

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155196	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/02/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ALTENHEIM HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3525 E HANNA AVE INDIANAPOLIS, IN 46237
---	---

(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 Investigation of Complaint IN00159590.</p> <p>Complaint IN00159590 - Substantiated. Federal/State deficiencies related to the allegations are cited at F-225, F-226 and F-323.</p> <p>Survey dates: December 1 & 2, 2014</p> <p>Facility number: 000103 Provider number: 155196 AIM number: 100290000</p> <p>Survey team: Diana Zgonc, RN-TC</p> <p>Census bed type: SNF/NF: 69 Total: 69</p> <p>Census payor type: Medicare: 13 Medicaid: 39 Other: 17 Total: 69</p> <p>Sample: 3</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC</p>	F000000		
---------	--	---------	--	--

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: 155196	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/02/2014
NAME OF PROVIDER OR SUPPLIER ALTENHEIM HEALTH & LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 3525 E HANNA AVE INDIANAPOLIS, IN 46237		
(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	
F000225 SS=D	<p>16.2-3.1.</p> <p>Quality review completed on December 05, 2014; by Kimberly Perigo, RN.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155196	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/02/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ALTENHEIM HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3525 E HANNA AVE INDIANAPOLIS, IN 46237
---	---

(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>progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and interview, the facility failed to ensure an injury of unknown origin was reported according to the facility policy for 1 of 3 residents reviewed for injuries in a sample of 3. (Resident #B)</p> <p>Findings include:</p> <p>A list of reportable incidents were requested upon entrance on 12/1/14 at 8:45 a.m., from the Administrator and Director of Nursing (DON) for the months of October and November of 2014. Resident #B was not on the list. During an interview on 12/1/14 at 10:10 a.m., the DON indicated she had provided a list of all the reportable incidents and there were only 3 for the months of October and November.</p> <p>The clinical record for Resident #B was reviewed on 12/1/14 at 11:05 a.m. Diagnoses for Resident #B included but were not limited to, skin disorder,</p>	F000225	<p>F225 483.13(c)(1)(ii)-(iii), (c)(2) – (4) I. The corrective actions to be accomplished for those residents found to have been affected by the practice. Resident #B showed no negative outcomes, physical evidence or mental anguish from the alleged incident reported to the ISDH on 11/9/2014. II. The facility will identify other residents that may potentially be affected by the practice. Residents who reside at Altenheim Health and Living Community who have the potential to be affected by the alleged practice. Resident's with a BIMS of 10 or greater and or families/responsible parties will be interviewed using the ISDH QIS abuse questionnaire to ensure all abuse allegations are identified and handled according to Federal, State and CarDon policy and procedures. No other concerns were identified. III. The facility will put into place the following systematic changes to ensure that the practice does not recur. The Administrator and director of</p>	12/22/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155196	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/02/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ALTENHEIM HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3525 E HANNA AVE INDIANAPOLIS, IN 46237
---	---

(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>osteopenia, hypertension (HTN), depressive disorder, anxiety and dementia.</p> <p>A nurses note dated 11/9/14 at 3:06 p.m., indicated the resident was observed in bed with a moderate amount of red blood on the sheet, pant leg and geri stocking. The resident had a laceration to the left calf that measured 6 centimeters (cm) X .2 cm X .2 cm (family and physician notified).</p> <p>A hospital "After Visit Summary" dated 11/10/14, indicated the resident had been seen in the Emergency Department for a left leg laceration. Discharge information included care instructions for a "Deep Skin Avulsion" (layers of skin or parts of body structures have been torn away).</p> <p>Review of the investigation documentation indicated staff denied knowing Resident #B sustained an injury to her leg. The record lacked documentation of the injury being reported according to the facility policy.</p> <p>During an interview with the DON on 12/1/14 at 4:00 p.m., she indicated we did not report the incident because we thought, through our investigation, the injury was caused by the sharp area where the foot rests would be attached to</p>		<p>nursing will be re-educated by the CarDon Clinical Nurse Specialist on the Abuse reporting policy and procedure and CQI abuse investigation checklist A CQI abuse investigation checklist is currently utilized by the administrator and director of nursing for each investigation to ensure future investigations have the necessary documentation to determine the decisions of reinstating employees, terminating employees and reporting employees to the ISDH and licensure boards of Indiana.</p> <p>QIS interview tool will be utilized to interview residents within the facility and family members to ensure no further risks of harm exists in the current care environment for those residents potentially affected In-service staff on the abuse reporting policy and procedure including; identifying multiple and various forms of abuse, reporting immediately, and overall review of abuse prevention. A post- test was utilized to ensure the staff comprehended the abuse guidelines and policy/procedure to protect the residents and families from harm. Social services will assess the resident and families to ensure mental anguish does not exist and refer those affected for appropriate treatment if indicated. Staff is to check all padding on wheel chairs twice weekly to ensure it is being effective for the reason it</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155196	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/02/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ALTENHEIM HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3525 E HANNA AVE INDIANAPOLIS, IN 46237
---	---

