

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 04/02/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SUNRISE ON OLD MERIDIAN	STREET ADDRESS, CITY, STATE, ZIP CODE 12130 OLD MERIDAN ST CARMEL, IN 46032
---	---

(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 a State Residential Licensure survey.</p> <p>Survey dates: April 1 and 2, 2013</p> <p>Facility number: 012141 Provider number: 012141 AIM number: NA</p> <p>Survey team: Janet Stanton, R.N.--Team Coordinator Michelle Hosteter, R.N. Gloria Bond, R.N.</p> <p>Census bed type: Residential--90 Total--90</p> <p>Census payor type: Other--90 Total--90</p> <p>Residential sample: 7</p> <p>These State Residential findings are cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on April 12, 2013, by Brenda Meredith, R.N.</p>	R000000	Response to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance of state law.	

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 04/02/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SUNRISE ON OLD MERIDIAN	STREET ADDRESS, CITY, STATE, ZIP CODE 12130 OLD MERIDAN ST CARMEL, IN 46032
---	---

(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

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 04/02/2013	
NAME OF PROVIDER OR SUPPLIER  SUNRISE ON OLD MERIDIAN				STREET ADDRESS, CITY, STATE, ZIP CODE 12130 OLD MERIDAN ST CARMEL, IN 46032			
(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			
R000033	<p>410 IAC 16.2-5-1.2(h)(1-2) Residents' Rights - Noncompliance (h) The facility must furnish on admission the following:</p> <p>(1) A statement that the resident may file a complaint with the director concerning resident abuse, neglect, misappropriation of resident property, and other practices of the facility.</p> <p>(2) The most recently known addresses and telephone numbers of the following:</p> <p>(A) The department. (B) The office of the secretary of family and social services. (C) The ombudsman designated by the division of disability, aging, and rehabilitation services. (D) The area agency on aging. (E) The local mental health center. (F) Adult protective services.</p> <p>The addresses and telephone numbers in this subdivision shall be posted in an area accessible to residents and updated as appropriate.</p> <p>Based on observation, interview and record review, the facility failed to post, in an area accessible to residents and updated as appropriate, all of the required agency addresses and phone numbers. This deficiency had the potential to impact 90 of 90 residents living in the facility.</p> <p>Findings include:</p> <p>The environmental tour was done on 4/2/13 beginning at 9:15 A.M., with the Director of Environmental Services and the Director of Resident</p>	R000033	<p>A) With respect to the specific resident(s) cited: No specific resident was identified in the Statement of Deficiencies. B) The cited concern has the potential to affect all residents in the facility. C) 4/3/13 Executive Director (ED) updated and posted contact information for all of the required agencies, i.e. State Department of Health, Ombudsman, Secretary of Family and Social Services, the Area on Aging, the local mental health center, and Adult Protective Services. D) 5/1/2013 a quarterly spot audit will be done to ensure that</p>	04/03/2013			

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 04/02/2013	
NAME OF PROVIDER OR SUPPLIER  SUNRISE ON OLD MERIDIAN				STREET ADDRESS, CITY, STATE, ZIP CODE 12130 OLD MERIDAN ST CARMEL, IN 46032			
(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>Services/Independent Living in attendance.</p> <p>During the tour, a framed posted notice related to filing a grievance was located in the front lobby and listed the addresses and phone numbers for ISDH (Indiana State Department of Health) and the Ombudsman.</p> <p>A posted notice listing the addresses and phone numbers for the office of the Secretary of Family and Social Services, the area Agency on Aging, the local mental health center, and Adult Protective Services was not found.</p> <p>In an interview on 4/2/13 at 11:00 A.M., the Executive Director indicated the only agency addresses and phone numbers that were posted would be the ones listed on the posted grievance notice. She indicated she thought those were the only addresses and phone numbers she was supposed to post.</p>		posting is updated and current.				

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 04/02/2013	
NAME OF PROVIDER OR SUPPLIER  SUNRISE ON OLD MERIDIAN				STREET ADDRESS, CITY, STATE, ZIP CODE 12130 OLD MERIDAN ST CARMEL, IN 46032			
(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 04/02/2013	
NAME OF PROVIDER OR SUPPLIER  SUNRISE ON OLD MERIDIAN				STREET ADDRESS, CITY, STATE, ZIP CODE 12130 OLD MERIDAN ST CARMEL, IN 46032			
(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 observation and interview, the facility failed to post a notice, in a place readily accessible to residents, identifying the location and availability of the annual and any subsequent surveys conducted by the State agency. This deficiency had the potential to impact 90 of 90 residents living in the facility.</p> <p>Findings include:</p> <p>On 4/1/13 at 11:30 A.M., a binder containing the last annual survey and subsequent complaint investigation surveys was found on the bottom shelf of a table positioned in the entry vestibule to the main lobby of the residential building of the facility campus. The binder had a label on the spine that read "Resident Rights." There was no other posted sign or notice in the area that indicated where the survey results were located.</p> <p>The environmental tour was done on</p>	R000090	<p>A) With respect to the specific resident(s) cited: No specific resident was identified in the Statement of Deficiencies.</p> <p>B) The cited concern has the potential to affect all residents in the facility.</p> <p>C) 4/3/2013 Executive Director updated current binder at front lobby to clearly communicate that the Resident Rights and the past Survey results were in that binder. Small framed notification of the location of the Resident Rights and Survey Reports was also posted-</p> <p>D) 5/1/2013 a quarterly spot audit will be done to ensure that binder and posting are visible, updated and current.</p>	04/03/2013			

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 04/02/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SUNRISE ON OLD MERIDIAN	STREET ADDRESS, CITY, STATE, ZIP CODE 12130 OLD MERIDAN ST CARMEL, IN 46032
---	---

