

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155793	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/10/2016
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NAME OF PROVIDER OR SUPPLIER  HAMILTON TRACE OF FISHERS	STREET ADDRESS, CITY, STATE, ZIP CODE 11851 CUMBERLAND RD FISHERS, IN 46037
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F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>This visit included the Investigation of Complaint IN00194438.</p> <p>Complaint IN00194438- Unsubstantiated.</p> <p>Survey dates: March 3, 4, 7, 8, 9, 10, 2016.</p> <p>Facility number: 012644 Provider number: 155793 AIM number: 201046710</p> <p>Census bed type: SNF: 50 SNF/NF: 53 Residential: 29 Total: 132</p> <p>Census payor type: Medicare: 30 Medicaid: 30 Other: 43 Total: 103</p> <p>These deficiencies reflect State findings</p>	F 0000	<p>March 28, 2016</p> <p>Kim Rhoades, Director Long-Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204</p> <p>Re: Allegation of Compliance</p> <p>Dear Ms. Rhoades:</p> <p>Please find enclosed the Plan of Correction to the annual Recertification and State Licensure Survey conducted on March 10, 2016. This letter is to inform you that the plan of correction attached is to serve as Hamilton Trace of Fishers credible allegation of compliance. We allege compliance April 8, 2016. We are requesting a desk review for this plan of correction.</p> <p>If you have any further questions, please do not hesitate to contact me at 317-813-4444.</p> <p>Sincerely,</p> <p>Benjy Grzych H.F.A. Administrator Hamilton Trace of Fishers</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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

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	<p>cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 30576 on March 16, 2016.</p>		<p>Submission of this plan of correction in no way constitutes an admission by Hamilton Trace of Fishers or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care or other services provided in this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Annual Recertification and State Licensure Survey on March 10, 2016. Please accept this plan of correction as Hamilton Trace of Fishers credible allegation of compliance by April 8, 2016</p> <p>This statement of deficiencies and plan of correction will be reviewed at the March Quality Assurance/Assessment Committee meeting.</p>		

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F 0156 SS=D Bldg. 00	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes:</p>				

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	<p>A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits,</p>			

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	<p>and how to receive refunds for previous payments covered by such benefits. Based on observation, interview, and record review, the facility failed to have a posting of names, addresses, and phone numbers of all pertinent State client advocacy groups. This had the potential to affect 2 of 103 residents in the facility. (Resident #26 and #135)</p> <p>Findings include:</p> <p>An interview was conducted with Resident #26 on 3/3/16 at 2:08 p.m. Resident #26 indicated she was upset about a concern she had in the dining room. She was observed with a telephone book. Resident # 26 indicated she had the telephone book to locate the phone number for the State Department of Health.</p> <p>A telephone interview was conducted with a family member of Resident #135 on 3/10/16 at 11:45 a.m. She indicated she had not seen a telephone number within the facility to call the state about her concerns with Resident #135.</p> <p>An environmental tour of the facility was conducted with the Maintenance Director and Environmental Services Director on 3/9/16 at 1:45 p.m. A binder at the front entrance of the facility indicated "State</p>	F 0156	<p><b>I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.</b> Resident #26 has been notified of where the postings of names, addresses, and phone numbers of all pertinent State client advocacy groups are located. Resident #135 family member has been notified of where the postings of names, addresses, and phone numbers of all pertinent State client advocacy groups are located. <b>II. The facility will identify other residents that may potentially be affected by the deficient practice.</b> Residents who reside at Hamilton Trace of Fishers have the potential to be affected by the alleged practice. <b>III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.</b> A copy of the required information of the following has been posted: resident rights, names, addresses and telephone numbers of all pertinent State client advocacy groups, the Medicaid Fraud control unit, and a statement regarding how to apply for and use Medicare and Medicaid benefits, and how to receive funds. Residents and families will be educated upon admission where this</p>	04/08/2016			