(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 wheelchair if they were currently being used. The foot rests were removed because the resident uses her feet to propel the wheelchair.</p> <p>On 12/1/14 at 10:15 a.m., the DON provided the undated "Reportable policy and procedure" and indicated the policy was the one currently being used by the facility.</p> <p>"... Immediate reporting, ... 2. Any/all injuries of unknown source or origin 6. Significant injuries (State mandate) include, but are not limited to these: ... serious, unusual ... injury."</p> <p>This Federal tag relates to Complaint IN00159590.</p> <p>3.1-28(c)</p>		<p>was placed. IV. The facility will monitor the corrective action by implementing the following measures. A CQI audit tool will be utilized to audit allegations of abuse to ensure the facility enacts all the necessary steps of investigation conducted daily, when allegation occurs, by the Director of Nursing or designee for 30 days and at the end of the 30 days the frequency will be continued until compliance is 100% and then performed monthly by the CS or Designee monthly to total of 12 months. The Director of Nursing or designee will conduct weekly Abuse QA audits by randomly interviewing a minimum of 5 staff members from all disciplines and all shifts weekly for 4 weeks and the results will be discussed with the director of clinical services to determine the ongoing frequency into the next 90 days to ensure staff are complying and understand and can identify abuse situations. The Administrator or designee will audit all allegations of abuse five times per week x 30 days, to monitor for comprehensive and complete investigation. This audit will continue weekly for duration of 12 months. Any concerns will be addressed. The QIS abuse questionnaire will be integrated into the facility routine customer service/care program and utilized monthly with residents to create</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155196	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/02/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ALTENHEIM HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3525 E HANNA AVE INDIANAPOLIS, IN 46237
---	---

(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
F000226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to ensure implementation of their policy in regard to reporting an injury of unknown origin for 1 of 3 residents reviewed for injuries</p>	F000226	<p>an environment of freedom to report potential abuse without the fear of retaliation. This QIS abuse tool will be performed on at least 10 residents with a BIMS of 10 or higher monthly ongoing. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Assessing wheel chairs for padding when indicated has been added to shower sheets for those residents in which padding is indicated. This will be an ongoing practice. Wheel chairs within the facility were audited for unsafe points or loosened padding V. Plan of Correction completion date.</p> <p>Plan of Correction date is: 12/22/2014</p> <p>F226 483.13 (c) I. The corrective actions to be accomplished for those residents found to have been affected by the practice. Resident #B showed no negative</p>	12/22/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155196	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/02/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ALTENHEIM HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3525 E HANNA AVE INDIANAPOLIS, IN 46237
---	---