(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>4/2/13 beginning at 9:15 A.M., with the Director of Environmental Services and the Director of Resident Services/Independent Living in attendance.</p> <p>In an interview on 4/2/13 at 10:30 A.M., after touring the 4th, 3rd, and 2nd floors of the building, the Director of Environmental Services and the Director of Resident Services indicated they had not seen and were not aware of any notice that was posted on any of the resident living floors that indicated where survey results could be found, or that the results were available for review.</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 04/02/2013	
NAME OF PROVIDER OR SUPPLIER  SUNRISE ON OLD MERIDIAN				STREET ADDRESS, CITY, STATE, ZIP CODE 12130 OLD MERIDAN ST CARMEL, IN 46032			
(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			
R000123	<p>410 IAC 16.2-5-1.4(h)(1-10) Personnel - Nonconformance (h) The facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (1) The name and address of the employee. (2) Social Security number. (3) Date of beginning employment. (4) Past employment, experience, and education, if applicable. (5) Professional licensure or registration number or dining assistant certificate or letter of completion, if applicable. (6) Position in the facility and job description. (7) Documentation of orientation to the facility, including residents' rights, and to the specific job skills. (8) Signed acknowledgement of orientation to residents' rights. (9) Performance evaluations in accordance with facility policy. (10) Date and reason for separation. Based on interview and record review, the facility failed to ensure 9 of 9 employees reviewed, who were hired since the last annual survey completed on 2/2/12, and between 1/29/13 and 2/27/13, had documentation of orientation to their specific job skills. (Employees #8, #9, #10, #11, #12, #13, #14, #15, and #16)</p> <p>Findings include:  Following the entrance conference on 4/1/13 at 9:45 A.M., the Executive Director provided the completed</p>	R000123	A) With respect to the specific resident(s) cited: No specific resident was identified in the Statement of Deficiencies. B) The cited concern has the potential to affect all residents in the facility. C) 4/22/13 Executive Director and Business Office Coordinator will ensure that documentation of orientation to team member's specific job skills will be placed in team member files within 30 days of hire. D) 5/1/13 All Coordinators will receive in-service training on Skills demonstration sheets. Sheets will be signed by team member and department coordinators within 30 days of	05/01/2013			

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 04/02/2013	
NAME OF PROVIDER OR SUPPLIER  SUNRISE ON OLD MERIDIAN				STREET ADDRESS, CITY, STATE, ZIP CODE 12130 OLD MERIDAN ST CARMEL, IN 46032			
(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>"Employee Records" form, listing all current employees of the facility with their job title and date of hire. Nine employees, all hired since the last annual survey on 2/2/12 and between 1/29/13 and 2/27/13, were randomly selected for employee record review.</p> <p>Documentation of orientation to their specific job skills was not found for the following new employees:</p> <p>R.N. #8, with a date of hire of 2/27/13; CNA #9, with a date of hire of 1/31/13; QMA #10, with a date of hire of 2/7/13; CNA #11, with a date of hire of 2/2/13; Dietary Server #12, with a date of hire of 2/14/13; Dietary Cook #13, with a date of hire of 2/2/13; Housekeeper #14, with a date of hire of 1/29/13; Housekeeper #15, with a date of hire of 1/30/13; Security Staff #16, with a date of hire of 2/13/13.</p> <p>In an interview on 4/2/13 at 3:00 P.M., the Executive Director indicated the facility had changed the process of documenting orientation to specific job skills. Previously, a form titled</p>		<p>hire and turned into Business Office. E) 5/1/2013 Executive Director will do monthly inspections of 5 random new hires within the last 90 days to ensure that skill demonstration sheets are in the file. Periodically thereafter ED will do quarterly audits. 5/1/13 BOC will not file team member files until the skills demonstration sheets have been completed and signed off.</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 04/02/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SUNRISE ON OLD MERIDIAN	STREET ADDRESS, CITY, STATE, ZIP CODE 12130 OLD MERIDAN ST CARMEL, IN 46032
---	---

(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
	"Skills Demonstration Documentation Instructions, "was used to document return-demonstration for each position. That form had been discontinued several months ago, and a new process or form had not replaced it. She indicated she had reviewed all 9 of the employees' files and was unable to locate any documentation of orientation to their specific job skills.			

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 04/02/2013	
NAME OF PROVIDER OR SUPPLIER  SUNRISE ON OLD MERIDIAN				STREET ADDRESS, CITY, STATE, ZIP CODE 12130 OLD MERIDAN ST CARMEL, IN 46032			
(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			
R000148	<p>410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected.</p> <p>Based on observation and interview, the facility failed to maintain hazardous chemicals and equipment in a secure manner on 2 of 4 floors/units. This deficiency had the potential to impact 19 residents, who were identified as self mobile, of 28 residents living on the third floor in the secured/locked Alzheimer's unit; and 13 residents, who were identified as self mobile, of 22 residents living on the fourth floor in the unit for early dementia residents.</p> <p>Findings include:  The environmental tour was done on</p>	R000148	<p>A) With respect to the specific resident(s) cited: No specific resident was identified in the Statement of Deficiencies. B) The cited concern has the potential to affect all residents in the facility. C) 4/3/2013 all knives/sharp utensils on both floor 3 and 4 have been secured into locked/secured cabinets. 4/3/13 all hand sanitizers on 3 rd floor have been removed from common areas secured in a locked cabinet. D) 4/26/13 Lead Care Managers will conduct an audit on each shift and ensure all knives have been accounted for and secured. 5/15/2013 Executive Director and Care Coordinators will do in-service</p>	05/15/2013			