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	<p>Advocacy Information" on the front of the binder. Inside of the binder, was a list of names, addresses, and phone numbers of pertinent State client advocacy groups. No actual posting of names, addresses, and phone numbers of all pertinent State client advocacy groups was observed.</p> <p>An observation of the binder was conducted with the Administrator on 3/10/16 at 12:15 p.m. He indicated the term "State Advocacy Information" located on the front of the binder was considered a posting, but could put up an actual posting of names, addresses, and telephone numbers.</p> <p>An observation of 3 signs on the 300 hall was made with the Administrator on 3/10/16 at 12:27 p.m. Of the 3 signs, one included a name, address and telephone number of an advocacy agency. No other advocacy agencies were indicated on the 3 signs. The same 3 signs were observed on another hall in the facility.</p> <p>3.1-4(j)(2) 3.1-4(j)(3)(A) 3.1-4(j)(3)(B) 3.1-4(j)(3)(C) 3.1-4(j)(3)(D) 3.1-4(j)(3)(E) 3.1-4(j)(3)(F)</p>		<p>information can be located. In addition, each unit has a posting detailing the location of these documents within the facility. <b>IV The facility will monitor the corrective action by implementing the following measures.</b> Administrator designee will audit monthly X 6 months. Locations of resident rights, state advocacy groups and applying and use of Medicare and Medicaid will be reviewed in resident council monthly 3 months then quarterly thereafter totaling 12 months. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed Facility Administrator will be responsible for ensuring compliance <b>V. Plan of Correction completion date.</b> Plan of Completion date is April 8, 2016.</p>				

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F 0226 SS=D Bldg. 00	<p>3.1-4(j)(3)(G)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to obtain a reference check for 1 of 10 employee personnel files reviewed. (CNA #3)</p> <p>Findings include:</p> <p>Employee personnel files were reviewed on 3/10/16 at 10:00 a.m. The record indicated (CNA #3) Certified Nursing Assistant's start date was 2/10/16.</p> <p>The personnel file for CNA #3 did not include references.</p> <p>An interview was conducted with Human Resources on 3/10/16 at 1:30 p.m. She indicated she could not located references for CNA #3.</p> <p>A work schedule for CNA #3 was provided by Human Resources on 3/10/16 at 1:41 p.m. It indicated CNA #3 had worked 67.30 hours, since her start date.</p>	F 0226	<p><b>I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.</b></p> <p>A reference check for C.N.A. # 3 has been completed.</p> <p><b>II. The facility will identify other residents that may potentially be affected by the deficient practice.</b></p> <p>Employees who are employed at Hamilton Trace of Fishers have the potential to be affected by the alleged practice.</p> <p><b>III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.</b></p> <p>The Human Resources Director will be educated regarding</p>	04/08/2016	

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	<p>An abuse policy was provided by the Director of Nursing on 3/10/16 at 2:28 p.m. It indicated, "Policy Interpretation and Implementation 1. The personal director, or other person designated by the administrator, will conduct employment background checks, reference checks and criminal conviction checks on persons making application for employment with this facility. Such investigation will be initiated prior to employment or offer of employment."</p> <p>3.1-28(a)</p>		<p>requirements of having reference checks completed on employees prior to hire.</p> <p>The Administrator or designee will audit current employee files for reference check completion.</p> <p>The Administrator or designee will complete reference checks prior to employment for new employees.</p> <p><b>IV The facility will monitor the corrective action by implementing the following measures.</b></p> <p>The Administrator or designee will audit new employee files weekly X 60 days, monthly X 90 days, and then quarterly for a total of 12 months for reference check completion.</p> <p>Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed</p> <p>Facility Administrator will be responsible for ensuring compliance</p>	

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F 0387 SS=D Bldg. 00	<p>483.40(c)(1)-(2) FREQUENCY &amp; TIMELINESS OF PHYSICIAN VISIT The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.</p> <p>A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.</p> <p>Based on interview and record review, the facility failed to ensure a medical doctor/nurse practitioner saw a resident every 60 days for 1 of 5 residents reviewed for unnecessary medications (Resident #105)</p> <p>Findings include:</p> <p>The clinical record for Resident #105 was reviewed on 3/10/16 at 11:30 a.m. The diagnoses for Resident #105 included, but were not limited to, pacemaker, heart failure, epilepsy, polycythemia vera (bone marrow disorder)</p> <p>The following medical doctor/nurse practitioner (md/np) visits were located in the clinical record: 3/18/15,</p>	F 0387	<p><b>V. Plan of Correction completion date.</b></p> <p>Plan of Completion date is April 8, 2016</p> <p><b>I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.</b></p> <p>Resident # 105 was seen by the Nurse practitioner on 1/24/15, 1/19/16, and 2/23/16.</p> <p><b>II. The facility will identify other residents that may potentially be affected by the deficient practice.</b></p> <p>Residents that reside in the facility have the potential to be affected by the alleged</p>	04/08/2016	

