

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/07/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN46203
---	---

(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
F0000	<p>This visit was for the Investigation of Complaints IN00096109, IN00097319 and IN00097468.</p> <p>This visit was in conjunction with the Post Survey Revisit to the Investigation of Complaint IN00094742, which resulted in an Immediate Jeopardy, completed on 08-19-11.</p> <p>This visit was in conjunction with the Post Survey Revisit to the Post Survey Revisit to the Investigation of Complaint IN00092695 completed on 07-07-11.</p> <p>Complaints: IN00096109 - Substantiated. No deficiencies related to the allegations are cited. IN00097468 - Substantiated. Federal/State deficiencies related to the allegations are cited at F157, F282, F314, F322, F323 and F441. IN00097319 - Substantiated. Federal/State deficiencies related to the allegations are cited at F314 and F322.</p> <p>Survey dates: September 29, 30 and October 4, 5 &amp; 7, 2011</p> <p>Facility number: 004700 Provider number: 155741</p>	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/07/2011
NAME OF PROVIDER OR SUPPLIER  FRIENDSHIP HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN46203		
(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>AIM number: 100266630</p> <p>Survey team: Mary Jane G. Fischer RN</p> <p>Census Bed Type: SNF/NF: 44 Total: 44</p> <p>Census Payor Type: Medicare: 2 Medicaid: 39 Other: 3 Total: 44</p> <p>Sample: 11 Supplemental Sample: 7</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 10/17/11 by Suzanne Williams, RN</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/07/2011
NAME OF PROVIDER OR SUPPLIER  FRIENDSHIP HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN46203		
(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	
F0157 SS=D	<p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review, the facility failed to inform a resident's physician for possible intervention when a resident appeared to have significant weight loss, for 2 of 3 residents sampled for weight loss in a sample of 11. [Residents "B" and "E"].</p>	F0157	Resident B no longer resides in the facility. Resident E has been weighed weekly since the survey, his weight has been discussed with the Registered Dietitian, and the resident has improved to where he requests "shakes" (ensure supplement). All residents in the facility are identified as having potential to be affected. All	11/04/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/07/2011
NAME OF PROVIDER OR SUPPLIER  FRIENDSHIP HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN46203		
(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>Findings include:</p> <p>1. The record for Resident "B" was reviewed on 09-29-11 at 10:05 a.m. Diagnoses included but were not limited to anoxic brain injury, seizures, dysphasia, and respiratory failure. The record indicated the resident had a tracheostomy and a gastrostomy feeding tube. These diagnoses remained current at the time of the record review.</p> <p>The resident's plan of care, dated 08-12-11, indicated the resident's "nutrition and hydration needs will be met through next review AEB [as evidenced by] no significant weight changes." Interventions to this plan of care instructed the nursing staff to monitor for tolerance of feeding and report diarrhea or vomiting, "monitor lab and weights as ordered. Report loss or abnormal, feeding as ordered, monitor fluid intake and skin turgor."</p> <p>Review of the "Monthly Weight Report," on 10-05-11 at 12:00 p.m., indicated the resident weighed 102.5 lbs. [pounds] in July 2011, 120.4 lbs in August 2011, and 96.4 lbs in September 2011. However, review of the weekly weights, dated 09-14-11, indicated the resident weighed 88.6 lbs, and the next available recorded weight was 88.3 lbs. on 09-28-11.</p>		<p>facility scales have been calibrated. Going forward they will be calibrated monthly on the last Friday of each month. Nursing staff was inserviced on 10/28/11 regarding proper use of facility scales. A return demonstration has been initiated and will continue until all staff have demonstrated how to accurately weigh a resident. Handouts were reviewed related to accurate weight and height measurements, calculating for amputees (when needed), and the importance of weighing a resident, each time, with catheters, additional clothing, shoes, etc. out of the way. Weekly weights will be completed by Tuesday each week, and will be reviewed by the Director of Nursing and the Dietary Manager. Any significant weight changes will trigger a re-weight which will be done by Wednesday each week. Monthly weights will be completed by the 7 th of each month, and will be reviewed by the Director of Nursing and the Dietary Manager. Any significant weight changes will trigger a reweight which will be done within 24 hours of the weight in question. Any significant weight changes that are confirmed with a reweight will be reported to the resident and/or responsible parties, and the resident's physician. The weights, along with skin and nutrition will be discussed in the S.W.A.T. (an interdisciplinary meeting), held on</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/07/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  FRIENDSHIP HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN46203
---	---

(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>Further review of the facility Nutrition Assessment notations, dated 08-15-11 indicated the resident was "dependent on g-tube feedings due to persistent vegetative state and inability to chew and swallow." The assessment indicated the resident's BUN (blood urea nitrogen - lab test) was 14, and dehydration concerns were not noted. The 09-12-11 notation indicated "Post hosp. [hospitalization] for UTI [urinary tract infection]. Hosp. d/c [discharge] noted feeding of Replete. Suggest continue TF [tube feeding] as prior to hosp. Fibersource HN 320 mg 5 times a day, followed by 100 ml of water. Sept [September] wt. recorded at 96.4 lbs, [arrow down] of 24 lbs. / 19.9% in one month ?? questionable. July [2011] weight recorded at 102.5 lbs. Request weekly wt. [weight] until stable wt. noted."</p> <p>The resident's record lacked documentation the physician was notified of the resident's weight loss.</p> <p>2. The record for Resident "E" was reviewed on 09-29-11 at 12:10 p.m. The resident's admission weight was documented as 154.6 lbs. on 09-09-11. On 09-21-11 the resident's weight was documented at 142.7 lbs, and on 09-28-11 the resident weighed 142.4 lbs. The</p>		<p>Thursday afternoons. The timeliness and accuracy of resident weights will be discussed in the Quality Assurance meeting monthly X 3 months and quarterly thereafter to monitor effectiveness of obtaining and recording accurate resident weights. The Administrator and Director of Nursing are responsible for compliance. Date of Completion November 4, 2011. Addendum: The staff in-service on 10/28/2011 included when to notify physicians and families of changes in condition, including significant weight changes.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/07/2011
NAME OF PROVIDER OR SUPPLIER  FRIENDSHIP HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN46203		
(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>record lacked any indication the resident had been reweighed or the physician notified of the resident's presumed weight loss. On 10-04-11, a request was made to re-weigh the resident. The resident weighed 133.5 lbs.</p> <p>Review of facility policy titled "Weighing Residents," on 09-30-11 at 11:40 a.m., and dated as revised on 11-98 indicated the following:</p> <p>"PURPOSE [bold type and underscored] Weighing residents regularly allows the nursing staff, dietitian, and physician to observe weight loss or gain."</p> <p>"POLICY [bold type and underscored] A resident's weight is taken on admission to the facility and at least monthly thereafter, or more often if ordered by the physician. The resident should be weighed at approximately the same week of the month, every month, to ensure true "monthly" weights are obtained. A weight loss of 5 % in 30 days or 10 % in 180 days should be reported to the charge nurse as well as the physician."</p> <p>5. Review of facility policy titled "Notification of changes - Policy/Procedure," on 10-05-11 at 12:00 p.m., and dated 09-20-2007, indicated the following:</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/07/2011
NAME OF PROVIDER OR SUPPLIER  FRIENDSHIP HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN46203		
(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>"POLICY [bold type and underscored] Resident and/or responsible parties will be notified of changes in resident conditions/care."</p> <p>"PURPOSE [bold type and underscored] To inform the resident and/or responsible party of care."</p> <p>"PROCEDURE [bold type and underscored] The facility will immediately inform the resident, consult with the resident's physician, and if known, notify the resident's legal representative or an interested family member when there is: (2) a significant change in the resident's physical, mental or psychosocial status, that is a deterioration in health, mental or psychosocial status in either life-threatening conditions or clinical complications, (3) a need to alter treatment significantly, that is a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment."</p> <p>This federal deficiency relates to complaint IN00097468.</p> <p>3.1-5(a)(2) 3.1-5(a)(3)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/07/2011
NAME OF PROVIDER OR SUPPLIER  FRIENDSHIP HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN46203		
(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	