(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 a sample of 3. (Resident #B)</p> <p>Findings include:</p> <p>A list of reportable incidents were requested upon entrance on 12/1/14 at 8:45 a.m., from the Administrator and Director of Nursing (DON) for the months of October and November of 2014. Resident #B was not on the list. During an interview on 12/1/14 at 10:10 a.m., the DON indicated she had provided a list of all the reportable incidents and there were only 3 for the months of October and November.</p> <p>The clinical record for Resident #B was reviewed on 12/1/14 at 11:05 a.m. Diagnoses for Resident #B included but were not limited to, skin disorder, osteopenia, hypertension (HTN), depressive disorder, anxiety and dementia.</p> <p>A nurses note dated 11/9/14 at 3:06 p.m., indicated the resident was observed in bed with a moderate amount of red blood on the sheet, pant leg and geri stocking. The resident had a laceration to the left calf that measured 6 centimeters (cm) X .2 cm X .2 cm (family and physician notified).</p> <p>A hospital "After Visit Summary" dated</p>		<p>outcomes physical evidence or mental anguish from the alleged incident reported to the ISDH on 11/9/2014 II. The facility will identify other residents that may potentially be affected by the practice. Residents who reside at Altenheim Health and Living Community have the potential to be affected by the alleged practice. Resident's with a BIMS of 10 or greater and or families/responsible parties will be interviewed using the ISDH QIS abuse questionnaire to ensure all abuse allegations are identified and handled according to Federal, State and CarDon policy and procedures. No other concerns were identified. III. The facility will put into place the following systematic changes to ensure that the practice does not recur. The Administrator and Director of Nursing will be re-educated by the CarDon Clinical Nurse Specialist on the Abuse reporting policy and procedure and CQI abuse investigation checklist QIS interview tool will be utilized to interview residents within the facility and family members to ensure no further risks of harm exists in the current care environment for those residents potentially affected In-service staff and on the abuse reporting policy and procedure including; identifying multiple and various forms of abuse, reporting immediately, and overall review of</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155196	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/02/2014
NAME OF PROVIDER OR SUPPLIER ALTENHEIM HEALTH & LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 3525 E HANNA AVE INDIANAPOLIS, IN 46237		
(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>11/10/14, indicated the resident had been seen in the Emergency Department for a left leg laceration. Discharge information included care instructions for a "Deep Skin Avulsion" (layers of skin or parts of body structures have been torn away).</p> <p>Review of the investigation documentation indicated staff denied knowing Resident #B had sustained an injury to her leg. The record lacked documentation of the injury being reported.</p> <p>During an interview with the DON on 12/1/14 at 4:00 p.m., she indicated we did not report the incident because we thought, through our investigation, the injury was caused by the sharp area where the foot rests would be attached to the wheelchair if they were currently being used. The foot rests were removed because the resident uses her feet to propel the wheelchair.</p> <p>On 12/1/14 at 10:15 a.m., the DON provided the undated "Reportable policy and procedure" and indicated the policy was the one currently being used by the facility.</p> <p>"... Immediate reporting, ... 2. Any/all injuries of unknown source or origin 6. Significant injuries (State mandate) include, but are not limited to these: ...</p>		<p>abuse prevention. A post- test was utilized to ensure the staff and contracted services comprehended the abuse guidelines and policy/procedure to protect the residents and families from harm. Social services will assess the resident and families to ensure mental anguish does not exist and refer those affected for appropriate treatment if indicated. IV. The facility will monitor the corrective action by implementing the following measures. A CQI audit tool will be utilized to audit allegations of abuse to ensure the facility enacts all the necessary steps of investigation conducted daily, when allegation occurs, by the Director of Nursing for 30 days and at the end of the 30 days the frequency will be continued until compliance is 100% and then performed monthly by the Director of Nursing or designee for a total of 12 months. The Director of Nursing or designee will conduct weekly QA audit by randomly interviewing a minimum of 5 staff members from all disciplines and all shifts weekly for 4 weeks and the results will be discussed with the director of clinical services to determine the ongoing frequency into the next 90 days to ensure staff are complying and understand and can identify abuse situations. The Administrator or designee will audit all allegations of abuse five</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155196	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/02/2014
NAME OF PROVIDER OR SUPPLIER ALTENHEIM HEALTH & LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 3525 E HANNA AVE INDIANAPOLIS, IN 46237		
(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	serious, unusual ... injury." This Federal tag relates to Complaint IN00159590. 3.1-28(a) 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 record review, observation, and interview, the facility failed to ensure a wheelchair was covered appropriately to prevent a deep skin avulsion (laceration	F000323	times per week x 30 days, to monitor for comprehensive and complete investigation. This audit will continue weekly for duration of 12 months. Any concerns will be addressed. The QIS abuse questionnaire will be integrated into the facility routine customer service/care program and utilized monthly with residents to create an environment of freedom to report potential abuse without the fear of retaliation. This QIS abuse tool will be performed on at least 10 residents with a BIMS of 10 or higher monthly ongoing. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. V. Plan of Correction completion date. Plan of Correction date is 12/22/2014	12/22/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155196	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/02/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ALTENHEIM HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3525 E HANNA AVE INDIANAPOLIS, IN 46237
---	---