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 04/02/2013	
NAME OF PROVIDER OR SUPPLIER  SUNRISE ON OLD MERIDIAN				STREET ADDRESS, CITY, STATE, ZIP CODE 12130 OLD MERIDAN ST CARMEL, IN 46032			
(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>4/2/13 beginning at 9:15 A.M., with the Director of Environmental Services and the Director of Resident Services/Independent Living in attendance.</p> <p>Unsecured hazardous chemicals and equipment were observed as follows:</p> <p>On the Fourth Floor:</p> <p>A plastic bottle with a pump dispenser, containing "Purell Hand Sanitizer," was observed on the sink counter in the common bathroom, a room next to the shower/Spa room. The label indicated the hand sanitizer contained 65% Ethyl Alcohol, with warnings "For external use only," "Flammable, keep away from fire or flame," "Do not use in the eyes," and "Keep out of reach of children. If swallowed, get medical help or contact a Poison Control Center right away."</p> <p>A plastic bottle with a pump dispenser of the "Purell Hand Sanitizer" was also observed on the sink counter in a common bathroom located immediately off of the living room area, and next to one of the entries into the unit dining room.</p> <p>Two large knives and two smaller</p>		<p>with all team members to ensure these items are all being secured on each shift. On-going Lead Care Managers will initial off on monitoring spreadsheet at end of each meal service to verify all sharp objects have been secured. Non-compliance will result in disciplinary action up to and including terminaton.</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 04/02/2013	
NAME OF PROVIDER OR SUPPLIER  SUNRISE ON OLD MERIDIAN				STREET ADDRESS, CITY, STATE, ZIP CODE 12130 OLD MERIDAN ST CARMEL, IN 46032			
(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>knives, each with a sharp cutting edge and point, were observed in an unlocked lower drawer located beneath the double, stacked oven in the servery/kitchenette. The servery/kitchenette was accessible from the dining room, through a wide entry from the main hallway and the theater/entertainment lounge area.</p> <p>In an interview during the tour, the Director of Resident Services indicated that all of the people living on the fourth floor, the Terrace Club unit, had early stages of dementia and were "higher functioning residents with Alzheimer's disease."</p> <p>During the initial orientation tour on 4/1/13 at 10:50 A.M., the Health Care Coordinator indicated that 13 of the 22 residents living on this floor/unit were either ambulatory, ambulatory with a walker, or were able to propel themselves in a wheelchair.</p> <p>On the Third Floor:</p> <p>During the entrance conference on 4/1/13 at 9:45 A.M., the Executive Director indicated the third floor unit was a locked/secured Alzheimer's unit.</p> <p>A plastic bottle with a pump dispenser</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 04/02/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SUNRISE ON OLD MERIDIAN	STREET ADDRESS, CITY, STATE, ZIP CODE 12130 OLD MERIDAN ST CARMEL, IN 46032
---	---

(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>of the "Purell Hand Sanitizer" was observed on top of a medication cart which was sitting in the main hallway, around the corner from the elevator.</p> <p>The servery/kitchenette had one unlocked lower cabinet drawer with a utensil tray holding too numerous to count metal forks with sharp tines and metal dinner knives with serrated edges. The drawer was located at the end of the counter, near to the dining room tables. Other eating utensils, including forks and knives, were observed in a silverware container on a counter at the opposite end of the servery, above the dishwasher, waiting to be washed in the dishwasher.</p> <p>Two knives with sharp edges and points, a sharp punch can opener, and a meat thermometer with a sharp pointed end, were observed in an unlocked lower cabinet drawer located next to the stove in the servery/kitchenette.</p> <p>The servery/kitchenette was located in the center of the unit, and was accessible through wide entryways on both sides leading from the main hall, and living room areas across the hall on each side.</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 04/02/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SUNRISE ON OLD MERIDIAN	STREET ADDRESS, CITY, STATE, ZIP CODE 12130 OLD MERIDAN ST CARMEL, IN 46032
---	---

(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>During the entrance conference on 4/1/13 at 9:45 A.M., the Executive Director indicated the third floor unit was a locked/secured Alzheimer's unit.</p> <p>During the initial orientation tour on 4/1/13 at 10:50 A.M., the Health Care Coordinator indicated that 16 of the 28 residents living on this floor/unit were ambulatory, and another 2 residents were able to propel themselves in a wheelchair.</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 04/02/2013	
NAME OF PROVIDER OR SUPPLIER  SUNRISE ON OLD MERIDIAN				STREET ADDRESS, CITY, STATE, ZIP CODE 12130 OLD MERIDAN ST CARMEL, IN 46032			
(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			
R000214	<p>410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident.</p> <p>Based on record review and interview, the facility failed to evaluate a resident after a change in condition in regards to swallowing concerns and weights for 1 of 5 residents reviewed for evaluation. (Resident #26)</p> <p>Findings include:</p> <p>The clinical record for Resident #26 was reviewed on 4/1/13 at 11:00 a.m.</p> <p>The Nutritional Assessment, dated 2/6/12, indicated Resident #26 was on a mechanical soft diet and nectar thickened liquids.</p> <p>The nurses notes, on 10/10/12 at 6:00 p.m., indicated, "...Res [resident] had episode of choking while eating meal, Staff assisted resident to standing position and res. coughed up large amt. [amount] of mucus. [sic] Res. stated that there was a piece of meat in his salad that he got choked on. Res coughing and clearing on</p>	R000214	<p>A) With respect to the specific resident(s) cited: 4/3/13 in respect to resident #26 Assisted Living Coordinator reviewed and confirmed proper diet orders were listed on care plan. 5/1/13 Care plan meeting will be held with resident #26 families to address nutritional needs. Care Plan will be updated after meeting is held. Resident #26 will have weekly weights for the next 3 months to observe for any further weight loss. Physician will be notified of weight trends and we will implement any new orders received. Dietician has been notified for consult. B) 05/1/2013 all weights for current residents will be reviewed to ensure identification of other residents have had any significant unplanned or avoidable weight loss. C) 5/1/2013 monthly weights will be reviewed/monitored by Health Care Coordinator. Any significant avoidable or unplanned weight losses of 5% or more will be reported immediately by the Health Care Coordinator to the Executive Director as well as</p>	05/01/2013			

