

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155329	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ROSEWALK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1302 N LESLEY AVE INDIANAPOLIS, IN 46219
--	--

(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
F000000	<p>This visit was for the Investigation of Complaint IN00143397.</p> <p>Complaint IN00143397-Substantiated. Federal/State deficiencies related to the allegations are cited at F157 and F323.</p> <p>Survey date: February 3, 2014</p> <p>Facility number: 000222 Provider number: 155329 AIM number: 100274950</p> <p>Survey team: Karina Gates, Generalist, TC Courtney Mujic, RN Beth Walsh, RN</p> <p>Census bed type: SNF: 11 SNF/NF: 140 Total: 151</p> <p>Census payor type: Medicare: 45 Medicaid: 82 Other: 24 Total: 151</p> <p>Sample: 3</p>	F000000	<p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after Feb 24th, 2014. Facility requests face to face IDR as facility disagrees with scope and severity of F323.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155329	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ROSEWALK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1302 N LESLEY AVE INDIANAPOLIS, IN 46219
--	--

(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>These deficiencies also reflects state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on Febuary 11, 2014, by Janelyn Kulik, RN.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155329	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/03/2014
NAME OF PROVIDER OR SUPPLIER  ROSEWALK VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1302 N LESLEY AVE INDIANAPOLIS, IN 46219		
(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	
F000157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review, the facility failed to notify the physician of elevated blood pressures after a fall and refusal of medications after a fall. This</p>	F000157	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of	02/24/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155329		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/03/2014	
NAME OF PROVIDER OR SUPPLIER  ROSEWALK VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 1302 N LESLEY AVE INDIANAPOLIS, IN 46219			
(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>affected 1 of 3 residents reviewed for falls (Resident #B).</p> <p>Findings include:</p> <p>The clinical record for Resident #B was reviewed on 2/3/14 at 1:30 p.m. The diagnoses for Resident #B included, but were not limited to: leukemia, Alzheimer's disease, trigeminal neuralgia, and abnormality of gait.</p> <p>A review of a Progress Note, dated 1/10/14 at 11:59 p.m., indicated, "At 4:45 [sic] Resident in room with door closed when alarm was going off. Observed resident on floor sitting between bed and couch...4:55 [sic] resident [sic] observed on floor between bed and w/c (wheelchair) in sitting position again [sic] was not able to state what she was doing..."</p> <p>A review of the sheet, Neurological Assessment, dated 1/10/14, indicated the following blood pressures after the falls above: 4:45 (a.m.)-236/105 5:00 (a.m.)-185/111 5:15 (a.m.)-196/105 5:30 (a.m.)-188/106 6:30 (a.m.)-192/102 7:00 (a.m.)-176/90.</p>		<p>regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after Feb 24th, 2014. F157 Notify of changes/injury/decline/room It is the practice of this provider to ensure that all alleged violations involving notify of changes/injury/decline/room are provided in accordance with State and Federal law through established procedures. What corrective action(s) will be taken for those residents found to have been affected by the deficient practice? The resident B no longer resides in the facility. Facility nurses were re-educated on physician notification of change of condition. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The DNS/designee conducted a chart audit for all residents who have fallen in the last 30 days to ensure physician was notified due to change in condition. All residents who reside in the facility have the potential to be affected by the alleged deficient practice. All facility nurses will be re-educated on the physician notification of change by the SDC on designee on or before 2/24/14. What measures will be put into place or</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155329		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/03/2014	
NAME OF PROVIDER OR SUPPLIER  ROSEWALK VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 1302 N LESLEY AVE INDIANAPOLIS, IN 46219			
(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>An interview with Unit Manager #1, on 2/3/14 at 3:38 p.m., indicated it was an expectation that Nursing notify the Physician if a resident had several elevated blood pressures over an hour. He also indicated a high blood pressure would be anything over 170's or 180's. Unit Manager #1 further indicated, the above blood pressures were not the normal blood pressure ranges for Resident #B and he was unsure why the Physician was not notified of the above elevated blood pressures after the falls. He also indicated there was no documentation that the Physician was notified of the elevated blood pressures.</p> <p>On 2/3/14 at 3:41 p.m., the Assistant Director of Nursing (ADON), indicated Nursing was expected to notify the Physician of continued elevated blood pressures after 30 minutes to an hour.</p> <p>In a policy dated 3/2010 and titled Resident Change of Condition, received by the ADON on 2/3/14 at 3:42 p.m., it indicated, "It is the policy of this facility that all changes in resident condition will be communicated to the physician and family/responsible party, and that appropriate, timely, and effective</p>		<p>what systemic changes will you make to ensure that the deficient practice does not recur? All facility nurses will be re-educated on the physician notification of change by the SDC on designee on or before 2/24/14. The facility house supervisor or designee will complete daily rounds each shift getting report from nurses ensuring all abnormal vitals and medications are reported to the MD per facility policy. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? A Change of condition audit tool will be completed twice weekly x 4 weeks, weekly x 4 weeks, then monthly thereafter. The change of condition audit tools will be reviewed by the CQI Committee monthly for six months after which the CQI team will re-evaluate the continued need for the audit. If a 100% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee. Date of Compliance 2/24/14.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155329	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ROSEWALK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1302 N LESLEY AVE INDIANAPOLIS, IN 46219
--	--