F0282 SS=D	<p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review and interview, the facility failed to ensure the residents' plans of care were followed in regard to interventions for the supervision of personal care, and prevention of falls and pressure ulcers, for 3 of 4 residents reviewed for care plans in a sample of 11. [Residents "C", "E" and "G"].</p> <p>Findings include:</p> <p>1. The record for resident "C" was reviewed on 09-29-11 at 2:40 p.m. Diagnoses included but were not limited to senile pre senile organic psychotic condition, neurotic disorder, anxiety and bipolar disorder. These diagnoses remained current at the time of the record review.</p> <p>Review of the Minimum Data Set assessment, dated 06-27-11, indicated the resident required supervision with hygiene and assistance with bathing.</p> <p>The resident's current plan of care, dated 07-01-11, indicated, "needs supervision for dressing and bathing due to left hemiparesis, with interventions which</p>	F0282	<p>Resident C has been provided with two electric razors. One is for shaving his face, the other for shaving his head. The facility's Occupational Therapist has worked with him to ensure that he is able to use the electric razors safely. Resident C's CNA Care Guide has been updated to include use of electric razors. All nursing staff will be inserviced by October 28, instructing them not to give razors to residents. Resident E has been provided padded side rails. His care plan and CNA Care Guide have been updated to include all fall prevention devices that are used with him. CNA #7 was counseled to review her CNA Care Guide daily and provide care to residents in accordance with the Guide. Nursing staff will be inserviced by October 28 reminding them of the importance of reviewing the CNA Care Guides and following the instructions on them. Nurses will also be inserviced on the importance of checking resident safety devices, bed and chair alarms, for placement and function each shift. This will be monitored through the use of the medication administration record (MAR) and unit rounds three</p>	11/04/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/07/2011
NAME OF PROVIDER OR SUPPLIER  FRIENDSHIP HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN46203		
(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>included "assist resident with ADLs [activities of daily living] as needed, assist resident to shower twice weekly."</p> <p>During an interview on 09-30-11 at 12:30 p.m., a visitor indicated a need to "check" on this resident as resident had a "safety razor in possession and cut [resident] head numerous times." When interviewed how this visitor obtained this information, the visitor indicated "a resident told me about it. [Resident] said there was blood everywhere."</p> <p>Review of the nurses notes, dated 09-15-11 [no time documented] indicated, "Resident in room and shaving [resident] scalp without supervision. Has cut self in 5 places and bleeding."</p> <p>The nurses notes dated 09-26-11 at 3:00 p.m. indicated "has shaved head and cut self in numerous places with razor. Has 3 razors in trash along with bloody tissue and washcloth."</p> <p>During a discussion with the Administrator and Director of Nurses at the daily exit conference on 09-29-11 at 3:40 p.m., the administrative staff verified the resident "gave self a shower the other day and [resident] head was cut to high heaven. [Resident] does own shaving." During further discussion, the</p>		<p>times a week for 12 weeks, and ongoing by the Director of Nursing.</p> <p>Resident G is very prone to pressure ulcers and has had skin issues since his admission in 2005. He uses a circulating air mattress to reduce pressure areas. A turn schedule has been implemented to ensure that resident is not on his back except during meal times. All nursing staff have been inserviced regarding Resident G's specific interventions to prevent further skin breakdown, how to properly float heels, and to promote wound healing. Charge nurses have been inserviced reminding them of the importance of observing Resident G frequently to make sure the designated turn schedule is followed.</p> <p>Resident G will continue to be followed by the Wound Care Center, as well as weekly wound rounds to monitor his skin. For continuum of care, the Director of Nursing and Wound Nurse met with the Wound Care Center and discussed what each entity might need for the resident's continued care, as one unit working together. A form was developed to ensure what the resident's status had been since the last visit, with a return of current measurements, treatments, and recommendations to the facility. This transition will begin on November 1st, with each consecutive visit for treatment.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/07/2011
NAME OF PROVIDER OR SUPPLIER  FRIENDSHIP HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN46203		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Administrator and Director of Nurses indicated they were unaware the resident had two episodes of cutting self.</p> <p>Interview on 10-04-11 at 12:00 p.m. the Director of nurses indicated "when we did a sweep of [resident] room we found 12 razors."</p> <p>2. The record for Resident "E" was reviewed on 09-29-11 at 12:10 p.m. Diagnoses included but were not limited to viral hepatitis, schizophrenic disorder and encephalopathy. These diagnoses remained current at the time of the record review.</p> <p>During the initial tour of the facility on 09-29-11 at 8:30 a.m., licensed practical nurse employee #3 indicated the resident was a "fall risk" and had recently fallen out of bed and sustained extensive bruising to face, arms and hands. The name plate outside of the resident's room had a "star" adjacent to the resident's name. The licensed practical nurse indicated the "star" was placed there to alert the staff the resident was a fall risk.</p> <p>Review of the Minimum Data Set assessment, dated 09-16-11, indicated the resident required extensive assistance with bed mobility and was assessed as "total" care/assistance from the staff with</p>		<p>The Licensed Nurses were inserviced, October 28, related to utilizing the C.N.A. shower sheets, a skin checklist, a tool to guide them in discerning different stages of wounds, the use of specific treatments for specific observations, and nutritional/supplemental interventions that might be used with residents noted to have skin issues, so as to act upon them timely. Wound rounds will continue to be conducted each Wednesday.</p> <p>All residents in the facility are identified as having potential to be affected.</p> <p>The Director of Nursing or designee will make rounds three times weekly to make sure that nursing staff is providing care to the residents as indicated on their CNA Care Guides. The DON will share her observations with the Quality Assurance Committee at least quarterly on an ongoing basis.</p> <p>The Administrator and Director of Nursing are responsible for compliance.</p> <p>Date of Completion November 4, 2011.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/07/2011
NAME OF PROVIDER OR SUPPLIER  FRIENDSHIP HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN46203		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>transfer.</p> <p>Review of the current plan of care, dated 09-27-11, indicated the resident "gets bruises and skin tears easily due to anticoagulant use." The "goal" indicated "resident will be free of serious injuries through next review." Interventions to this plan of care included "Pad side rails on bed with pillows, pillow cases, bed pad alarm in bed, PSA [personal safety alarm] in wheelchair to alert staff if resident tries to transfer without assistance."</p> <p>A subsequent current plan of care dated 09-22-11, indicated the resident had the "Potential for injuries from falls due to recent history of falls." Interventions included "Monitor resident for steadiness and balance, personal safety alarm [PSA] when up in wheelchair, pressure pad alarm in bed."</p> <p>The certified nurses aide assignment sheet with resident specific information indicated the resident required a bed pad alarm and a PSA when up in the wheelchair.</p> <p>Review of the hospital patient information/discharge orders, dated 09-09-11 indicated the resident required "bed rest - may sit on side of bed with assistance. The patient is currently A &amp; O</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/07/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  FRIENDSHIP HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN46203
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>[alert and oriented] times 1 [self]."</p> <p>Review of the Nursing Admission Skin condition report, dated 09-09-11 indicated that at the time of admission to the facility the resident had "multiple bruises and scapping &lt;sic&gt; to bilateral upper extremities, scapping &lt;sic&gt; to right knee cap." "Initial care plan: problem fall risk. Approach: bed alarm, call light in reach. Goal: no falls."</p> <p>Review of the nurses notes indicated the following:</p> <p>"09-09-11 4:00 p.m. Alert to self, inappropriate speech noted. Resident on bedrest. Attempted to climb OOB [out of bed] times 3 times this shift bed alarm placed."</p> <p>"09-10-11 10:30 a.m. - Pt. [patient] has tried to climb out of bed times 2 this shift."</p> <p>"09-10-11 10:00 p.m. - Bed alarm in place alarms when res. [resident] moving about in bed."</p> <p>"09-14-11 6:00 a.m. - Sitting up on side of bed multiple times during this noc [night]."</p> <p>"09-18-11 8:00 p.m. - Alert to person</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/07/2011
NAME OF PROVIDER OR SUPPLIER  FRIENDSHIP HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN46203		
(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>Inappropriate speech at times. Resident attempt to get OOB times 2. Likes to side on edge of bed."</p> <p>"09-21-11 11:20 a.m. - Pt. found in room lying on floor on left side, alarm sounding, fall matt at bed side. pt alert verbal abrasion/laceration .5 in length area blue/purple with bright red drng [drainage], s/t skin tear noted to left elbow measures .6 by .5 cm [centimeters] flap intact."</p> <p>During an observation on 10-05-11 at 9:40 a.m., the resident was seated in a wheelchair in room. The resident, in a continuing motion, placed the palms of both hands on the armrests of the wheelchair and attempted a standing position.</p> <p>The resident was observed with white kerlix/gauze type dressings to bilateral arms from the wrists to the elbows. The siderails of the resident's bed were not padded to protect the resident from additional injury.</p> <p>During a subsequent observation on 10-05-11 at 9:50 a.m., the resident continued attempts at standing. Upon entering the resident's room, the resident lacked a PSA alarm while seated in the wheelchair. During this observation, an alarm was observed on the resident's</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/07/2011
NAME OF PROVIDER OR SUPPLIER  FRIENDSHIP HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN46203		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>nightstand. CNA [Certified Nurses Aide] employee #7 entered the resident's room. When interviewed, the CNA indicated she was unaware the resident required a PSA. When requested, the CNA reviewed her assignment sheet which instructed staff of the need for the personal alarm. The CNA turned toward the nightstand and stated, "that probably needs to be on the wheelchair and attached to [resident]." The Director of Nurses was in attendance during this observation.</p> <p>3. The record for Resident "G" was reviewed on 10-05-11 at 11:20 a.m. Diagnoses for resident "G" included but were not limited to diabetes, schizophrenic, paraplegia and a history of pressure ulcers. The resident's record indicated an allergy to tape.</p> <p>Review of the Minimum Data Set assessment, dated 10-04-11, indicated the resident required extensive assistance with bed mobility, and total care for transfer, dressing and personal hygiene. In addition, the assessment indicated the resident was assessed at risk for developing pressure ulcers and currently had 3 stage two ulcers.</p> <p>Review of the current plan of care dated 07-22-11, indicated the resident was a</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/07/2011
