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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155327 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>08/06/2014 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>UNIVERSITY HEIGHTS HEALTH AND LIVING COMMUNITY | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1380 E COUNTY LINE RD S<br>INDIANAPOLIS, IN 46227 |
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| F000000 | <p>This visit was for the Investigation of Complaints IN00152521, IN00153371, IN00153712, and IN00153948.</p> <p>Complaint IN00152521 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00153371 - Substantiated. Federal/state deficiencies related to the allegations are cited at F323.</p> <p>Complaint IN00153712 - Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00153948 - Unsubstantiated due to lack of evidence.</p> <p>Survey dates:<br/>August 4, 5, &amp; 6, 2014</p> <p>Facility number: 000220<br/>Provider number: 155327<br/>AIM number: 100267650</p> <p>Survey team:<br/>Diana Zgonc, RN-TC<br/>Dorothy Plumber, RN</p> <p>Census bed type:<br/>SNF: 24<br/>SNF/NF: 136<br/>Total: 160</p> <p>Census payor type:</p> | F000000 | Submission of this plan of correction does not constitute an admission by University Heights Health and Living Community or its management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. University Heights Health and Living, respectfully request consideration for paper compliance for this survey. |  |
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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| F000323<br>SS=D    | <p>Medicare: 32<br/>Medicaid: 102<br/>Other: 26<br/>Total: 160</p> <p>Sample: 8</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on August 13, 2014; by Kimberly Perigo, RN.</p> <p>483.25(h)<br/>FREE OF ACCIDENT<br/>HAZARDS/SUPERVISION/DEVICES<br/>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 observation, interview, and record review, the facility failed to ensure a resident in the dementia unit who intrusively wandered received adequate supervision to prevent altercations with other residents for 1 of 3 residents review for accident supervision. (Resident #G)</p> <p>Findings include:</p> <p>The clinical record of Resident #G was reviewed on 8/5/14 at 1:50 p.m.</p> | F000323       | <p>1. Corrective Action – Resident G was sent to Hancock Regional Hospital for inpatient geriatric psychiatric evaluation and treatment.</p> <p>2. Other residents potential for impact – Residents will be identified for intrusively wandering upon a new or worsening behavior event. Residents identified to have the intrusive behavior will have their plan of care reviewed by the Interdisciplinary Team (IDT), to include evaluation as needed by</p> | 09/01/2014           |

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|  | <p>Diagnoses included, but were not limited to, Alzheimer's disease, anemia (low blood cell count), anxiety, depression, hypertension (high blood pressure), and diabetes.</p> <p>A quarterly Minimum Data Set (MDS) assessment completed on 5/6/14, assessed Resident #G as severely cognitively impaired and unable to make daily decisions; as requiring extensive assistance of 1 staff member for dressing, eating, and personal hygiene; and needed limited assistance from staff for walking in and around the unit. Resident #G was coded as wandering 1-3 days during the assessment period and was coded as not invading the privacy of the other residents.</p> <p>Resident #G had a care plan in place with a start date of 5/20/13, indicating Resident #G wandered and was at risk for elopement. Interventions include, but were not limited to, "...5/20/13 Remove resident from other resident's rooms and unsafe situations. When resident begins to wander, provide comfort measures for basic needs ( e.g. pain, hunger, toileting, too hot/cold, etc.)...5/26/13: If resident begins to intrusively wander, try sitting with her to look at a magazine, talk about going shopping, assist her to fold some laundry...."</p> |   | <p>attending physician/NP, psychiatricphysician, and/or psychology services. The IDT team will update the plan of care and nursing assignment sheet.</p> <p>3.WhatMeasures – Staff facility will be re-educatedon the Behavior Program including interventions for residents with behaviorsand documentation of behaviors. Residentswill be assessed upon admission, quarterly, and significant change forwandering risk. Residents with new orworsening behavior of intrusive wandering will have a behavior event initiatedto include a minimum of 72 hour monitoring. The IDT team will review the new or worseningbehaviors in clinical meeting and weekly IDT meeting until the behavior hasstabilized. Care plans and assignmentsheets will be updated as needed.</p> <p>4.Monitored-Quality Assurance – Social ServicesDirector or designee will complete audit of the behavior monitoring weekly x 4weeks, monthly x 2 months, then quarterly. Audit results will be reported to the Quality Assurance PerformanceImprovement Committee monthly. If 95%compliance is not achieved then the plan of correction will be updated and newinterventions initiated.<br/>Compliance date Sept 1, 2014</p> |                      |   |

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|                    | <p>A review of the nursing progress notes for Resident #G indicated Resident #G was ambulating in the dementia unit on 7/25/14 at 6:30 a.m., when Resident #G attempted to enter the room of Resident #H, who was attempting to exit the room. Resident #H attempted to stop Resident #G from entering and "made contact with his hand to the face of Resident #G."</p> <p>The nursing progress notes indicated the residents were separated and Resident #G was taken to a quiet room. Skin assessments were completed for both residents and no injuries were noted. Family and physician were notified.</p> <p>Following the altercation, the facility implemented an intervention to keep the door to Resident H's room closed, and indicated the careplan and the assignment sheets for the certified nursing assistants (CNA) were updated.</p> <p>A review of the social service progress notes for 7/25/14 at 1:38 p.m., indicated Resident #G was unable to complete a Brief Interview for Mental Status (BIMS) and Resident #G was walking around with a nurse. The social service note indicated Resident #G showed no signs or symptoms of mood distress.</p> <p>During a review of an incident reported</p> |               |   |                      |