(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>interventions occurs...2. Acute Medical Change, a. Any sudden or serious change in the resident's condition manifested by a marked change in physical or mental behavior will be communicated to the physician with a request for physician visit promptly and/or acute care evaluation. The licensed nurse in charge will notify the physician...d. All nursing actions/interventions will be documented in the medical record as soon as possible after resident needs have been met."</p> <p>At 3:45 p.m., on 2/3/14, the ADON indicated elevated blood pressures over an hour were considered an "Acute Medical Change."</p> <p>A review of Progress Note, dated 1/11/14 at 4:12 p.m., for Resident #B indicated, "Res (Resident) refused morning med pass several times. Res was re- approached [sic] numerous times. Reported meds were not given to husband due to her refusal."</p> <p>A review of the January MAR (medication administration record) indicated morning medications were given on 1/11/14.</p> <p>During an interview with Unit</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155329	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ROSEWALK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1302 N LESLEY AVE INDIANAPOLIS, IN 46219
--	--

(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>Manager #1, on 2/3/14 at 2:10 p.m., he indicated it was an expectation for Nursing to notify the Physician when a Resident refused medication. He also indicated he was unsure why the MAR indicated the resident received the medication when the "progress notes clearly state the morning medications were not given." The Unit Manager also indicated when s Physician was notified of changes, the notification should be put in the Progress Notes.</p> <p>On 2/3/14 at 3:38 p.m., the Unit Manager indicated there was no documentation that the Physician was notified of the refusal of morning medications.</p> <p>At 3:42 p.m., on 2/3/14, the ADON indicated the Physician was supposed to be notified for refusal of medications.</p> <p>In a policy, dated 3/2010 and titled Resident Change of Condition, received by the ADON on 2/3/14 at 3:42 p.m., it indicated, "Routine Medical Change a. All symptoms and unusual signs will be documented in the medical record and communicated to the attending physician promptly. Routine changes are a minor change in</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155329	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ROSEWALK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1302 N LESLEY AVE INDIANAPOLIS, IN 46219
--	--