NAME OF PROVIDER OR SUPPLIER  FRIENDSHIP HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN46203		
(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>"risk for skin breakdown due to total dependence on staff for bed mobility, total incontinence of bowel due to paraplegia, peripheral vascular disease and long term history of pressure ulcers." Interventions to this plan of care included "pressure reducing mattress, and reposition at least every two hours."</p> <p>A review of the CNA [certified nurse aide] assignment sheet instructed the staff to "turn side to side. Limit time in chair to meals only. Keep heels off bed. Blue multi-podus boots at night and up in chair."</p> <p>On 09-30-11 at 9:15 a.m. the resident was observed lying on back in bed. The CNA turned the resident to the left side for observation of the resident's skin.</p> <p>During this observation, a dressing was observed and dated 09-29-11. The skin adjacent to the dressing was bright red in color along the right side and bottom edge of the dressing. The resident's upper back, scapula area, had a small dime size reddened area observed. During this observation licensed practical nurse employee #3 was in attendance. The nurse indicated she was unaware why the resident's skin was bright red in color and further stated "I think it's from the tape. [Resident] is going to the Wound Clinic</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/07/2011
NAME OF PROVIDER OR SUPPLIER  FRIENDSHIP HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN46203		
(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	
F0314 SS=G	<p>today. The area up here [pointing to the dime size reddened area] won't blanch. I don't know what it's from."</p> <p>During an observation on 10-05-11 at 9:40 a.m., the resident was positioned to the left side. At 12:00 p.m., the resident was positioned on back with a pillow beneath the resident's ankles. The resident's heels were on the bed.</p> <p>During interview at on 10-05-11 at 12:30 p.m., the Director of Nurses indicated the staff "cannot use a pillow to position the heels off the bed because the pillow will just sink down."</p> <p>This federal deficiency relates to complaint IN00097468.</p> <p>3.1-35(g)(2)</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, record review and interview, the facility failed to ensure a</p>	F0314	Resident B no longer resides at the facility. Resident B's shower report dated 9-18-11 lacked	11/04/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/07/2011
NAME OF PROVIDER OR SUPPLIER  FRIENDSHIP HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN46203		
(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>resident who entered the facility without pressure areas, received the treatment and services to prevent pressure areas from developing, and a resident who had a history of pressure ulcers received the treatment and services needed to prevent infection or new pressure areas from developing. This resulted in residents acquiring multiple pressure ulcers, for 2 of 4 residents reviewed for pressure ulcers in a sample of 11. [Residents "B" and "G"].</p> <p>Findings include:</p> <p>1. The record for Resident "B" was reviewed on 09-29-11 at 10:05 a.m. Diagnoses included but were not limited to anoxic brain injury, seizures, dysphasia, and respiratory failure. The record indicated the resident had a tracheostomy. These diagnoses remained current at the time of the record review.</p> <p>Review of the resident's Minimum Data Set assessment, dated 08-12-11, indicated the resident required total assistance from the staff for bed mobility, transfer, dressing, hygiene and bathing. The assessment indicated the resident was at risk for the development of pressure ulcers but did not have any open areas at the time of the assessment.</p>		<p>identification of skin issues or concerns because the resident had been admitted to the local hospital. The Director of Nursing observed the resident's skin, after staff bathed him and noted comments on the resident's skin. The shower sheet, dated 9-17-11 and confirmed no pressure areas were present. While in the facility, Resident B was on a circulating air mattress to reduce pressure ulcer risk, was provided a micro-bead neck pillow for positioning of neck, head, and ears, provided micro-bead bolsters to float his heels, a wedge cushion to assist in 1/4 turns to off load weight on his protruding bony prominences, received skin lotion upon turns, and was repositioned every 2 hours per a designated turn schedule, to sure ensure pressure interventions. Resident G is very prone to pressure ulcers and has had skin issues since his admission in 2005. He uses a circulating air mattress to reduce pressure areas. A turn schedule has been implemented to ensure that resident is not on his back except during meal times,when in bed. C.N.A's have been instructed to get the resident up for meals 1-2 times daily, at present, to maintain blood circulation, increased socialization, and more dignified existence, but will return to his designated turn schedule when he has been returned to bed. All</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155741		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/07/2011	
NAME OF PROVIDER OR SUPPLIER  FRIENDSHIP HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN46203			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>Review of the Care Area Assessment Documentation Notes, also dated 08-12-11, indicated "Resident is at risk for pressure ulcers due to total dependence on staff for bed mobility and total incontinence of bowel. No pressure ulcers are noted at this time."</p> <p>Review of the resident's Minimum Data Set assessment, dated 09-16-11, indicated the resident did not have any pressure ulcers.</p> <p>The resident's plan of care dated 08-12-11, indicated the resident was at "risk for skin breakdown due to total incontinence of bowel and total dependence on staff for bed mobility." A handwritten notation [undated] indicated "resident presents with extremely bony prominences and is on a turn schedule." Interventions to this plan of care included "use turn schedule and wedge cushion when on rt. [right] / lft. [left] side. Ensure catheter tubing not against leg or hip. Observe skin for redness."</p> <p>The record indicated the resident had a hospital stay from 09-02-11 thru 09-06-11 and return to the facility with no open areas, but was assessed upon re-admission for pressure wounds and was determined to be at "high risk" as noted on the</p>		<p>nursing staff have been inserviced, in regards to, Resident G's specific interventions to prevent further skin breakdown and to promote wound healing. Charge nurses have been inserviced reminding them of the importance of more frequent observations and interactions with Resident G, and ensure his turn schedule is followed. Resident G will continue to be followed by the Wound Care Center as well as weekly wound rounds to monitor his skin. All residents in the facility are identified as having potential to be affected. All nursing staff have been inserviced regarding the importance of following resident care plans to prevent skin breakdown and promote wound healing. This inservice included pressure reducing methods such as floating heels and utilizing turn schedules. Two new tools have been developed for nurses to utilize when a skin issue is found during a shower or a skin assessment. The tools work like a decision tree, matching up a description of wound stages and a product recommended for each stage to get a treatment initiated without waiting for an assessment by the wound nurse. This includes a nutrient tool explaining the use of supplements including (but not limited to) folic acid, Vitamin C, and protein supplements. CNAs will be informed of new skin issues and</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/07/2011
NAME OF PROVIDER OR SUPPLIER  FRIENDSHIP HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN46203		
(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>Nursing Readmission Assessment dated 09-06-11.</p> <p>Review of the "Shower Report" dated 09-18-11 [Sunday] indicated "washed resident up 09-17-11, did not give full bed bath, in hospital 09-18-11." The record lacked identification of skin issues or concerns.</p> <p>Review of the nurses notes, dated 09-18-11 at 10:30 a.m., indicated the "resident noted to have increased tremors. diaphoretic, axillary [temperature] 101.0, blood pressure 141/114, pulse 112, sat [oxygen saturation level] at 89%. MD [Medical Doctor] notified." "New order to send resident to [name of local area hospital] for treatment and evaluation."</p> <p>Review of the Emergency Room nursing notes, dated 09-18-11, indicated the following: "Pt. with multiple Stage 1 dime size decubs. [decubitus] along spine and to bilateral pelvic bones."</p> <p>The hospital history and physical, dated 09-18-11, noted the resident had "pressure areas of concern on the cervical, thoracic, lumbar pcoesses &lt;sic&gt;, sacral. Left buttocks, with abrasion (s) to the right ear, and a concern with the right hand between the thumb and index finger. Physical</p>		<p>how to alter their ADL care, on a daily basis, to promote healing. CNAs are also reminded to communicate any skin changes noted to the charge nurse for follow-up. The Director of Nursing or designee will make rounds three times weekly to make sure that nursing staff is providing care to the residents as indicated on their CNA Care Guides, with specific attention to pressure ulcer prevention interventions. The DON will share her observations with the Quality Assurance Committee at least quarterly on an ongoing basis. Additionally, The Quality Assurance Committee will review the findings of the Wound Rounds monthly X 3 months and quarterly thereafter to monitor the effectiveness of our skin program. The Administrator and Director of Nursing are responsible for compliance. Date of Completion November 4, 2011. Addendum: The in-service on 10/28/2011 instructed C.N.A.s to refer to their C.N.A Care Guides for interventions to prevent pressure ulcers. Various interventions were discussed, such as floating heels, use of circulating air mattresses, turn schedules (which may be every two hours, hourly, or other frequency depending on resident needs). Wounds and skin are inspected daily during treatment administration, and the DON notified of changes so that care</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/07/2011