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|                    | <p>to the division via voicemail on 7/25/14 2:21 p.m., the incident occurred at approximately 1:45 p.m. on 7/25/14. Resident #G opened the door to the room of Resident #H and sat down on his bed. Resident #H had been napping just prior to Resident #G entering the room. The report indicated staff had entered the room and observed Resident #H hitting Resident #G and yelling, "I told you to stay out." The report indicated the residents were separated and pain and skin assessments were completed.</p> <p>A review of the nursing progress notes for Resident #G for 7/25/14 at 4:08 p.m., indicated, "Resident was found in another resident room. She was laying on top of another resident. Other resident had a hold of her and was hitting her in face/head. 2 cm (centimeter) x 2.5 cm hematoma noted above Right eye. Residents were separated and this resident was placed on 1:1 with staff. MD (medical doctor) and daughter aware."</p> <p>During an interview with CNA #4 and the ADON on 8/5/14 at 3:15 p.m., CNA #4 indicated she had been present on the dementia unit on 7/25/14, when both incidents involving Resident #G occurred. CNA #4 indicated Resident #G had attempted to go into the room of</p> |               |   |                      |

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|                    | <p>Resident #H when the door was open, but was easily redirected out of the room. CNA #4 indicated staff were assisting residents into the courtyard for an activity on 7/25/14 at 1:30 p.m., and had to go past the room of Resident #H to get to the courtyard. CNA #4 indicated Resident #H had the door closed, and she had looked in on him while assisting a resident to go outside. CNA #4 indicated that when she came back and checked on Resident #H again, she found Resident #G lying on top of Resident #H and Resident #H had his legs wrapped around the legs of Resident #G, had his left arm across the chest of Resident #G, and was hitting Resident #G with his open right hand as he stated, "I told you not to come in here." CNA #4 indicated Resident #H immediately released Resident #G when staff entered the room and Resident #G was removed from the room. CNA #4 indicated Resident #G was upset after the incident, but was taken to a quiet room, had legs and back massaged, and eventually calmed.</p> <p>The next nursing progress note for Resident #G was 7/25/14 at 9:26 p.m., and indicated Resident #G, "Remains on a 1:1 this shift. No s/s [signs or symptoms] of discomfort noted. Will continue to monitor."</p> |               |   |                      |

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|                    | <p>The next nursing progress note was dated 7/26/14 at 3:34 a.m., and indicated Resident #G, "..has had a 1:1 aid [sig] this shift. Res up walking at beginning of shift but CNA was able to direct her to stay out of other res rooms. Res fell asleep around approx 12:30 [a.m.] and has stayed in bed for rest of shift...."</p> <p>Social service progress notes from 7/26/14 at 2:09 p.m., indicated Resident #G was lying down..."Continues to wander but with 1:1 supervision at this time...."</p> <p>A social services progress note for 7/29/14 at 3:45 p.m., indicated the Social Services Director (SSD) spoke with the POA for Resident #G informing the POA of need for Resident #G to have evaluation and treatment at an inpatient psychiatric unit to address medications and wandering behavior that had placed Resident #G at risk while also impeding the privacy of others. The POA indicated she was in agreement with the need for further evaluation and was in agreement with a referral to a psychiatric unit.</p> <p>A follow up report sent to the division on 8/1/14, indicated Resident #G remained on 1:1 supervision while awake and would see the psychiatrist on 8/1/14.</p> |               |   |                      |

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|                    | <p>Nursing progress note for 8/2/14 at 6:57 p.m., indicated Resident #G "hit her head on the door this evening, no apparent injuries noted."</p> <p>Nursing progress note for 8/4/14 at 5:32 a.m., indicated, "Resident did not sleep all night was redirected to bed several times but resident refused to stay in bed. CNA found resident under another resident bed this morning. No appearant [sig] of injury noted. DON notified."</p> <p>During tour of the facility on 8/4/14 at 10:10 a.m., Resident #G was noted to be in the bed. At 10:12 a.m., Resident #G was observed exiting the room into the hallway of the unit. CNA #4 immediately approached Resident #G and attempted to redirected the resident. Resident #G was not easily redirected.</p> <p>At 11:30 a.m., on 8/4/14, Resident #G was observed ambulating in the hallway accompanied by CNA #4.</p> <p>On 8/4/14 at 2:00 p.m., Resident #G was observed ambulating in the hallway of the facility with a CNA.</p> <p>On 8/5/14 at 9:30 a.m., Resident #G was observed ambulating in the dementia with a CNA within arms reach. Resident #G was walking at a fast pace with her</p> |               |   |                      |

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|                    | <p>eyes closed and was trying to go between two other residents. While the CNA was attempting to assist the other resident, who was ambulating with a walker, Resident #G ran into a reclining chair that was sitting in the hallway. Resident #G did not appear to notice the chair or stop when she hit the chair and continued to push through the other residents.</p> <p>On 8/5/14 at 3:00 p.m., accompanied by the Assistant Director of Nursing (ADON), Resident #G was observed reclining in a chair in the living room of the dementia unit. The ADON indicated where the hematoma had been located following the incident on 7/25/14. The ADON indicated the area was now healed. Resident #G was noted to have a fading greenish purple bruise to her left lower jaw and another fading greenish purple bruise to her right lower jaw. Both bruises were approximately the size of a quarter.</p> <p>During the interview on 8/6/14 at 2:00 p.m., the DoN indicated the facility did not have a specific policy for wandering residents.</p> <p>This Federal tag relates to Complaint IN00153371.</p> <p>3.1-45(a)(2)</p> |               |   |                      |

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