(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>physical and mental behavior, abnormal laboratory and x-ray results that are not life threatening.</p> <p>b. The nurse in charge is responsible for notification of physician and family/responsible party prior to end of assigned shift when a significant change in the resident's condition is noted...f. Document resident change of condition and response in the medical record. Documentation will include time and family/physician response..."</p> <p>The ADON indicated, on 2/3/14 at 3:45 p.m., refusal of medications was a routine medical change.</p> <p>This Federal tag relates to Complaint IN00143397.</p> <p>3.1-5(a)(2)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155329	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/03/2014
NAME OF PROVIDER OR SUPPLIER  ROSEWALK VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1302 N LESLEY AVE INDIANAPOLIS, IN 46219		
(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	
F000323 SS=G	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to implement a fall intervention used to reduce injury from a fall resulting in a hospitalization with subdural hematoma for 1 of 3 residents reviewed for falls. (Resident #A)</p> <p>Findings include:</p> <p>The clinical record for Resident #A was reviewed on 2/3/14 at 12:00 p.m. She was admitted to the facility the evening of 1/22/14. Her daughter, Family Member #1, was present upon her admission. The diagnoses for Resident #A included, but were not limited to: acute hepatic encephalopathy, cirrhosis and liver failure.</p> <p>The 1/23/14, 5:19 p.m. Comprehensive Admission Assessment indicated the following: Oriented to: person Mental status: alert Answers questions: inappropriately Eye condition/vision: impaired</p>	F000323	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after Feb 24th, 2014. Facility requests face to face IDR as facility disagrees with scope and severity of this deficiency F323 FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES It is the practice of this provider to ensure that all alleged violations involving free of accident/ hazards/supervision/devices are provided in accordance with State and Federal law through established procedures. What corrective action(s) will be taken for those residents found to have been affected by the deficient practice? Resident A no longer resides in the facility. How will you identify other residents having the potential to be affected	02/24/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155329		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/03/2014	
NAME OF PROVIDER OR SUPPLIER  ROSEWALK VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 1302 N LESLEY AVE INDIANAPOLIS, IN 46219			
(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>vision-bilateral Neuro: upper body weakness, lower body weakness Non-verbal indicators of pain: Resident makes non-verbal sounds that may indicate pain: i.e. crying, whining, gasping, moaning or groaning</p> <p>The 1/22/14 care plan for Resident #A indicated the problem was, "Resident is a new admission to the facility." The goal was, "Resident needs will be met." The approaches to be implemented by nursing in regard to safety/mobility were, "Supervise and assist with mobility and safety as needed. Resident will have no injury related to falls. Observe for fall risk contributors such as medications, hypotension, pain, unsteady gait. Encourage and remind resident to use call light. Refer to therapies for screening. Provide assistance for transfers, bed mobility. Keep room free of clutter. Provide appropriate assistive devices. Non skid footwear, bed alarm 1/23/14, bed against wall 1/23/14, mat on floor 1/24/14, chair alarm 1/24 (1/24/14), composure mattress 1/24/14."</p> <p>A telephone interview was conducted with Family Member #1</p>		<p>by the same deficient practice and what corrective action will be taken? All residents who reside in the facility have the potential to be affected by the alleged deficient practice. All facility nursing staff will be re-educated on fall prevention, safety and injury prevention by the SDC on designee on or before 2/24/14. The IDT team will be educated on appropriate fall interventions, safety, and injury prevention by the DNS/ED or designee on or before 2/24/14. An audit of all residents who are at risk for a falls was completed. The medical record/care plans were audited by the DNS/Designee to ensure fall interventions were in place per residents plan of care and per resident's previous history What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? All facility nursing staff will be re-educated on fall prevention, safety and injury prevention by the SDC on designee on or before 2/24/14. The IDT team will be educated on appropriate fall interventions, safety, and injury prevention by the DNS/ED or designee on or before 2/24/14. The DNS or designee will review the preadmission packet and implement fall and safety interventions prior to the resident's admission to the facility. The house supervisor or designee will visit the resident</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155329	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/03/2014
NAME OF PROVIDER OR SUPPLIER  ROSEWALK VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1302 N LESLEY AVE INDIANAPOLIS, IN 46219		
(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>on 2/3/14 at 2:00 p.m. She indicated she was present at her mother's admission to the facility around 7:00 p.m. the evening of 1/22/14. She indicated, "I told the nurse on admission I was very concerned there were no bed rails." Family Member #1 indicated when she left the facility that evening, there was no mat on the floor next to her mothers bed, no rails on the side of the bed, and the bed was not against the wall. She indicated she spoke with (name of Social Services Director) and another staff member, whose name she could not recall, by telephone the following day regarding her mother not having rails on the side of her bed and her concern with her mother "falling out of bed." She indicated she was told the rails were illegal and would need an order. Family Member #1 indicated she returned to the facility at 4:30 p.m. the afternoon of 1/23/14 to visit her mother and "the bed was against the wall." She indicated there was no mat on the floor on the other side of the bed. She indicated, "I left that evening, maybe an hour later. I got a call at 1:30 a.m. that she fell out of bed and was sent to (name of hospital.)"</p> <p>The 1/22/14, 7:21 p.m. nurses note</p>		<p>upon admission and ensure interventions are in place and appropriate interventions are present that meets the resident's present needs. The IDT team will meet with each new admission on the following their admit and review their fall risk and ensure appropriate interventions for the resident are in place for prevention and safety. The IDT will also review all residents with significant change and residents quarterly who are determined to be a fall risk. The care plan and resident profile will be updated based on the IDT/ supervisor review. The DNS/Designee will conduct rounds daily on each shift to ensure fall interventions are in place based on the care plan. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? A Fall CQI audit tool will be completed twice weekly x 4 weeks, weekly x 4 weeks, then monthly thereafter. The fall CQI tools will be reviewed by the CQI Committee monthly for six months after which the CQI team will re-evaluate the continued need for the audit. If a 100% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee. Date of Compliance 2/24/14.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155329	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/03/2014
NAME OF PROVIDER OR SUPPLIER  ROSEWALK VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1302 N LESLEY AVE INDIANAPOLIS, IN 46219		
(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, "Admit this (age and race) female to (room and bed), resident is alert...nurse informed by daughter that resident has a torn rotator cuff..."</p> <p>The 1/22/14, 8:00 p.m. nurses note indicated, "PT (patient) lying in bed at this time...Family has left. Daughter and POA (Power of Attorney) had concern about 2 medicines ordered..."</p> <p>The 1/23/14, 8:06 a.m. Social Services progress note indicated, "Met with resident this morning to complete the initial assessment. Resident is alert to self, but not oriented to time or place. Resident was not able to answer any of the questions from this writer. Resident was not able to complete the initial assessments due to lack of ability to respond...This writer shall call the family to gather necessary info (information.)" This note was created by the Social Services Director.</p> <p>The 1/23/14, 10:47 a.m. Social Services progress note indicated, "This writer spoke with residents dtr (daughter) via phone, was able to gather social hx (history) per dtr. Dtr explained that res (resident) was</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155329	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/03/2014
NAME OF PROVIDER OR SUPPLIER  ROSEWALK VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1302 N LESLEY AVE INDIANAPOLIS, IN 46219		
(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>living with her husband in the community home and her plan is to be able to rehab (rehabilitate) to home. Resident was alert and oriented x3 (person, place, time) prior to her hospitalization and was very independent. Dtr explained that resident has psoarsis (sic) and hepatic encephalopathy which caused increased confusion and disorientation and that she had high ammonia (sic) levels. Dtr explained that since admission to the hospital, res has not been oriented to time/place, however does seem to recognize family members. Res is not able to communicate her needs at this time...CP (care plan) meeting has been scheduled via phone for tomorrow afternoon."</p> <p>An interview was conducted with the SSD (Social Services Director) on 2/3/14 at 2:32 p.m. The SSD indicated the other staff member present during the telephone conversation with Family Member #1 was Resident #A's Nurse Case Manager.</p> <p>An interview was conducted with Resident #A's Nurse Case Manager on 2/3/14 at 2:45 p.m. regarding Family Member #1's concern with Resident #A potentially falling out of</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155329	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ROSEWALK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1302 N LESLEY AVE INDIANAPOLIS, IN 46219
--	--