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 04/02/2013	
NAME OF PROVIDER OR SUPPLIER SUNRISE ON OLD MERIDIAN				STREET ADDRESS, CITY, STATE, ZIP CODE 12130 OLD MERIDAN ST CARMEL, IN 46032			
(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>own...."</p> <p>On 1/14/13 at 6:20 p.m., the nurses notes indicated "Res. choked on food while eating dinner. Became cyanotic. Unable to clear completely with Heimlich maneuver. Color improved and res able to speak but says it feels like something is in his throat. Thick mucus in mouth,. Able to swallow but with difficulty. Wife notified. 911 called and res sent to ER [emergency room] for eval. [evaluation]. 9:45 p.m. Res. returned from ER accompanied by wife per her car. Alert. Able to swallow without difficulty. Only findings was aspiration pneumonia...."</p> <p>Review of Resident #26 weights over the last four months were: January -140.5, February-137, March-131, April-128.</p> <p>The information provided, on 4/2/13 at 4:45 p.m., by the Executive Director (ED) indicated the resident had been assessed by a dietician on 1/8/13, and 3/21/13. The ED indicated at this time they had changed companies that provided their dietician services in the last month. The assessment from 1/8/13, Nutritional Assessment Recommendations form indicated,</p>		<p>completing notification to the physician. The Health Care Coordinator/designee will seek dietician consult for weight loss. D) 5/1/13 Recommendations will be included in the residents updated care plan. All residents identified with significant, avoidable weight loss will be included in weekly quality review to ensure notifications have been made, any new orders or recommendations have been implemented, dietary consults have been completed, care plans have been updated to reflect recommendations, and interventions have been reviewed for effectiveness. Non-compliance will result in disciplinary action up to and including termination.</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 04/02/2013	
NAME OF PROVIDER OR SUPPLIER  SUNRISE ON OLD MERIDIAN				STREET ADDRESS, CITY, STATE, ZIP CODE 12130 OLD MERIDAN ST CARMEL, IN 46032			
(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>"...please recheck Jan. (January) wt. (weight)-questionable loss ...." A box was marked indicating Nursing was responsible for following up on recommendations.</p> <p>Review of a form from the new dietician company titled, "Dietician's Quarterly Quality Assurance Report Meal/Service/Dining Room Observation/ Menu Compliance," indicated the resident had a diet served accurately on 3/21/13. The resident had a diet served accurately with liquids being provided and the diet located on diet board /serving list corresponds to doctor order.</p> <p>There was no other information provided related to the resident's having episodes of choking and aspiration pneumonia being addressed or evaluated.</p> <p>In an interview with the Executive Director on 4/2/13 at 5:25 p.m., she indicated she did not have any more information related to swallowing concerns for Resident #26.</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 04/02/2013	
NAME OF PROVIDER OR SUPPLIER  SUNRISE ON OLD MERIDIAN				STREET ADDRESS, CITY, STATE, ZIP CODE 12130 OLD MERIDAN ST CARMEL, IN 46032			
(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			
R000217	<p>410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows:</p> <p>(1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident.</p> <p>(2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review.</p> <p>(3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request.</p> <p>(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.</p> <p>(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.</p> <p>Based on interview and record review, the facility failed to insure that a Service Plan addressed fall prevention services to be provided for 1 of 2 residents reviewed for history of falls (Resident #12), or services to be provided to 1 of 1 resident reviewed for swallowing problems and</p>	R000217	A) With respect to the specific resident(s) cited: 4/3/13 for Resident #26 Assisted Living Coordinator reviewed and confirmed proper diet orders and swallowing concerns were listed on care plan. 4/3/13 #12 Care Plan was reviewed and interventions were listed. 4/26/13 residents #12, #26, #44, and #84	05/08/2013			