NAME OF PROVIDER OR SUPPLIER  FRIENDSHIP HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN46203		
(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>Exam: Integumentary - warm, diaphoretic, back has multiple DTT's [deep tissue injuries] over spine and pelvis, right hand between thumb and index finger has a malodorous wound with whitish discharge, no surrounding warmth, erythematous."</p> <p>Review of the Hospital Critical Care notation - final report dated 09-18-11 thru 09-23-11, indicated "skin breakdown - this does not appear to be cellulitis but does have significant breakdown."</p> <p>Review of the Hospital Wound Care notation, dated 09-19-11, indicated "Upon assessment, patient noted to have multiple dime sized [illegible word] to spinal colum &lt;sic&gt; along with coxscy &lt;sic&gt; adn &lt;sic&gt; sacral and iliac crest area."</p> <p>Review of the Wound Care "Final Report" notation, dated 09-18-11 thru 09-23-11, indicated the following: "right ear - multiple dried scabbed areas - all intact, no drainage noted,"  "right hand - between thumb and first finger - intact linear brown scab, without erythema, without drainage,"  "left hand between thumb and first finger approx. [approximately] 1 cm [centimeter] by 0.2 cm by 0.1 linear</p>		<p>measures can be modified if needed. Residents with wounds will be reassessed weekly by the designated Wound Nurse. Wounds will be discussed at a weekly interdisciplinary team meeting so that we can track changes in existing wounds and incidents of new wounds. This interdisciplinary team will include the Wound Nurse, the DON, the Administrator, and the Dietary Supervisor. All residents will be checked once weekly during a shower to identify new skin issues. As previously stated, the QA Committee will review the findings of the Wound Rounds monthly X 3 months and quarterly thereafter to monitor the effectiveness of our skin program. This will evaluate both the effectiveness of treatment of existing wounds and prevention of new wounds.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/07/2011
NAME OF PROVIDER OR SUPPLIER  FRIENDSHIP HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN46203		
(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>wound with 100 % pink base."</p> <p>"Spinous process with multiple small round darkened red and/or purple circular areas over bony prominences: all intact,"</p> <p>"right hip with approx. 2 cm circular blanchable erythema - intact,"</p> <p>"Assessment and Plan: right ear resolving, left hand present on admission - from braces at facility per family member, spinous process - deep tissue injury present on admission."</p> <p>During an observation on 10-04-11 at 9:15 a.m., the resident was observed in contact isolation for MRSA [methicillin resistant staphylococcus aureus]. The hospital nursing staff turned the resident to the right side, and six areas, dark brown in color, were observed along the resident's spine. In addition, the resident had dressings over two areas noted on the coccyx, left buttocks and a circular area adjacent to the area noted on the left buttocks. In addition "scarred" areas were observed between the thumb and index finger of both the right and left hand, as well as the resident's right ear.</p> <p>During an interview on 09-29-11 at 12:15 p.m., an interested family member indicated that upon arriving at the hospital</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/07/2011
NAME OF PROVIDER OR SUPPLIER  FRIENDSHIP HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN46203		
(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>[reference date 09-18-11] they could smell an odor but "couldn't figure out where it was coming from." "[Resident] wore braces - and they [in reference to the staff at the facility] were supposed to leave them on for 4 hours and then off for 4 hours. The braces were left on [resident] both hands. There was the brace and under the brace was like an ace bandage. We, my [family member] and I, kept smelling a horrible smell. It seemed like it was coming from [resident's] hands. We took off the brace and then the bandage, the odor was horrible and there was a wound between the thumb and forefinger on both hands. It looked like someone cut it open."</p> <p>2. The record for Resident "G" was reviewed on 10-05-11 at 11:20 a.m. Diagnoses for resident "G" included but were not limited to diabetes, schizophrenic, paraplegia and a history of pressure ulcers. The resident's record indicated an allergy to tape.</p> <p>Review of the Minimum Data Set assessment, dated 10-04-11, indicated the resident required extensive assistance with bed mobility, and total care for transfer, dressing and personal hygiene. In addition, the assessment indicated the resident was assessed at risk for</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/07/2011
NAME OF PROVIDER OR SUPPLIER  FRIENDSHIP HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN46203		
(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>developing pressure ulcers and currently had 3 stage two ulcers.</p> <p>Review of the current plan of care dated 07-22-11, indicated the resident was a "risk for skin breakdown due to total dependence on staff for bed mobility, total incontinence of bowel due to paraplegia, peripheral vascular disease and long term history of pressure ulcers." Interventions to this plan of care included pressure reducing mattress, and reposition at least every two hours.</p> <p>A review of the CNA [certified nurse aide] assignment sheet instructed the staff to "turn side to side. Limit time in chair to meals only. Keep heels off bed. Blue multi-podus boots at night and up in chair."</p> <p>During the initial tour of the facility on 09-29-11 at 8:30 a.m., employee licensed practical nurse employee #3 indicated the resident had wounds with an area on the buttocks and right heel.</p> <p>During observation on 09-30-11 at 9:15 a.m., the resident was observed lying on back in bed. The CNA turned the resident to the left side for observation of the resident. During this observation a dressing was observed on the resident's buttocks/coccyx area and dated 09-29-11.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/07/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  FRIENDSHIP HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN46203
---	---

(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 skin adjacent to the dressing was bright red in color along the right side and bottom edge of the dressing. The resident's upper back, scapula area, had a small dime size reddened area observed. During this observation, licensed practical nurse employee #3 was in attendance. The nurse indicated she was unaware why the resident's skin was bright red in color and further stated "I think it's from the tape. [Resident] is going to the Wound Clinic today. The area up here [pointing to the dime size reddened area] won't blanch. I don't know what it's from."</p> <p>The record indicated the resident was seen by a local Wound Care Clinic for treatment, with a recent visit dated 09-30-11. The notation indicated the resident had "ulcers of the sacrum, and the buttocks and also of right heel and the ischium. The ulcer of the coccyx is...1.7 cm [centimeters] by 0.8 cm by 1.2 cm. with 1.2 cm of undermining. The right heel is 0.8 cm. by 0.4 cm. by 0.1 cm, and the buttocks measured at 1.2 cm. by 1.0 cm. by 0.2 cm."</p> <p>During an observation on 10-05-11 at 9:40 a.m., the resident was positioned to the left side. At 12:00 p.m., the resident was positioned on back with a pillow beneath the posterior of the ankles. The resident's heels were on the bed.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/07/2011
NAME OF PROVIDER OR SUPPLIER  FRIENDSHIP HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN46203		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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	
F0322 SS=G	<p>During interview on 10-05-11 at 12:30 p.m., the Director of Nurses indicated the staff "cannot use a pillow to position the heels off the bed because the pillow will just sink down."</p> <p>This federal deficiency relates to complaints IN00097319 and IN00097468.</p> <p>3.1-40(a)(1) 3.1-40(a)(2)</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>Based on record review and interview, the facility failed to ensure the nutrition needs and hydration needs were met, in that when a resident was dependent for nutrition via a feeding tube, the facility failed to ensure the resident's nutrition and hydration needs were met which resulted in the need for hospitalization for the treatment of malnutrition and dehydration, for 1 of 3 residents with feeding tubes in a sample of 11. [Resident "B"].</p> <p>Findings include:</p>	F0322	Resident B no longer resides at the facility. Resident B was first admitted to our facility on the evening of July 22, 2011. Some of his diagnoses upon admission to the facility, were as follows, but not limited to: Hypoxic Encephalopathy, s/p Candida Albicans, Malnutrition, s/p Aspiration Pneumonia, s/p Peg tube, s/p tracheotomy, dehydration, and in a Persistent Vegetative State. All residents in the facility are identified as having potential to be affected. All facility scales have been calibrated. Nursing staff was inserviced on	11/04/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/07/2011
NAME OF PROVIDER OR SUPPLIER  FRIENDSHIP HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN46203		