(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>bed. She indicated Resident #A being a fall risk was discussed with Family Member #1. She stated, "I remember discussing side rails are for seizure precautions and we don't use them for fall risk." Regarding what fall interventions were in place for Resident #A she indicated, "We used a bed alarm, bed against wall, floor mat at bedside." Regarding the mat on the floor not having been implemented until after Resident #A's fall on 1/24/14, she indicated, "I don't know why." Regarding what intervention to reduce and/or prevent injury from a potential fall was in place for the other side of Resident #A's bed, given one side of the bed was against the wall, she indicated, "I can't answer what was in place for the other side of the bed." Regarding if there was any intervention in place to reduce or prevent injury from a fall as care planned, she indicated, "Not that I can see."</p> <p>The 1/24/14, 2:00 a.m. nurses note indicated, "CNA (Certified Nursing Assistant) reported hearing resident alarm an (sic) entered room, resident on floor next to bed. bed in lowest position, c/o (complains of) severe pain to right arm, skin tear to chin and right arm. unable to move</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155329		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/03/2014	
NAME OF PROVIDER OR SUPPLIER  ROSEWALK VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 1302 N LESLEY AVE INDIANAPOLIS, IN 46219			
(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>right arm. on call notified, resident sent to (name of hospital) for eval (evaluation) via care ambulance, Daughter and Husband notified, ADNS (Assistant Director of Nursing) notified, all appropriate paperwork sent with resident."</p> <p>The 1/24/14, 1:46 a.m. Fall Event indicated the following:</p> <p>"Was fall witnessed: No Describe what the resident was doing prior to the fall: in bed Describe the position of the resident when first observed after fall: prone (body lying face down) Describe location of the fall: room/bedside Is the resident in pain and or experiencing difficulty in movement of extremities: Yes, right arm Did the resident hit his/her head: Yes Describe injuries, if any, and the immediate treatment provided: skin tear to chin, right arm, c/o pain severe to right arm. Resident or witness statement of how fall occurred: resident unable to say how fall occurred, CNA stated hearing alarm, entered resident romm (sic), resident on floor next to bed What intervention (s) was put into</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155329	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ROSEWALK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1302 N LESLEY AVE INDIANAPOLIS, IN 46219
--	--