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 04/02/2013	
NAME OF PROVIDER OR SUPPLIER  SUNRISE ON OLD MERIDIAN				STREET ADDRESS, CITY, STATE, ZIP CODE 12130 OLD MERIDAN ST CARMEL, IN 46032			
(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>weight loss (Resident #26). In addition, the facility failed to ensure that an agreed upon Service Plan was signed and dated by the resident and/or responsible party for 4 of 7 sample residents reviewed. (Residents #12, #26, #44, and #84)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #44 was reviewed on 4/1/13 at 2:10 P.M. Diagnoses included, but were not limited to, dementia with behavior disturbance, remote past history of alcohol abuse, depression, benign prostatic hypertrophy, hypertension, abdominal aortic aneurysm, and gastroesophageal reflux disease.</p> <p>The most recent Service Plan was dated 10/1/12. There were signatures for the Executive Director, Health Care Coordinator, and Department Coordinator on the last page, and were dated 10/1/12.</p> <p>The lines for signatures from the resident and/or a family/responsible party was blank.</p> <p>In an interview on 4/2/13 at 3:00 P.M., the Executive Director indicated this Service Plan was the most recent. She was unable to locate any other</p>		<p>families have been invited in for a care plan meeting to review and sign care plans. B) 05/08/13 all care plans on Floors 1 &amp; 2 will be audited by care coordinators to review and confirm all care plans are up to date and have current information and signatures. C) 5/1/13 Health Care Coordinator/Licensed Nurse will review residents with change in conditions or change in care needs to ensure proper documentation and care plans are updated. 5/1/13 Health Care Coordinator/License Nurse will follow up with primary care doctor/therapy and any recommendations will be included in care plan. 5/1/13 Care Coordinators will ensure monthly care plan meeting invites include families/responsible party, as well as the resident if they are able to participate. If resident's family/responsible party cannot attend the care plan meeting, a copy of the care plan will be sent to them. Resident if able or resident's responsible party will be asked for signature of the care plan. D) 5/1/13 Executive Director will spot check for 3 months 5 care plans mentioned in quality review to ensure that proper documentation is in place to communicate updated needs as well as signatures in place or documentation that care plan meetings have been planned. After 3 months Executive Director will reivev 3 care plans quarterly.</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 04/02/2013	
NAME OF PROVIDER OR SUPPLIER  SUNRISE ON OLD MERIDIAN				STREET ADDRESS, CITY, STATE, ZIP CODE 12130 OLD MERIDAN ST CARMEL, IN 46032			
(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>document with a signature from the resident or family/responsible party that would indicate the Plan had been reviewed and agreed upon at that time.</p> <p>2. The "Individualized Service Plan" record for Resident #84 was reviewed on 4/2/2013 at 2 P.M. Diagnoses included, but were not limited to, Alzheimer's disease, and hypertension (high blood pressure).</p> <p>The Service Plan, dated February 18, 2013, was not signed and dated by the resident or family/ responsible party.</p> <p>3. The clinical record review for Resident # 12 was completed on 4/2/13 at 10:00 a.m. Diagnoses included, but were not limited to, depression, possible Lewy body dementia, Parkinson's disease and colitis.</p> <p>The progress notes, dated 8/26/12 at 7:00 a.m., indicated, "...caregiver reported that resident c/o [complains] R [right] left pain she reported that she was sitting on floor [and] felt 'bones rubbing'. [right] leg longer than [left]. Res. [resident] c/o pain 10/10 when standing; 6/10 when standing. Resident states she didn't fall...."</p> <p>The nursing notes dated 12/6/12,</p>		<p>Executive Director will complete monitor spreadsheet. Non-compliance will result in disciplinary action up to and including termination.</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 04/02/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SUNRISE ON OLD MERIDIAN	STREET ADDRESS, CITY, STATE, ZIP CODE 12130 OLD MERIDAN ST CARMEL, IN 46032
---	---

(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, "...1100 Res self reports a fall, unable to give specifics. Small raised area to R upper forehead, res states she must have hit the floor, but did not hit the wall or furnishings. Approx [approximately] 5 cm [centimeters] curved ST [skin tear] to RFA [right forearm] cleansed, stripped and covered. Res tol [tolerated] without c/o. MAE [Moves all extremities] without diff [difficulties] per res baseline ROM [range of motion]...."</p> <p>12/8/12- 1:17 p.m. Tylenol given for left hip soreness. 12/9/12 -8:06 a.m. Tylenol given for left hip soreness. 12/10/12- 3:00 p.m. "...Res continues to complain of left hip and knee pain when walking. Raised area noted at left hip that res. states is sore. Dtr [daughter] here and requested to take res to [name of hospital]...." 5:52 p.m. Dtr returned to community. Res has fx [fractured] knee cap and immobilizer in place to left leg...."</p> <p>The 10/22/12, service plan indicated "rarely" under the falls category and under the safety scoring section indicated "no concerns noted in safety section." The service plan had no signature by the responsible party or the resident.</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 04/02/2013	
NAME OF PROVIDER OR SUPPLIER  SUNRISE ON OLD MERIDIAN				STREET ADDRESS, CITY, STATE, ZIP CODE 12130 OLD MERIDAN ST CARMEL, IN 46032			
(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>There was no service plan after 10/22/12 indicating any safety concerns related to falls, including the fall with fracture from 12/6/12.</p> <p>In an interview with the Associate Living Coordinator on 4/1/13 at 2:30 p.m. she indicated this was the most recent service plan for Resident #12.</p> <p>4. The clinical record for Resident #26 was completed on 4/1/13 at 11 a.m. Diagnoses included, but were not limited to, Parkinson's like illness, history of a fall with a subdural hematoma, and benign prostatic hypertrophy.</p> <p>The Assisted Living Nutrition Assessment, dated 2/6/12, indicated, "Mechanical Soft NTL (nectar thick liquid)...."</p> <p>The most recent service plan was dated 11/13/12. The service plan indicated under Dining and Nutrition "...You may need to put the food in his hand and cut his food in the kitchen before bringing out...Food texture and type Regular texture regular diet...."</p> <p>The service plan was not signed by the responsible party or the resident.</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 04/02/2013	
NAME OF PROVIDER OR SUPPLIER  SUNRISE ON OLD MERIDIAN				STREET ADDRESS, CITY, STATE, ZIP CODE 12130 OLD MERIDAN ST CARMEL, IN 46032			
(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			
	In an interview on 4/1/13 at 2:30 P.M., the Assisted Living Coordinator indicated a lot of the service plans are not signed because families do not come to the service plan meetings.						