(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>injury) for 1 of 3 residents reviewed for injuries in a sample of 3. (Resident #B)</p> <p>Findings include:</p> <p>The clinical record for Resident #B was reviewed on 12/1/14 at 11:05 a.m. Diagnoses for Resident #B included but were not limited to, skin disorder, osteopenia, hypertension (HTN), depressive disorder, anxiety and dementia.</p> <p>A care plan dated 11/12/14, indicated the resident was at risk for skin breakdown related to fragile skin and a history of skin tears. The goal for the care plan indicated the resident would be free from injuries and skin tears.</p> <p>A nurses note dated 11/9/14 at 3:06 p.m., indicated the resident was observed in bed with a moderate amount of red blood on the sheet, pant leg and geri stocking. The resident had a laceration to the left calf that measured 6 centimeters (cm) X .2 cm X .2 cm (family and physician notified).</p> <p>A hospital Emergency Department (ED) note dated 11/10/14, indicated the resident sustained a 5 cm gaping laceration over the left lateral lower leg yesterday while being transferred from</p>		<p>I. The corrective actions to be accomplished for those residents found to have been affected by the practice.</p> <p>Resident B's wheelchair was immediately assessed, no defective hardware was noted. Prongs were not exposed, however, padding reinforced to give a more protective barrier.</p> <p>Resident B did have a care plan for risk for breakdown and fragile skin.</p> <p>Resident B was transferred properly according to Physicians orders and care plan on 11/09/2014.</p> <p>A gel protective cushioning device was ordered and applied to resident B's wheel chair.</p> <p>II. The facility will identify other residents that may potentially be affected by the practice.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155196	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/02/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ALTENHEIM HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3525 E HANNA AVE INDIANAPOLIS, IN 46237
---	---

(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>her wheelchair. The wound was cleansed, steri strips and dressing applied. The physician's consult also indicated, "we should avoid closing the laceration due to the extended time since the injury." The hospital "After Visit Summary" dated 11/10/14, indicated the resident discharge information included care instructions for a "Deep Skin Avulsion" (layers of skin or parts of body structures have been torn away). The resident was to follow-up with the physician for re-evaluation of the wound. The physician's orders for care included cleansing around the left lower extremity steri-strips, pat dry and apply a non-adherent pad, wrap loosely from the toe to upper extremity. Monitor pedal (foot/below the injury) pulses and change the dressing once daily.</p> <p>The investigation documentation provided by the DON on 12/1/14 at 3:55 p.m., indicated ... the padding, which was in place to prevent skin tears, was wearing down to the wheelchair hook up.</p> <p>During an interview with the DON on 12/1/14 at 4:00 p.m., she indicated there were no protocols in place, at that time, for staff to check on the condition of the padding/covering, which was in place to cover the pedal hooks to prevent skin tears.</p>		<p>Resident's wheel chairs who required any padding was assessed to ensure padding was intact and in good condition.</p> <p>Resident's chairs that require any padding was added to the facility shower sheets to be checked at a minimum of two times weekly to ensure good condition, and that they remain intact.</p> <p>III. The facility will put into place the following systematic changes to ensure that the practice does not recur.</p> <p>Nursing staff will be re-educated on following nurse aide assignment sheets and the new policy of assessing wheel chairs needing padding at the time of their showers, at least twice weekly.</p> <p>Nursing staff will be re-educated on safe transfers as per facility policy.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155196	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/02/2014
NAME OF PROVIDER OR SUPPLIER ALTENHEIM HEALTH & LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 3525 E HANNA AVE INDIANAPOLIS, IN 46237		
(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>Observations of the wheelchair indicated the area where the foot rests would be attached was being covered because the foot rests had been removed.</p> <p>This Federal tag relates to Complaint IN00159590.</p> <p>3.1-45(1) 3.1-45(2)</p>		<p>Nursing staff educated on new policy of checking padding to wheel chairs on shower days, atleast twice weekly.</p> <p>Resident's chairs that require any padding was added to the facility shower sheets to be checked at a minimum of two times weekly to ensure good condition, and that they remain intact.</p> <p>IV. The facility will monitor the corrective action by implementing the following measures.</p> <p>Charge nurse are to review shower sheets that will be filled out by the CNA who gave the shower and will review the condition of padding on wheelchairs, which will indicate the current condition of said padding and will replace or reinforced as needed. This will be an ongoing practice.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155196	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/02/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ALTENHEIM HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3525 E HANNA AVE INDIANAPOLIS, IN 46237
---	---

(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>Director of Nursing or designee will review shower sheets and will follow up to ensure that any padding needing replaced or reinforced was completed as they have been instructed. This will be an ongoing practice.</p> <p>Results of the reviews will be presented at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.</p> <p>V. Plan of Correction completion date.</p> <p>Plan of Correction date is 12-22-2014</p>	