(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>place to prevent another fall: mat on floor."</p> <p>The 1/24/14, 8:10 a.m. IDT (Interdisciplinary Team) progress note indicated, "IDT Review of fall that occurred at 115AM. Staff entered room due to alarm sounding to find resident on the floor next to the bed in prone position. Resident with complaints of pain to right arm. Family and MD notified of fall and RUE (right upper extremity) pain. Orders were obtained to send resident to ER (emergency room) for eval of right arm pain although resident has a history of right rotator cuff tear. Family notified of new orders to transfer to ER. Short term 15 minute checks and neurochecks initiated immediately after fall. A mat was placed on the floor next to bed immediately after fall as well to create one safe exit from bed. Will also place a scoop mattress to provide bed boundaries while resident is in bed. Resident was assisted back to bed with assistance of 2 and gait belt with RUE support. Resident remains out at the hospital at this time. Will continue all previous interventions and continue to monitor." This note indicated the ADNS was in attendance for this fall review.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155329		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/03/2014	
NAME OF PROVIDER OR SUPPLIER  ROSEWALK VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 1302 N LESLEY AVE INDIANAPOLIS, IN 46219			
(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			
	An interview was conducted with the ADNS on 2/3/14 at 3:00 p.m. regarding the information used to determine which fall interventions were appropriate for Resident #A and Resident #A's bed having been against the wall with no mat on the floor next to her bed prior to the fall. She indicated, "We used to have a separate fall risk assessment on admission," but currently used the admission assessment and the IDT fall risk assessment for determining appropriate interventions. "It was determined she did not need a mat on the floor...We do bed against wall to give less of a risk for rolling out of bed. I don't know why there was no mat in place. I guess we didn't feel there was a need...It's not typical to have the bed against the wall and no mat. She didn't move a lot. Some people have mats; some don't. If they (a resident) had a fall, we will put a mat down. She wasn't determined to be at risk for falling out of bed, but yes, she did have her bed against the wall as a fall prevention." Regarding whether Resident #A had been determined as being more likely to fall or roll out of one side of bed as opposed to the other, she indicated, "I don't believe so." Regarding the purpose of						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155329	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ROSEWALK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1302 N LESLEY AVE INDIANAPOLIS, IN 46219
--	--