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 04/02/2013	
NAME OF PROVIDER OR SUPPLIER  SUNRISE ON OLD MERIDIAN				STREET ADDRESS, CITY, STATE, ZIP CODE 12130 OLD MERIDAN ST CARMEL, IN 46032			
(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			
R000246	<p>410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact.</p> <p>Based on record review and interview, the facility failed to ensure QMA (Qualified Medication Aide) staff were receiving permission from nurses to give PRN (as needed )medications to residents for 3 of 5 records reviewed for PRN medication use. (Resident #12, Resident #26, and Resident #101)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #26 was completed on 4/1/13 at 11 a.m. Diagnoses included, but were not limited to, Parkinson's like illness, history of a fall with a subdural hematoma, and benign prostatic hypertrophy.</p> <p>The Medication Administration Record (MAR) for Resident # 26 for January 2013, indicated the resident received Tramadol 37.5/325 mg 1</p>	R000246	<p>A. With respect to the specific resident(s) cited: In regards to residents #12, #26, and #101. 4/25/13 all MARS were reviewed to ensure nurses were following policy to ensure co-signatures in place within 24 hours of PRN verbal approval. B. The cited concern has the potential to affect all residents in the facility. C. 4/22/13 an in-service provided by Health Care Coordinator to all QMA's and nurses on procedure for co-signatures for the PRN Medications given. Direction of in-service will be as follows: The QMA is to notify and receive approval for any PRN medication given. The nurse will give a verbal approval to the QMA. Nurse will be required within 24 hours to co-sign the PRN documentation into the MAR. D. 5/1/2013 Health Care Coordinator will do monthly random MAR audits to ensure all signatures and documentation of PRN Medications is in place. 4/30/13 Executive Director will audit 4</p>	04/22/2013			

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 04/02/2013	
NAME OF PROVIDER OR SUPPLIER  SUNRISE ON OLD MERIDIAN				STREET ADDRESS, CITY, STATE, ZIP CODE 12130 OLD MERIDAN ST CARMEL, IN 46032			
(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>tablet every four hours as needed for pain on the following dates: 1/14, 1/15, 1/16, 1/17, 1/17, 1/19, 1/20, 1/21, 1/22, 1/23, 1/24 and 1/28. All of the boxes were signed by QMA # 6 or QMA #7. There were no nurses signatures or any documentation related to receiving permission from nursing staff to give the PRN medication.</p> <p>The nursing notes for Resident #26 did not indicate in any of the entries from January 2013, that a nurse had given permission to QMA to give the PRN medication.</p> <p>2. The clinical record review for Resident # 12 was completed on 4/2/13 at 10 a.m. Diagnoses included, but were not limited to, depression, possible Lewy body dementia, Parkinson's and colitis.</p> <p>The Medication Administration Record for December 2012, indicated Resident #12 had received Tylenol two tabs every 4 hours as needed for pain on the following dates: 12/6, 12/9-, 12/10, 12/11, 12/12, 12/13-twice, 12/14, 12/16, 12/17, 12/18, 12/18-three times. All of the boxes were signed by QMA # 6 or QMA #7. There were no nurses signatures or any documentation</p>		<p>MARS per month for 4 months then will do periodic audits to ensure signatures are in place. Compliance is defined as all signatures are in place within 24 hours of PRN medications being given. Non-compliance will result in disciplinary action up to and including termination.</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 04/02/2013	
NAME OF PROVIDER OR SUPPLIER  SUNRISE ON OLD MERIDIAN				STREET ADDRESS, CITY, STATE, ZIP CODE 12130 OLD MERIDAN ST CARMEL, IN 46032			
(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>related to receiving permission from nursing staff to give the PRN medication.</p> <p>The nursing notes for Resident #12 did not indicate in any of the entries from December 2012, that a nurse had given permission to QMA to give the PRN medication.</p> <p>3. The clinical record for Resident #101 was reviewed on 4/2/13 at 1:45 p.m. Diagnoses included, but were not limited to chronic pain, chronic obstructive pulmonary disease and degenerative disk disease.</p> <p>The Medication Administration Record for March 2013, indicated Resident #101 had received Tramadol 25 milligrams every 6 hours as needed for pain on the following dates: 3/2, 3/5, 3/7, 3/8, 3/11, 3/12, 3/14, 3/16, 3/17, 3/20 and 3/21. All of the boxes were signed by QMA # 6 or QMA #7. There were no nurses signatures or any documentation related to receiving permission from nursing staff to give the PRN medication.</p> <p>The nursing notes for Resident #101 did not indicate in any of the entries from March 2013 that a nurse had given permission to QMA to give the</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 04/02/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SUNRISE ON OLD MERIDIAN	STREET ADDRESS, CITY, STATE, ZIP CODE 12130 OLD MERIDAN ST CARMEL, IN 46032
---	---