(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>1. The record for Resident "B" was reviewed on 09-29-11 at 10:05 a.m. Diagnoses included but were not limited to anoxic brain injury, seizures, dysphasia, and respiratory failure. The record indicated the resident had a tracheostomy and a gastrostomy feeding tube. These diagnoses remained current at the time of the record review.</p> <p>Review of the Resident's Minimum Data Set assessment, dated 08-12-11, indicated the resident required total assistance from the staff for bed mobility, transfer, dressing, hygiene, bathing and feeding.</p> <p>Review of the Care Area Assessment Documentation Notes, also dated 08-12-11, indicated "Resident is unable to swallow due to persistent vegetative state. [Resident] relies on g-tube [gastrostomy] for all nutrition and hydration."</p> <p>The resident's plan of care, dated 08-12-11, indicated the resident's "nutrition and hydration needs will be met through next review AEB [as evidenced by] no significant weight changes." Interventions to this plan of care instructed the nursing staff to "monitor for tolerance of feeding and report diarrhea or vomiting, monitor lab and weights as ordered. Report loss or abnormal,</p>		<p>October 28, 2011 regarding proper use of facility scales. A return demonstration was done to ensure staff is weighing residents accurately. We have designated one nursing staff member who is responsible for obtaining all weekly and monthly weights. Weekly weights will be completed by Tuesday each week, and will be reviewed by the Director of Nursing and the Dietary Manager. Any significant weight changes will trigger a re-weight which will be done by Wednesday each week. Monthly weights will be completed by the 7 th of each month, and will be reviewed by the Director of Nursing and the Dietary Manager. Any significant weight changes will trigger a re-weight which will be done within 24 hours of the weight in question. Any significant weight with confirmed with a re-weight will be reported to the resident and/or responsible parties, and the resident's physician. The timeliness and accuracy of resident weights will be discussed in the Quality Assurance meeting monthly X 3 months and quarterly thereafter to monitor effectiveness of obtaining and recording accurate resident weights and timely notification of physicians and resident family when a significant weight change occurs. All nursing staff has been inserviced on the importance of accurate and complete documentation of intake and</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155741		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/07/2011	
NAME OF PROVIDER OR SUPPLIER  FRIENDSHIP HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN46203			
(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>feeding as ordered, monitor fluid intake and skin turgor."</p> <p>Review of the September 2011 physician rewrite indicated the resident was to receive Fibersource 320 c.c. per g-tube 5 times a day with 100 c.c. of free water with each feeding.</p> <p>Review of the "Monthly Weight Report," on 10-05-11 at 12:00 p.m., indicated the resident weighed 102.5 lbs. [pounds] in July 2011, 120.4 lbs in August 2011, and 96.4 lbs in September 2011. However, review of the weekly weights, dated 09-14-11, indicated the resident weighed 88.6 lbs., and the next available recorded weight was 88.3 lbs. on 09-28-11.</p> <p>Further review of the facility Nutrition Assessment notations, dated 08-15-11, indicated the resident was "dependent on g-tube feedings due to persistent vegetative state and inability to chew and swallow."</p> <p>The dietician nutrition assessment indicated the resident's BUN (blood urea nitrogen - lab test) was 14, and dehydration concerns were not noted, and the use of Fibersource at 320 c.c., 5 times a day would provide 1920 kcalories and 84.8 grams of protein.</p>		<p>output records for residents who are fed via g-tube. The Administrator and Director of Nursing are responsible for compliance. Date of Completion November 4, 2011..Addendum: All residents are assessed for risk for dehydration upon admission and then quarterly and when significant changes occur. Residents are monitored daily for changes in condition, such as diarrhea, urine appearance, fluid intake at meals. Residents who are identified as being at high risk for dehydration will be care planned to address this risk. All staff will be inserviced on 11/15/2011 regarding the signs of dehydration as well as various interventions to promote adequate hydration to the residents.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/07/2011
NAME OF PROVIDER OR SUPPLIER  FRIENDSHIP HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN46203		
(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 09-12-11 notation indicated "Post hosp. [hospitalization] for UTI [urinary tract infection. Hosp. d/c [discharge] noted feeding of Replete. Suggest continue TF [tube feeding] as prior to hosp. Fibersource HN 320 mg 5 times a day, followed by 100 ml of water. Sept [September] wt. recorded at 96.4 lbs, [arrow down] of 24 lbs. / 19.9% in one month ?? questionable. July [2011] weight recorded at 102.5 lbs. Request weekly wt. [weight] until stable wt. noted."</p> <p>Documentation provided by the Director of Nurses on 09-30-11 at 1:05 p.m., indicated the resident was transported to the local area hospital and then returned to the facility on the following occasions:</p> <p>To the hospital on 07-25-11 and returned to the facility on 08-01-11, to the hospital on 09-03-11 and returned to the facility on 09-06-11, to the hospital on 09-06-11 and returned to the facility on 09-18-11, and on 09-23-11, and then once again transported to the local area hospital on 09-28-11 and remained there at the time of this visit.</p> <p>Review of hospital records on 10-04-11 at 9:15 a.m., indicated the resident had been admitted to the local area hospital on the following dates and diagnoses:</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/07/2011
NAME OF PROVIDER OR SUPPLIER  FRIENDSHIP HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN46203		
(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>09-03-11 with diagnoses which included "systemic inflammatory response syndrome and positive blood cultures - fungemia,"</p> <p>09-18-11 with diagnoses which included "shock likely a combination of hypovolemia and sepsis, severe dehydration with a BUN [blood urea nitrogen level] over 100 due to inadequate &lt;sic&gt; fluid administration, right lower lung collapse, severe malnutrition, acute kidney injury - likely secondary to dehydration,"</p> <p>09-28-11 with diagnoses which included "malnutrition."</p> <p>Review of the Tube Feeding Record for September 2011 prompted the nursing staff to document the formula total, water total, water tube flush, residual checked, intake, and output. The nursing staff failed to document as follows:</p> <p>09-01-11 6:00 a.m. to 2:00 p.m. shift - no documentation for output, 2:00 p.m. to 10:00 p.m. shift no documentation noted for formula total, water total, water tube flush, resident check intake or output.</p> <p>09-02-11 6:00 a.m. to 2:00 p.m. shift - no</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/07/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN46203
---	---

(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
	documentation noted for formula total, water total, water tube flush or output.  09-07-11 6:00 a.m. to 2:00 p.m. shift - no documentation noted for output.  09-08-11 6:00 a.m. to 2:00 p.m. shift - no documentation noted for output.  09-09-11 6:00 a.m. to 2:00 p.m. shift - no documentation noted for output.  09-10-11 6:00 a.m. to 2:00 p.m. shift - no documentation noted for output.  09-11-11 6:00 a.m. to 2:00 p.m. shift - no documentation noted for output.  09-12-11 6:00 a.m. to 2:00 p.m. shift - no documentation noted for formula total, water total, water tube flush, residual or output.  09-13-11 6:00 a.m. to 2:00 p.m. shift - no documentation noted for formula total, water total, water tube flush residual checked, intake or output.  09-14-11 6:00 a.m. to 2:00 p.m. shift - no documentation noted for formula total, water total, water tube flush residual checked, intake or output.  09-15-11 6:00 a.m. to 2:00 p.m. shift - no			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/07/2011
NAME OF PROVIDER OR SUPPLIER  FRIENDSHIP HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN46203		
(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>documentation noted for formula total, water total, water tube flush residual checked, intake or output.</p> <p>09-16-11 6:00 a.m. to 2:00 p.m. shift - no documentation noted for formula total, water total, water tube flush residual checked, intake or output.</p> <p>09-17-11 6:00 a.m. to 2:00 p.m. shift - no documentation noted for formula total, water total, water tube flush residual checked, intake or output.</p> <p>Although the tube feeding record lacked documentation on the above dates, the documentation that was provided indicated the resident did not receive 1600 c.c. of Fibersource feeding as directed, but rather 1280 c.c. of the Fibersource with 320 c.c. on the evening shift 320 c.c. on the night shift, and 640 c.c. was documented on the day shift.</p> <p>The record lacked documentation from September 1, 2011 thru September 2, 2011, at which time the resident was hospitalized and returned to the facility on September 6, 2011, and then September 6, 2011 thru September 18, 2011, in regard to if the nutrition and hydration needs of the resident were being met.</p> <p>2. Review of the facility "Hydration</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/07/2011
NAME OF PROVIDER OR SUPPLIER  FRIENDSHIP HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN46203		
(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>Program" on 10-05-11 at 12:00 p.m., and dated 08-98, indicated the following:</p> <p>"POLICY [bold type] In that residents requiring thickened liquids are at risk for dehydration due to inaccessibility of fluids staff shall offer fluids on a regular schedule per a documented hydration program to those residents noted to be at increased risk due to poor fluid intake, abnormal creatinine level etc."</p> <p>The policy failed to address the hydration needs of a resident dependent upon tube feedings for nutrition and hydration needs.</p> <p>3. Review of the facility policy titled "Intake and Output Recording, on 09-30-11 at 11:40 a.m., and dated 12-96, indicated the following:</p> <p>"PURPOSE [bold type and underscored] To provide an accurate record of the residents intake and output."</p> <p>"POLICY [bold type and underscored] An intake and output record is maintained when needed to monitor the resident's fluid balance. Intake and output will be recorded on residents with the following: tube feedings, anchored catheter, a physician's order for I &amp; O [intake and output]."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/07/2011
NAME OF PROVIDER OR SUPPLIER  FRIENDSHIP HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN46203		
(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	