(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>having a mat on the floor next to a resident's bed, she indicated, "A resident wouldn't injure themselves as badly with a mat next to the bed." Regarding the relationship between Resident A's injury after her fall and not having a mat next to her bed, the ADNS indicated, "She did obtain a subdural hematoma. If it (the mat) were in place prior, it may have prevented a subdural hematoma."</p> <p>The ADNS provided a copy of the IDT Fall Risk Assessment on 2/3/14 at 3:30 p.m. It indicated all new admissions were at risk for falls. It indicated risk factors identified for Resident #A were a history of falls, impaired vision, difficulty with standing, walking or transfers, and used a mobility device.</p> <p>The 1/24/14, 11:48 IDT progress note indicated, "IDT-care plan scheduled via phone this morning with dtr...Dtr states that res is at the hospital at this time and will not be returning..."</p> <p>The 1/24/14, 12:18 p.m. Nurse Practitioner note indicated, "Apparently patient fell last night and was sent out to the hospital for evaluation. She was admitted for subdural hematoma."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155329	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ROSEWALK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1302 N LESLEY AVE INDIANAPOLIS, IN 46219
--	--

(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 1/24/14 History and Physical from the hospital indicated, "History of present illness: The patient was admitted to the hospital with subdural hematoma, fall, encephalopathy on 1/24/2014...She had been only recently discharged from our hospital to ECF (extended care facility) for conservative care. There, she fell apparently and suffered a lip laceration. The head CT showed subdural hematoma. She is now admitted for management of this...Diagnostic Data: I reviewed her x-rays. She has an acute hematoma on the right frontotemporal region, 4 mm thick, and moderate cerebral atrophy...Impression: 1. Subdural hematoma...4. Arm pain, quite exquisite. I will order films of the elbow and wrist to look for occult fracture."</p> <p>The 1/24/14 hospital notes indicated the following:</p> <p>"EXAM: CT HEAD WO IV CONTRAST. INDICATION: Head injury. COMPARISON: 01/15/2014 FINDINGS: There is an acute extra-axial hematoma over the right frontotemporal region. This</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155329	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ROSEWALK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1302 N LESLEY AVE INDIANAPOLIS, IN 46219
--	--

(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>measures up to 4 mm in thickness... IMPRESSION: Acute right frontotemporal extra-axial hematoma, likely subdural. This measures up to 4 mm in thickness and exhibits no significant mass effect. This critical result was discussed with (name of doctor) in the emergency room at 4:20 AM on 01/24/2014."</p> <p>The 1/29/14, 3:53 p.m. Significant Event note from the hospital indicated, "1439 (2:39 p.m.). No palpable pulse. No audible respirations."</p> <p>The Fall Management Program policy was provided by the Administrator on 2/3/14 at 1:40 p.m. It indicated, "It is the policy of (name of facility) to ensure residents residing within the facility will maintain maximum physical functioning through the establishment of physical, environmental, and psychosocial guidelines to prevent injury related to falls...Fall Risk...2. All new admissions will be considered at fall risk based upon his/her new living arrangements, and his/her reasons for being admitted in to the nursing facility..."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155329	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/03/2014
NAME OF PROVIDER OR SUPPLIER  ROSEWALK VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1302 N LESLEY AVE INDIANAPOLIS, IN 46219		
(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	
	This Federal tag relates to Complaint IN00143397.  3.1-45(a)(2)				