for with) calcium alginate and cover with (symbol for with) ABD pad. secure with (symbol for with) coverall [sic] QD.</p> <p>At 11:10 a.m., on 9/6/12, the DoN (Director of Nursing) indicated she was unsure of why the 8/24/12 Physician's Order had wound treatment written for twice a day when the (name of wound clinic) Physician Orders/Patient Instructions indicated wound treatment was to be done</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/06/2012
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>once a day.</p> <p>During an interview with the Wound Nurse, on 9/6/12 at 12:00 p.m., he indicated he clarified the above orders for treatment because the (name of wound clinic) Physician Orders/Patient Instructions were different than the 8/24/12 Physician's Order. The Wound Nurse also indicated that he does not know why the 8/24/12 Physician's Order was written for the above treatment twice a day and not once a day, as instructed by the wound clinic, because he did not write the order.</p> <p>This Federal Tag was cited on 7/19/2012. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-50(a)(2)</p>				