(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>PRN medication.</p> <p>In an interview with RN # 1 on 4/2/13 at 2:25 p.m., he indicated the QMA should get permission from the nurse and document on the back of the MAR. He indicated it is not necessarily documented in the nurses notes that they received permission. He also indicated if it is something like Tylenol, they can give and let him know later it was given.</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 04/02/2013	
NAME OF PROVIDER OR SUPPLIER  SUNRISE ON OLD MERIDIAN				STREET ADDRESS, CITY, STATE, ZIP CODE 12130 OLD MERIDAN ST CARMEL, IN 46032			
(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			
R000273	<p>410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24.</p> <p>Based on observation, documentation and interview, the facility failed to ensure all areas where food was prepared, stored, and served were clean and sanitary practices were followed for 1 of 1 kitchens and 3 of 4 resident areas (Severy/Kitchenette ) where food is served and stored.</p> <p>Findings include:</p> <p>1. During the initial tour of the kitchen on 4/1/13 at 9:45 a.m., the following things were observed:</p> <p>Cook # 3 had thick curly hair that was not covered, a beard and mustache that were not covered, and he was preparing chicken. Server # 2 and Server # 4 were walking by the food prep area and they did not have hair nets on. The Dining Services Director also did not have a hair net on.</p> <p>The ice machine was observed to have a brown substance growing on the inside of it.</p> <p>The refrigerator, designated AL-reach</p>	R000273	<p>A) With respect to the specific resident(s) cited: No specific resident was identified in the Statement of Deficiencies. B) The cited concern has the potential to affect all residents in the facility. C) 4/3/2013 hair nets were placed at kitchen door. 5/1/13 team members in-serviced that hair nets or hats must be in place at all times in the kitchen. Lead Cook, Hostess and Dining Services Director will monitor compliance of hair nets daily. 4/3/2013 Ice Machine was completely dismantled by Director of Environmental Services and cleaned from top to bottom to ensure no residual residue was not in machine. 4/3/13 large covers were put in place for all food that was uncovered. Lead Cook, Hostess or dining services director will ensure daily these covers are in place. 4/3/13 covers for mixer and slicer were in place. 4/5/13 food that was incorrectly labeled or dated was discarded. D) 04/18/13 Cleaning Schedules are in place and all dietary team members will be in serviced on the proper cleaning schedule and need to keep completed forms for records. 5/1/13 in-service will be</p>	04/18/2013			

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 04/02/2013	
NAME OF PROVIDER OR SUPPLIER  SUNRISE ON OLD MERIDIAN				STREET ADDRESS, CITY, STATE, ZIP CODE 12130 OLD MERIDAN ST CARMEL, IN 46032			
(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>in, had 9 unlabeled and undated liquid containers in it. There were 5 uncovered cheese danishes in a box.</p> <p>The walk-in refrigerator had a cart stacked with items on it. The cart had 7 uncovered pies.</p> <p>The refrigerator, designated as the side by side, had a container of uncovered lemons, a box of chocolate eclairs with plastic tongs inside of the box.</p> <p>The meat slicer and mixer both had debris on them. Cook #3, on 4/1/13 at 10 a.m., indicated he had just used the slicer and indicated he planned to use again for lunch.</p> <p>In an interview with Cook #3 at 10:10 a.m. he indicated they usually do not cover the pies, the meat slicer, or the mixer.</p> <p>In an interview with the Dishwasher # 17, on 4/1/13 at 10:15 a.m., .she indicated they use the temperature gauge on the outside of the dishwasher to check it. She indicated they do not have any way of monitoring for sanitation other than the outside temperature gauge. She indicated the dishwasher was chemical. The Executive Director</p>		<p>completed in regards to cleaning schedules. Dining Services Director will monitor completion of all tasks. 5/1/13 ED will do spot checks on a monthly basis to ensure cleaning schedules are in place. 5/1/13 in-service completed to inform all team members to ensure they are labeling food correctly, covering food correctly, and ensuring if the dates are not on there to remove from kitchen area. 4/22/13 Dining Services Director will do weekly audits of all refrigerators on 1, 3 &amp; 4 th floors to ensure there are no unlabeled opened containers. 4/22/13 Audits will be turned into Executive Director weekly. Non-compliance will result in disciplinary action up to and including termination.</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 04/02/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SUNRISE ON OLD MERIDIAN	STREET ADDRESS, CITY, STATE, ZIP CODE 12130 OLD MERIDAN ST CARMEL, IN 46032
---	---

(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 she wasn't sure if system was chemical or heat sanitation. She indicated they did not have the manufacture's guide for the machine.</p> <p>In an interview with the Dining Services Director at 9:50 a.m. he indicated staff should have hair nets on and that he was unsure of where the hairnets were. He indicated items in the refrigerator should be labeled and dated.</p> <p>A request was made to the Executive Director, on 4/1/13 at 3:15 p.m. and 4/2/13 at 9 a.m., for any cleaning schedules and policies related to sanitization, hairnet use, covering of refrigerated food items, and of dating and labeling of food.</p> <p>The cleaning lists provided were blank. The Executive Director indicated on 4/2/13 at 9:45 a.m. they do not keep the cleaning lists after they are marked.</p> <p>The only policy provided as of the exit conference on 4/2/13 at 5:45 p.m. was the Personal Appearance and Hygiene policy, dated 6/14/96 and updated 11/02/98. The policy indicated, "...Hairstyles are neat, clean and simple. An approved hair restraint such as the following must</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 04/02/2013	
NAME OF PROVIDER OR SUPPLIER  SUNRISE ON OLD MERIDIAN				STREET ADDRESS, CITY, STATE, ZIP CODE 12130 OLD MERIDAN ST CARMEL, IN 46032			
(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>be worn at all times while working in the kitchen: Hair net, Chef's hat, Clean Sunrise baseball cap,. Mustaches are trimmed neat and clean...."</p> <p>2. On 4/2/13 at 9:15 A.M., the following was observed in the servery/kitchenettes on the third and fourth floors:</p> <p>2a. On the Fourth Floor:</p> <p>The inside floor of a top oven had a large amount of black, burnt food spillage. In an interview at that time, the Director of Environmental Services and the Director of Resident Services indicated the Caregivers (nursing staff) were responsible for maintaining and cleaning the ovens.</p> <p>2b. On the Third Floor (the secured/locked Alzheimer's unit):</p> <p>A large "Coke" bottle, half-filled with some type of frozen substance, was observed in the freezer compartment. There was no label of the contents, or date it was originally opened or placed in the freezer.</p> <p>There were 4 pitchers with unlabeled, undated fluids in the refrigerator. An undated, open pint carton of "Whipping Cream" was found on a</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 04/02/2013	
NAME OF PROVIDER OR SUPPLIER  SUNRISE ON OLD MERIDIAN				STREET ADDRESS, CITY, STATE, ZIP CODE 12130 OLD MERIDAN ST CARMEL, IN 46032			
(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>shelf inside the refrigerator door. There were 6 eggs in a bowl on a shelf of the refrigerator. In an interview at that time, CNA #7 indicated the eggs were "raw" and not hard-boiled. The eggs were not dated.</p> <p>Two pitchers filled with a clear liquid, identified by CNA #7 as water, and 2 large bottles of wine--both half empty, were observed in another refrigerator/cooler under the counter. CNA #7 indicated the wine was for the residents on the Alzheimer's unit for "general use." The bottles were not dated with an "opened" date or a "use by" date.</p> <p>The oven floor had black, burnt food spillage.</p> <p>2c. On 4/2/13 at 10:30 A.M., the following was observed in the kitchenette on the second floor:</p> <p>A squeeze "ketchup" type bottle containing a pale yellow oily liquid was observed on the counter next to the sink. There was no label of the contents, and no "use by" date.</p> <p>The refrigerator had 2 carafes of a clear liquid, 1 tall glass of a white liquid, 3 raw eggs, a plastic cup with a</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 04/02/2013	
NAME OF PROVIDER OR SUPPLIER  SUNRISE ON OLD MERIDIAN				STREET ADDRESS, CITY, STATE, ZIP CODE 12130 OLD MERIDAN ST CARMEL, IN 46032			
(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			
	large block of butter, and an opened block of butter with the end of the paper wrapping open. Another opened block of butter was observed on a shelf inside the refrigerator door. The carafes and glass had no label of the contents, and none of the items were dated with an "opened" date or a "use by" date.						