F0323 SS=G	<p>4. Facility policy titled "Gastrostomy Tube Feeding," reviewed on 09-30-11 at 11:40 a.m., indicated the following:</p> <p>"PURPOSE To provide the resident with essential nutrition and hydration through a tube inserted through a surgical opening into the stomach."</p> <p>"Document in Nurse's Notes the type of feeding, amount of feeding, amount of water, resident tolerance and other pertinent information."</p> <p>This Federal deficiency relates to complaints IN00097319 and IN00097468.</p> <p>3.1-44(a)(2)</p> <p>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.</p> <p>A. Based on record review and interview, the facility failed to ensure the safety and supervision of the residents in that a resident who required supervision with ADLs (activities of daily living) was allowed to shave independently, which resulted in bleeding and multiple cuts to the head. This deficient practice affected 1 of 3 residents who required supervision</p>	F0323	Resident C has been provided with two electric razors. One is for shaving his face, the other for shaving his head. The facility's Occupational Therapist has worked with him to ensure that he is able to use the electric razors safely. Resident C's CNA Care Guide has been updated to include use of electric razors. All nursing staff will be inserviced by	11/04/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/07/2011
NAME OF PROVIDER OR SUPPLIER  FRIENDSHIP HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN46203		
(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>for activities of daily living in a sample of 11. [Resident "C"].</p> <p>B. Based on observation, record review and interview, the facility failed to ensure the safety of residents and provide the assistive devices needed to alert the staff of unassisted transfer/ambulation for 1 of 3 residents reviewed for falls in the sample of 11, resulting in injuries to the face which were deep purple in color with multiple bruises and abrasions around both eyes, cheeks, chin and forehead, and a large knot/hematoma on the left cheek bone adjacent to the left eye. [Resident "B"].</p> <p>C. Based on observation, record review and interview, the facility failed to ensure the whereabouts of residents in that the facility allowed residents the code to the locked front door, which resulted in a resident missing from the facility for a period of time without staff being aware the resident had left the premises, for 3 of 3 residents reviewed who were allowed information related to the locked front door in which they were able to come and go from the facility premises without the staff knowing the residents' whereabouts, in a sample of 11. [Residents "J", "H", "K"].</p> <p>Findings include:</p>		<p>October 28, instructing them not to give razors to residents. Resident E had falls resulting in multiple bruises. Resident E now has padded side rails. His care plan and CNA Care Guide have been updated to include all fall prevention devices that are used with him. CNA #7 was counseled to review her CNA Care Guide daily and provide care to residents in accordance with the Guide. Nursing staff will be inserviced by October 28 reminding them of the importance of reviewing the CNA Care Guides and following the instructions on them. Nurses will also be inserviced on the importance of checking resident safety devices such as personal safety alarms. Resident J has agreed to sign out prior to any outings from the facility. Residents H and K have agreed not to leave the facility unless accompanied by a family member or staff member. All residents in the facility are identified as having potential to be affected. The exit codes have been changed and all staff has been instructed not to give the exit code to any residents. All staff has been inserviced to allow residents to sit outside in the enclosed patio area or allow them to sit on the front porch if accompanied by staff or a family member or other responsible person. The Administrator and Director of Nursing are responsible for</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/07/2011
NAME OF PROVIDER OR SUPPLIER  FRIENDSHIP HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN46203		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>A.) The record for resident "C" was reviewed on 09-29-11 at 2:40 p.m. Diagnoses included but were not limited to senile pre senile organic psychotic condition, neurotic disorder, anxiety and bipolar disorder. These diagnoses remained current at the time of the record review.</p> <p>Review of the Minimum Data Set assessment, dated 06-27-11, indicated the resident required supervision with hygiene and assistance with bathing.</p> <p>The resident's current plan of care, dated 07-01-11, indicated, "needs supervision for dressing and bathing due to left hemiparesis, with interventions which included "assist resident with ADLs [activities of daily living] as needed, assist resident to shower twice weekly."</p> <p>During an interview on 09-30-11 at 12:30 p.m., a visitor indicated a need to "check" on this resident as resident had a "safety razor in possession and cut [resident] head numerous times." When interviewed how this visitor obtained this information, the visitor indicated "a resident told me about it. [Resident] said there was blood everywhere."</p> <p>Review of the nurses notes, dated</p>		<p>compliance.Date of Completion November 4, 2011.Addendum: All staff was inserviced on 10/28/2011 instructing them not to allow residents to keep disposable razors. The Director of Nursing or designee will make rounds three times weekly to make sure that nursing staff is providing care to the residents as indicated on their CNA Care Guides. This will include placement of personal safety alarms, code alerts to prevent elopement, fall prevention interventions, and hazards such as disposable razors. The findings on these rounds will be shared with the interdisciplinary team at morning meeting on the business day after the rounds. The DON will also share her observations with the Quality Assurance Committee at least quarterly on an ongoing basis.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155741		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/07/2011	
NAME OF PROVIDER OR SUPPLIER  FRIENDSHIP HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN46203			
(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>09-15-11 [no time documented] indicated, "Resident in room and shaving [resident] scalp without supervision. Has cut self in 5 places and bleeding."</p> <p>The nurses notes dated 09-26-11 at 3:00 p.m. indicated "has shaved head and cut self in numerous places with razor. Has 3 razors in trash along with bloody tissue and washcloth."</p> <p>During a discussion with the Administrator and Director of Nurses at the daily exit conference on 09-29-11 at 4:00 p.m., the administrative staff verified the resident "gave self a shower and the other day and [resident] head was cut to high heaven. [Resident] does own shaving."</p> <p>During further discussion, the Administrator and Director of Nurses indicated they were unaware the resident had two episodes of cutting self.</p> <p>During an interview on 09-30-11 at 9:15 a.m. CNA [certified nurses aide] employee #9 indicated the residents "aren't supposed to have razors at all."</p> <p>During interview on 09-30-11 at 9:20 a.m. CNA #7 indicated "I think if they are independent then they can have razors."</p> <p>During interview on 09-30-11 at 9:45</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/07/2011
NAME OF PROVIDER OR SUPPLIER  FRIENDSHIP HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN46203		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>a.m., licensed practical nurse employee #1 indicated "No resident if supposed to have a razor in their possession."</p> <p>During interview on 10-04-11 at 12:00 p.m., the Director of Nurses indicated "when we did a sweep of [resident] room we found 12 razors."</p> <p>B.) The record for Resident "E" was reviewed on 09-29-11 at 12:10 p.m. Diagnoses included but were not limited to viral hepatitis, schizophrenic disorder and encephalopathy. These diagnoses remained current at the time of the record review.</p> <p>Review of the hospital patient information/discharge orders, dated 09-09-11, indicated the resident required "bed rest - may sit on side of bed with assistance. The patient is currently A &amp; O [alert and oriented] times 1 [self]."</p> <p>Review of the Nursing Admission Skin condition report, dated 09-09-11 indicated that at the time of admission to the facility the resident had "multiple bruises and scapping &lt;sic&gt; to bilateral upper extremities, scapping &lt;sic&gt; to right knee cap." "Initial care plan: problem fall risk. Approach: bed alarm, call light in reach. Goal: no falls."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/07/2011
NAME OF PROVIDER OR SUPPLIER  FRIENDSHIP HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN46203		
(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 initial tour of the facility on 09-29-11 at 8:30 a.m., licensed practical nurse employee #3 indicated the resident was a "fall risk" and had recently fallen out of bed and sustained extensive bruising to face, arms and hands. The name plate outside of the resident's room had a "star" adjacent to the resident's name. The licensed practical nurse indicated the "star" was placed there to alert the staff the resident was a fall risk.</p> <p>Review of the Minimum Data Set assessment, dated 09-16-11, indicated the resident required extensive assistance with bed mobility and was assessed as "total" care/assistance from the staff with transfer.</p> <p>Review of the current plan of care, dated 09-27-11, indicated the resident "gets bruises and skin tears easily due to anticoagulant use." The "goal" indicated "resident will be free of serious injuries through next review." Interventions to this plan of care included "Pad side rails on bed with pillows, pillow cases, bed pad alarm in bed, PSA [personal safety alarm] in wheelchair to alert staff if resident tries to transfer without assistance.</p> <p>A subsequent current plan of care dated 09-22-11, indicated the resident had the</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/07/2011
NAME OF PROVIDER OR SUPPLIER  FRIENDSHIP HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN46203		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>"Potential for injuries from falls due to recent history of falls." Interventions included "Monitor resident for steadiness and balance, personal safety alarm [PSA] when up in wheelchair, pressure pad alarm in bed."</p> <p>The certified nurses aide assignment sheet with resident specific information indicated the resident required a bed pad alarm and a PSA when up in the wheelchair.</p> <p>Review of the nurses notes indicated the following:</p> <p>"09-09-11 4:00 p.m. Alert to self, inappropriate\ speech noted. Resident on bedrest. Attempted to climb OOB [out of bed] times 3 times this shift bed alarm placed."</p> <p>"09-10-11 10:30 a.m. - Pt. [patient] has tried to climb out of bed times 2 this shift."</p> <p>"09-10-11 10:00 p.m. - Bed alarm in place alarms when res. [resident] moving about in bed."</p> <p>"09-14-11 6:00 a.m. - Sitting up on side of bed multiple times during this noc [night]."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/07/2011
