

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  10/07/2011
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NAME OF PROVIDER OR SUPPLIER  FRIENDSHIP HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN46203
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F0000	<p>This visit was for a Post Survey Revisit to the Post Survey Revisit completed on 8-19-11 to the Investigation of Complaint IN00092695 completed on 07-07-11.</p> <p>This visit was in conjunction with the Post Survey Revisit to Complaint IN00094742, which resulted in Immediate Jeopardy, completed on 8-19-11.</p> <p>This visit was in conjunction with the Investigation of Complaints IN00096109, IN00097319 and IN00097468.</p> <p>Complaint IN00092695 - not corrected</p> <p>Survey dates: September 29, 30 and October 4, 5 &amp; 7, 2011</p> <p>Facility number: 004700 Provider number: 155741 AIM number: 100266630</p> <p>Survey team: Mary Jane G. Fischer RN</p> <p>Census Bed Type: SNF/NF: 44 Total: 44</p> <p>Census Payor Type: Medicare: 2</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.

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F0241 SS=D	<p>Medicaid: 39 Other: 3 Total: 44</p> <p>Sample: 11 Supplemental sample: 7</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 10/17/11 by Suzanne Williams, RN</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, record review and interview, the facility failed to ensure the dignity of a resident in that when a resident had multiple abrasions, scrapes and scratches and visible bloody clothing, the nursing staff failed to ensure the resident had clean clothes, for 1 of 11 sampled residents. [Resident "E"].</p> <p>Findings include:</p> <p>The record for Resident "E" was</p>	F0241	Resident E's scrapes have (scabbed and or healed) with no current active bleeding. The resident's arms and legs are kept covered with clothing, he has had less episodes of scratching, and his overall condition has improved. All residents in the facility are identified as having potential to be affected. An all staff inservice was initiated on October 7, with small groups, educating diligent practice of infection control standards in all departments, especially with additional infections as, HIV-Aids, Hepatitis B and C, and Clostridium Difficile. An inservice with all nursing staff was held on October 28, 2011 regarding resident dignity and a review of	11/04/2011	

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	<p>reviewed on 09-29-11 at 12:10 p.m. Diagnoses included but were not limited to viral hepatitis "B", schizophrenic disorder and encephalopathy. These diagnoses remained current at the time of the record review.</p> <p>Review of the Nursing Admission Skin condition report, dated 09-09-11, indicated that at the time of admission to the facility the resident had "multiple bruises and scapping &lt;sic&gt; to bilateral upper extremities, scapping &lt;sic&gt; to right knee cap."</p> <p>Nursing notes indicated shortly after admission to the facility, the resident fell out of bed and sustained abrasions, skin tears and lacerations to the face, forehead and arms and fingers.</p> <p>During an observation on 10-05-11 at 9:40 a.m., the resident was seated in a wheelchair with a gauze wrapping to bilateral lower arms from wrist to elbows.</p>		<p>diligent infection control practices. In this meeting, nursing staff were reminded of the importance of infection prevention with proper handwashing techniques. There was a review for proper containment of body fluids, such as blood, stool, and urine, plus timeframes for the life of viruses and spores on inanimate objects and in dried blood. They were reminded of dignity infarctions if a resident wasn't appropriately dressed in clean clothing and well groomed, especially in the dining room during meals or group activities. Charge nurses who are in attendance at meals will observe residents for appropriate dress and infection control issues and will promptly address any problems found. The Activity Director will observe residents in group activities and report to nursing staff any dignity or infection control issues noted at that time. Additionally, all department heads were reminded to be alert to such issues and report any problems to nursing promptly. Resident dignity and infection control will be discussed at the Quality Assurance meeting monthly X three months and then quarterly thereafter on an ongoing basis to monitor for compliance in these areas. The Administrator and Director of Nursing are responsible for compliance. Date of Completion November 4, 2011. Addendum: The Director of Nursing or</p>		

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	<p>During a subsequent observation on 10-05-11 at 11:55 a.m., the resident remained seated in the wheelchair, but was observed in the main dining room. The resident's white T-shirt was blood splattered as well as the gray sweatpants. The resident's third finger on the left hand was actively bleeding. A body assessment was requested and conducted by certified nurses aide employee #7. The employee indicated the resident had been bleeding earlier in the morning and the nurses "had to put a dressing on [resident] arms." The CNA verified the resident's T-shirt was soiled with blood as well as the gray sweatpants.</p> <p>During an observation on 10-05-11 at 12:40 p.m. with the Director of Nurses in attendance, the resident was observed seated in the wheelchair at a table in the main dining room, with a staff member attempting to feed the resident. Although the resident's soiled</p>		<p>designee will make rounds three times weekly to make sure that nursing staff is providing care to the residents as indicated on their CNA Care Guides. During these rounds, the DON or designee will also observe for infection control issues and resident dignity issues and document any issues identified. The findings on these rounds will be shared with the interdisciplinary team at morning meeting on the business day after the rounds. The DON will also share her observations with the Quality Assurance Committee at least quarterly on an ongoing basis.</p>		

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	<p>T-shirt had been changed and replaced with a hospital gown, the resident's hands remained blood smeared and the blood splattered sweatpants had not been changed prior to the resident receiving the noon meal.</p> <p>This federal deficiency was cited on 07-07-11 and 08-19-11. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-3(t)</p>				