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 04/02/2013	
NAME OF PROVIDER OR SUPPLIER  SUNRISE ON OLD MERIDIAN				STREET ADDRESS, CITY, STATE, ZIP CODE 12130 OLD MERIDAN ST CARMEL, IN 46032			
(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			
R000349	<p>410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.</p> <p>Based on record review and interview, the facility failed to have complete and accessible documentation for 1 of 7 residents reviewed for documentation. (Resident #12)</p> <p>Findings include:</p> <p>The clinical record review for Resident # 12 was completed on 4/2/13 at 10 a.m. Diagnoses included, but were not limited to, depression, possible Lewy body dementia, Parkinson's and colitis.</p> <p>The progress notes for 8/26/12 at 7:00 a.m., indicated, "...caregiver reported that resident c/o [complains] R [right] left pain she reported that she was sitting on floor [and] felt 'bones rubbing'. [right] leg longer than [left]. Res. [resident] [complain] pain 10/10 when standing; 6/10 when standing. Resident states she didn't</p>	R000349	<p>A) With respect to the specific resident(s) cited: No specific resident was identified in the Statement of Deficiencies. B) The cited concern has the potential to affect all residents in the facility. C) 5/1/13 Audit of current residents with services will be completed by Healthcare Coordinator and we will request completion of all progress notes to be submitted to ensure all records are current. 5/15/2013 Health Care Coordinator will meet/speak with each outside provider by and communicate Sunrise on Old Meridian's expectations that each week they must provide us with all documentation of care provided to our residents under their care. D) 5/1/13 ongoing Health Care Coordinator will ensure weekly reports from all outside services including but not limited to hospice, wound care, home care, therapy will send weekly reports/charting for each resident they provide services to. 5/1/13 ongoing Health Care Coordinator</p>	05/15/2013			

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 04/02/2013	
NAME OF PROVIDER OR SUPPLIER  SUNRISE ON OLD MERIDIAN				STREET ADDRESS, CITY, STATE, ZIP CODE 12130 OLD MERIDAN ST CARMEL, IN 46032			
(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>fall...."</p> <p>The nursing notes for 12/6/12 indicated, "...1100 Res self reports a fall, unable to give specifics. Small raised area to R upper forehead, res states she must have hit the floor, but did not hit the wall or furnishings. Approx [approximately] 5 cm [centimeters] curved ST [skin tear] to RFA [right forearm] cleansed, stripped and covered. Res tol [tolerated] without c/o. MAE [Moves all extremities] without diff (difficulties) per res baseline ROM (range of motion)...."</p> <p>12/8/12- 1:17 p.m. Tylenol given for left hip soreness.</p> <p>12/9/12 -8:06 a.m. Tylenol given for left hip soreness.</p> <p>12/10/12- 3:00 p.m. "...Res continues to complain of left hip and knee pain when walking. Raised area noted at left hip that res. states is sore. Dtr [daughter] here and requested to take re to (name of hospital)...." 5:52 p.m. Dtr returned to community. Res has fx [fractured] knee cap and immobilizer in place to left leg...."</p> <p>The 10/22/12, service plan indicated "rarely" under the falls category and under the safety scoring section indicated "no concerns noted in safety section."</p>		<p>and ED will audit 5 charts per month to ensure all documentation is being provided accurately and timely. Compliance is defined as all documentation being provided to our wellness team. Non-compliance will result in providers no longer being able to provide services to our residents.</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 04/02/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SUNRISE ON OLD MERIDIAN	STREET ADDRESS, CITY, STATE, ZIP CODE 12130 OLD MERIDAN ST CARMEL, IN 46032
---	---

(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>In an interview with the Associate Living Coordinator, on 4/1/13 at 2:30 p.m., she indicated this was the most recent service plan for Resident #12.</p> <p>In an interview with the Executive Director, on 4/2/13 at 5:25 p.m., she indicated physical therapy had seen resident #12 after fall on 12/10/12, but the notes were not in the chart as physical therapy kept their own documentation. She indicated she did not have access to them.</p>			