NAME OF PROVIDER OR SUPPLIER  FRIENDSHIP HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN46203		
(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>"09-18-11 8:00 p.m. - Alert to person inappropriate speech at times. Resident attempt to get OOB times 2. Likes to sit on edge of bed."</p> <p>"09-21-11 11:20 a.m. - Pt. found in room lying on floor on left side, alarm sounding, fall matt at bed side. pt alert verbal abrasion/laceration 5 in length area blue/purple with bright red drng [drainage], s/t skin tear noted to left elbow measures .6 by .5 cm [centimeters] flap intact."</p> <p>During the initial tour of the facility on 09-29-11 at 8:30 a.m., the resident was observed seated in a wheelchair. The resident's face was deep purple in color with multiple bruises and abrasions around both eyes, cheeks, chin and forehead. The resident had a large knot on the left cheek bone adjacent to the left eye.</p> <p>During an observation on 10-05-11 at 9:40 a.m., the resident was seated in a wheelchair in room. The resident, in a continuing motion, placed the palms of both hands on the armrests of the wheelchair and attempted a standing position.</p> <p>During a subsequent observation on 10-05-11 at 9:50 a.m., the resident</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/07/2011
NAME OF PROVIDER OR SUPPLIER  FRIENDSHIP HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN46203		
(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>continued attempts at standing. Upon entering the resident's room, the resident lacked a PSA alarm while seated in the wheelchair. During this observation an alarm was observed on the resident's nightstand. CNA [Certified Nurses Aide] employee #7 entered the resident's room. When interviewed the CNA indicated she was unaware the resident required a PSA. When requested the CNA reviewed her assignment sheet which instructed staff of the need for the personal alarm. The CNA turned toward the nightstand and stated, "that probably needs to be on the wheelchair and attached to [resident]." The Director of Nurses was in attendance during this observation.</p> <p>The resident was observed with white kerlix/gauze type dressings to bilateral arms from the wrists to the elbows. The siderails of the resident's bed were not padded to protect the resident from additional injury.</p> <p>C 1.) The record for resident "J" was reviewed on 09-30-11 at 9:30 a.m. Diagnoses included but were not limited to paranoid schizophrenia, restless legs paraplegia and diabetes mellitus. These diagnoses remained current at the time of the record review.</p> <p>Review of the Minimum Data Set assessment dated 05-05-11, indicated the</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/07/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  FRIENDSHIP HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN46203
---	---

(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>resident had no cognitive impairment; however, the resident' plan of care indicated the resident was at risk for confusion and disorganized thought due to the diagnosis of schizophrenia. The resident also had a history of noncompliance with medications. The resident used a wheelchair for mobility.</p> <p>Review of an incident reported to ISDH, dated 09-17-11 at approximately 5:00 a.m., indicated the following:</p> <p>"[Resident] states that [resident] left the facility at about 5:00 a.m. and wheeled self to [name of local area restaurant] approximately seven blocks from the facility. After arriving at [name of local area restaurant], [resident] telephoned a friend to meet [resident] and [other family member] as well. [Family member] telephoned the facility at about 8:30 a.m. indicated [resident] was at [name of local area restaurant]. CNA [name documented of employee #9] went to the restaurant to bring [resident] back but [resident] refused to come back with her at that time. [Name of CNA] then left [resident] at [name of local area restaurant] with [family member] and friend. [Resident] had his friend bring [resident] back to the facility later that morning."</p> <p>Further review of the report indicated the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/07/2011
NAME OF PROVIDER OR SUPPLIER  FRIENDSHIP HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN46203		
(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>Assistant Administrator spoke with the resident and reminded the resident of the need to "sign in and out of the facility." The resident indicated [resident] "made a mistake today and in the future will sign out prior to leaving the facility."</p> <p>Statements, handwritten, by facility staff member indicated she "thought" she saw the resident around 6:00 a.m., however, the facility staff was unaware of the resident's whereabouts for approximately 2 - 2 1/2 hours.</p> <p>During observation on 10-04-11 at 11:25 a.m., the local area restaurant was approximately 1/2 mile from the facility. Getting to the restaurant necessitated crossing four lanes of moving traffic from north to the south lanes, and two lanes of traffic for the east west lanes of traffic.</p> <p>Review of the Social Service Review and Resident Interview, dated 08-08-11 indicated "Outside Supervision Needs - "understands the facility LOA policy (Signing in/out), and may sit out on front porch unsupervised."</p> <p>Although the incident occurred on 09-17-11, the facility failed to do a post elopement assessment until 10-05-11.</p> <p>C 2.) The record for Resident "H" was</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/07/2011
NAME OF PROVIDER OR SUPPLIER  FRIENDSHIP HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN46203		
(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>reviewed on 10-05-11 at 11:00 a.m.</p> <p>Diagnoses included but were not limited to anoxic brain damage, blindness - low vision and hypotension. These diagnoses remained current at the time of the record review.</p> <p>Review of the resident's Minimum Data Set, dated 07-22-11, indicated the resident had no cognitive impairment but did display short term memory loss. During observation on 10-04-11 at 1:10 p.m., the resident was observed with a stumbling gait.</p> <p>During an observation on 10-04-11 at 1:10 p.m., this resident was observed walking toward the front door of the facility with another resident's family member. The resident accessed the key pad, entered the code and exited the building with this visitor.</p> <p>During interview, on 10-04-11 at 1:45 p.m., the resident indicated [resident] did not get the code from a staff member. The resident was reminded the code had been changed the previous Friday, 09-30-11, and again asked to think about where [resident] obtained the code. The resident stated "I have short term memory problems I don't remember." The resident became confrontational and asked "Do you mean I have to ask someone to let me</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/07/2011
NAME OF PROVIDER OR SUPPLIER  FRIENDSHIP HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN46203		
(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>out to go to church ?" The Director of Nurses who was in attendance stated, "Yes." The resident then stated [resident] let self out of the facility on Sunday to attend church without anyone letting her out.</p> <p>The elopement risk assessment was not conducted until 10-05-11.</p> <p>C 3.) The record for Resident "K" was reviewed on 10-04-11 at 2:00 p.m. Diagnoses included but were not limited to cerebral vascular accident, neuropathy, vision abnormalities, left sided paresis, right sided craniotomy and hypertension. These diagnoses remained current at the time of the record review.</p> <p>A review of the resident's Minimum Data Set assessment, dated 08-31-11, indicated the resident had no cognitive impairment or memory loss. The resident used a motorized wheelchair for mobility.</p> <p>A physician order dated 08-26-11 indicated the resident's physician allowed the resident to go LOA by self.</p> <p>During an observation on 10-04-11 at 11:30 a.m., the resident was observed in a motorized wheelchair approximately 6 blocks from the facility on Keystone Avenue, a four lane divided street that runs north and south.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/07/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  FRIENDSHIP HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN46203
---	---

(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>Review of the "Sign In/Out" sheet, dated 10-04-11, indicated the staff member "signed" the resident as returned to the facility at 11:00 a.m.</p> <p>Further review of the "Sign In/Out sheet, indicated the resident left the facility on 09-16-11 at 12:30 p.m., but lacked a staff member's signature of the resident's return to the facility. There was no indication the staff were aware of the resident's whereabouts.</p> <p>During an interview on 10-04-11 at 1:00 p.m. the Director of Nurses indicated the resident liked to cross the street and watch the golfers [at the local area golf course].</p> <p>During interview on 10-04-11 at 2:30 p.m., the Assistant Administrator indicated he telephoned the staff member who verified she had not actually looked at the exact time the resident returned, but rather knew it was around the time she "ate" and then "took her smoke break."</p> <p>C 4.) During observation on 10-05-11 at 10:30 a.m., a group of nursing students were observed in the facility. One nursing student approached the front door and verbally stated the code to exit the facility. During interview on 10-05-11 at 10:40 a.m., the Director of Nurses was alerted</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/07/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN46203
---	---

(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>who then indicated the students were given the code but must not be aware of the importance not to verbally state the code in the event there are residents in the area.</p> <p>Review of Friendship Healthcare Center "Rules for Residents, on 09-30-11 at 11:00 a.m., and dated as "revised" January 2009 indicated the following:</p> <p>"It is the policy of Friendship Healthcare to expect resident to behave in such a manner that the safety, well being and right of others are respected."</p> <p>"4. Residents are not to cause injury to themselves or others."</p> <p>"6. Residents are not to leave the facility without signing out. They must sign back in upon return. LOA [leave of absence] resident need to be accompanied by a staff member, family member, or responsible party. Residents should remain within fenced areas when outside, unless accompanied by a suitable attendant."</p> <p>"12. Upon admission, no resident will be allowed outside unsupervised until having been assessed for elopement potential."</p> <p>Review of Inservice education on 09-30-11 at 1:30 p.m., instructed the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/07/2011
