

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/26/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEARTH AT STONES CROSSING LLC THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2339 S SR 135 GREENWOOD, IN 46143
---	---

(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
--------------------	--	---------------	---	----------------------

R000000	<p>This visit was for the Investigation of Complaint IN00146450.</p> <p>Complaint IN00146450 - Substantiated. No state residential deficiencies related to the allegations are cited.</p> <p>Unrelated state residential deficiency is cited.</p> <p>Survey dates: March 25 & 26, 2014</p> <p>Facility number: 005722 Provider number: 005722 AIM number: n/a</p> <p>Survey team: Diana Zgonc, RN-TC</p> <p>Census bed type: Residential: 119 Total: 119</p> <p>Census payor type: Other: 119 Total: 119</p> <p>Sample: 4</p> <p>This state residential finding is cited in accordance with 410 IAC 16.2.</p>	R000000	<p>The statements made in this Plan of Correction are not an admission to, nor does it constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the community has taken or is planning to take the actions set forth in the following Plan of Correction. All alleged deficiencies cited have been or are to be corrected by the date or dates indicated.</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:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/26/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEARTH AT STONES CROSSING LLC THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2339 S SR 135 GREENWOOD, IN 46143
---	---

(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
--------------------	--	---------------	---	----------------------

	Quality review completed on March 27, 2014; by Kimberly Perigo, RN.			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/26/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEARTH AT STONES CROSSING LLC THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2339 S SR 135 GREENWOOD, IN 46143
---	---

(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
--------------------	--	---------------	---	----------------------

R000090	<p>410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency</p> <p>(g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following:</p> <p>(1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to:</p> <p>(A) epidemic outbreaks; (B) poisonings; (C) fires; or (D) major accidents.</p> <p>If the division cannot be reached, a call shall be made to the emergency telephone number published by the division.</p> <p>(2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative.</p> <p>(3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility.</p> <p>(4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the:</p> <p>(A) employee's full name; and (B) dates and hours worked during the past twelve (12) months.</p> <p>(5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any</p>			
---------	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/26/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEARTH AT STONES CROSSING LLC THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2339 S SR 135 GREENWOOD, IN 46143
---	---

(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>subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability.</p> <p>(6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request</p> <p>Based on record review and interview, the facility failed to report an unusual occurrence according the facility policy for 1 of 3 residents reviewed for unusual occurrences in a sample of 5 (Resident #B).</p> <p>Findings include:</p> <p>The record for Resident #B was reviewed on 3/25/14 at 2:50 P.M. Diagnoses for Resident #B included, but were not limited to, hypertension, osteoarthritis, vertigo, dyslipidemia, bypass surgery, anemia, and seizures.</p> <p>On entrance to the facility on 3/25/14 at 1:15 P.M., a list of resident's with falls were requested. On review of the list, a fall was noted for Resident #B on March 5, 2014.</p> <p>A nurses note dated 3/5/14 at 7:45 P.M., indicated the resident was complaining about pain in her right knee and hip.</p>	R000090	<ol style="list-style-type: none"> Resident in this case went to Rehab to regain previous levels of independence with ADL's. We anticipate her return to Assisted Living. All residents have the potential to be affected by this alleged deficient practice. An audit of resident charts will be completed to ensure that any unusual occurrences per ISDH policy and procedure have been correctly reported. Any unusual occurrences found to not have been reported will be reported at that time. A review of the ISDH Reportable Unusual Occurrences policy will occur by the Corporate Clinical Staff of Hearth Management to the 	04/18/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/26/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEARTH AT STONES CROSSING LLC THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2339 S SR 135 GREENWOOD, IN 46143
---	---

(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>A facility document titled "Resident Incident/Accident Form" dated 3/5/14 indicated the resident was being assisted by staff in the shower. Resident #B's foot caught the lip of the shower causing her to fall forward and the aide lowered her to the floor. The resident was sent to the hospital emergency department and diagnosed with a right hip fracture and would be going to rehabilitation for the injury.</p> <p>A facility document titled "Resident Incident/Accident Form" dated 9/7/13 indicated the resident was found on the floor near the elevator. Resident #B complained of right hip pain and was sent to the hospital emergency room and diagnosed with a right hip fracture.</p> <p>The record lacked documentation of the falls and fractures on 3/5/14 and 9/7/13 being reported according to the facility policy.</p> <p>During an interview with the Director of Nursing on 3/25/14 at 3:50 P.M., she indicated the fall and fracture on 3/5/14 was not reported because they knew how it happened.</p> <p>During an interview with the</p>		<p>Executive Director and the Clinical Services team at The Hearth at Stones Crossing. An in-service will also be conducted to all staff by the Executive Director regarding identifying and reporting unusual occurrences.</p> <p>4. The ED and/or designee will conduct a review of resident unusual occurrences to ensure they have been appropriately reported weekly x4 weeks; monthly x1 month and quarterly thereafter. Results of these audits will be reviewed by the QA Committee, who will establish the threshold of compliance and make further recommendations accordingly.</p> <p>5. These systematic changes will be completed by 4/18/14</p>	
--	--	--	---	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 03/26/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEARTH AT STONES CROSSING LLC THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2339 S SR 135 GREENWOOD, IN 46143
---	---

(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>Administrator on 3/25/14 at 4:00 P.M., she indicated the falls and fractures were not reported, because the resident was not totally dependent.</p> <p>An undated facility policy titled "Reportable Unusual Occurrences" and provided by the Administrator on 3/25/14 at 4:15 P.M., indicated: "Purpose: To ensure that reportable occurrences are recorded and monitored to facilitate compliance with state and federal laws. ... Significant Injuries ... serious unusual and/or life threatening injury ..."</p>			