NAME OF PROVIDER OR SUPPLIER  FRIENDSHIP HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN46203		
(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>nursing staff as follows:</p> <p>"For our residents' safety, please be sure to not [underscored] give out the door code to our resident's. The door code may be given to family members. however, please politely ask them to respect the rules of out facility and not give the code out to their loved one or any other resident. Please be advised, any employee caught giving the code out to a resident will be immediately terminated."</p> <p>This federal deficiency relates to complaint IN00097468.</p> <p>3.1-45(a)(2)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/07/2011
NAME OF PROVIDER OR SUPPLIER  FRIENDSHIP HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN46203		
(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	
F0441 SS=F	<p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on record review and interview, the facility failed to ensure an effective infection control program in which the facility implemented and maintained documentation, and the surveillance of</p>	F0441	An Infection Control Program had been initiated for September, 2011. This program included a floor map with color coding of infections within the facility during that time. Antibiotic and	11/04/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/07/2011
NAME OF PROVIDER OR SUPPLIER  FRIENDSHIP HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN46203		
(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>infections could be monitored for 1 of 1 Infection Control program reviewed. This deficient practice affected 3 of 11 sampled and 7 of 7 supplemental sampled residents with the potential to affect all 44 residents who resided in the facility. [Residents "B", "E", "G", "L", "M", "N", "O", "P", "Q" and "R"].</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. A request was made to review the Infection Control Surveillance data at the Entrance conference on 09-29-11 at 8:00 a.m.</li> <li>2. During the Initial tour of the facility on 09-29-11 at 8:30 a.m., Licensed Practical Nurse indicated 6 residents were currently receiving antibiotics on her Unit (south).</li> <li>3. At the Daily Exit Conference on 09-29-11 at 3:30 p.m., the Infection Control information/surveillance data was again requested.</li> <li>4. On 09-30-11 at 11:10 a.m., the facility Consultant binder was reviewed. Facility staff member employee #2 indicated all consultant documentation, including information from the pharmacy, in regard to antibiotic usage, was contained in this binder. Further review of the contents of this binder lacked any information related</li> </ol>		<p>Anti-Infectives were not fully tracked during that time. Communication was addressed with each nurse and Infection Control inservices were initiated on the evening of October 7, 2011 for all facility staff via small group discussions and a 2 page handout which included timeframes for the life of viruses and spores on inanimate objects and found in dried blood. Diligent hand washing practices with all other infection control practices have been discussed and initiated. On October 15, 2011, all staff were re-inserviced on the diligent use of infection control practices and how those practices effect everyone from residents, healthcare workers, dietary, housekeeping, visitors, vendors, and all families. These practices were reviewed again on October 28 and will continue to be reviewed via State provided posters, infection control pamphlets, informative inservices, and random monitoring.</p> <p>No residents were confirmed to be adversely affected, with the incomplete infection program, at the time of survey. Infection control has been addressed, stressed, and will be re-addressed with staff, through education of current practices, especially the most important practice diligent hand washing, and any new recommendation by the CDC.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/07/2011
NAME OF PROVIDER OR SUPPLIER  FRIENDSHIP HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN46203		
(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>to antibiotic usage and the residents involved in the facility.</p> <p>5. At 12:30 p.m., on 09-30-11 the Director of Nurses verified the facility did not have an established Infection Control Program in which it monitored, investigated, controlled or prevented the spread of Infection. In addition the Director of Nurses was unable to produce surveillance data which could have the potential to prevent the spread of Infection.</p> <p>6. The record for Resident "B" was reviewed on 09-29-11 at 10:05 a.m. Diagnoses included but were not limited to a history of candida bacteria urinary tract infection, tracheostomy, and anoxic brain injury. These diagnoses remained current at the time of the record review.</p> <p>The record indicated the resident had been sent to a local area hospital on 09-01-11 for treatment and evaluation. The resident returned to the facility on the same date. On 09-02-11 the local area hospital telephoned the facility for the need of the resident to return to the hospital for treatment due to infection. The resident remained in the hospital until 09-06-11 when returned to the facility with a diagnosis of Candida Bacteremia. On 09-18-11 the resident displayed signs</p>		<p>All residents in the facility are identified as having potential to be affected.</p> <p>A tool for suspect infection with criteria to meet to enable the nurse to talk intelligently with the physician will be utilized, along with a surveillance tool containing detailed information @ labs, cultures obtained, x-rays ordered, with results. The surveillance form includes rational for use of antibiotics and antifungals and will be used to track and trend infections, along with the use of a floor plan which will note types of infections in color-coding. All nurses were inserviced on the use of the infection control tracking tools through out October and again on the October 28, 2011 inservice. A daily tool for CNAs to utilize during provision of resident care, will be initiated on November 1st, to assist in communication of a present infection, the use of antibiotic/antifungals and how it may effect the care provided. All staff were inserviced in small groups, initiated on October 7th in regards to infection control practices, hand washing, HIV/AIDS, Hepatitis B and C virus, and C diff. The nursing staff were inserviced again on October 28, 2011 on current infection control practices, importance of diligent hand washing, and the prevention of infections. Hand washing brochures are in the facility as a means to educate</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/07/2011
NAME OF PROVIDER OR SUPPLIER  FRIENDSHIP HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN46203		
(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>and symptoms of mental status changes and was once again sent to the local area hospital where the resident was determined to have sepsis, a urinary tract infection and pneumonia. The resident returned to the facility until 09-28-11 when the family determined the resident again displayed signs and symptoms of infection and had the resident sent to the local area hospital. The resident was diagnosed with pneumonia and MRSA [methicillin resistant staphylococcus aureus] and was placed in contact isolation.</p> <p>7. A request was made on 09-30-11 at 12:00 p.m., in regard to the current number of residents who had physician orders to receive antibiotics. The Director of Nurses contacted the pharmacy on 09-30-11 and received the following information:</p> <p>North Unit - Resident "P" had a diagnosis of urinary tract infection and was started on the antibiotic Ceftin on 09-24-11.</p> <p>Resident "Q" had a diagnosis of Clostridium difficile and received Vancomycin 4 times a day for 14 days. The antibiotic was started on 09-23-11.</p> <p>Resident "R" had a diagnosis of cellulitis</p>		<p>staff, residents and visitors on the importance of hand washing to reduce the spread of infections. The Director of Nursing or designee will monitor antibiotic/antifungal use three times per week for eight weeks, then twice weekly for four weeks, then monthly thereafter. The DON or designee will share her observations from this monitoring at morning meetings and at the Quality Assurance meetings no less than quarterly with input from the Medical Director and Consultant Pharmacist. The Administrator and Director of Nursing are responsible for compliance. Date of Completion November 4, 2011.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/07/2011
NAME OF PROVIDER OR SUPPLIER  FRIENDSHIP HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN46203		
(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>and was started on the antibiotic Keflex 4 times a day for 7 days.</p> <p>South Unit - Resident "L" had a diagnosis of sepsis and was started on Bactrim DS 2 times a day for 10 days.</p> <p>Resident "M" had a diagnosis of probiotic and was started on Florastar 2 times a day for 14 days.</p> <p>Resident "G" had a diagnosis of urinary tract infection and was started on the antibiotic Cefitin.</p> <p>Resident "E" had a diagnosis of right lung infiltrate and was started on Levaquin for 10 days.</p> <p>Resident "N" had a diagnosis of cellulitis of the right hip after a recent hip fracture. The resident was started on the antibiotic Doxycycline for 7 days.</p> <p>Resident "O" had a diagnosis of respiratory infection and was started on the antibiotic Doxycycline for 7 days.</p> <p>8. On 09-30-11 at 1:40 p.m., the facility requested and received a report from the pharmacy in regard to the identification of residents and the antibiotic prescribed.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/07/2011
NAME OF PROVIDER OR SUPPLIER  FRIENDSHIP HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN46203		
(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>9. Resident "B" was listed on the report as having received antibiotic treatment physician orders on 09-02-11, 09-07-11, 09-18-11, 09-24-11, and 09-26-11.</p> <p>This federal deficiency relates to complaint IN00097468.</p> <p>3.1-18(a) 3.1-18(b)(1)(A) 3.1-18(b)(1)(B) 3.1-18(b)(1)(C) 3.1-18(b)(3)</p>				