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	<p>11/24/15, 1/19/16&amp; 2/23/16.</p> <p>During an interview with Family Member #6, on 3/10/16 at 9:38 a.m., Family Member #6 indicated Resident #105's cardiologist and the family decided to have the Facility MD follow Resident #105 for her pacemaker (instead of the cardiologist), in addition to her other health concerns. Family Member #6 indicated Resident #105 used to see her cardiologist every 6 months.</p> <p>During an interview with the Director of Nursing (DON), on 3/10/16 at 10:42 a.m., the DON indicated that even after contacting the MD/NP's office there was no indication that Resident #105 was seen by the Facility MD/NP during the 3/18/15-11/24/15 timeframe.</p> <p>3.1-22(d)(1)</p>				<p>deficient practice</p> <p><b>III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.</b></p> <p>Residents that reside in the facility will be reviewed for physician/np visits</p> <p>Resident's physicians were notified of those residents that had not been seen every 60 days and request for MD/NP visit was made</p> <p>Medical records will audit residents routinely to ensure MD/NP visits are made every 60 days</p> <p><b>IV The facility will monitor the corrective action by implementing the following measures.</b></p> <p>DON or designee will conduct random resident audits to ensure MD/NP visits are completed every 60 days, weekly x 4 weeks, 2 x monthly x 2 months, then monthly x 3 months</p>		

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F 0406 SS=D Bldg. 00	<p>483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES</p> <p>If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.</p> <p>Based on observation, interview and record review, the facility failed to assess and evaluate a resident coughing and choking during meal times for 1 of 1 residents observed in random dining observations. (Resident #135)</p>	F 0406	<p>Results of this audit will bereviewed at the monthly Quality Assurance Committee meeting and frequency andduration of reviews will be adjusted as needed</p> <p>Facility Administrator will be responsible forensuring compliance</p> <p><b>V. Plan of Correction completion date.</b></p> <p>Plan of Completion date is April 8, 2016</p> <p><b>I. The corrective actions to be accomplished forthose residents found to have been affected by the deficient practice.</b></p>	04/08/2016

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	<p>Findings include:</p> <p>The clinical record for Resident #135 was reviewed on 3/8/16 at 2:00 p.m. The diagnosis for Resident #135 included, but were not limited to, dysphagia oropharyngeal phase.</p> <p>A physician order dated, 12/17/15, indicated Resident #135 was to receive gluten restricted diet, regular texture, and nectar-thick liquids.</p> <p>A care plan dated 1/20/16, indicated "(name of resident) Resident #135 is noted with dysphagia, and potential for complications." The interventions included, but were not limited to, "Observe resident for difficulty swallowing, coughing, watering eyes during meals, and/or aspiration."</p> <p>A Speech Therapy Discharge Summary dated, 1/25/16, indicated Resident #135 was "tolerating thin liquids without overt s/sx (signs and symptoms) aspiration via (through) SafeStraw and use of chin tuck. Demonstrates improved insight with use of compensatory safe swallow strategies".</p> <p>A progress note dated, 2/19/16, indicated "resident (Resident #135) was in dinning (sic) room when resident expressed signs of choking. writer and fellow nurse brought resident into hallway and performed Heimlich maneuver. after multiple attempts, resident continued to</p>		<p>Resident #135 was evaluated and treated by Speech therapy</p> <p><b>II. The facility will identify other residents that may potentially be affected by the deficient practice.</b></p> <p>Residents that cough or chokeduring meal times have the potential to be affected by the alleged deficientpractice</p> <p><b>III. The facility will put into place the following systematic changes to ensure thatthe deficient practice does not recur.</b></p> <p>Nurse Managers will review residents in the clinicalmeeting Monday through Friday for new incidents of coughing and choking</p> <p>Speech therapy screen will be requested forresident's that experience new incident of coughing or choking and are not receivingcurrent speech therapy services</p> <p><b>IV The facility will monitor the corrective action by implementing the</b></p>	

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	<p>gasp for air, became cyanotic (blue in color), dusky with O2 (oxygen) sat (saturation) of 77%. applied O2, called for help from other staff nurses and called 911. while waiting for ambulance, writer suctioned resident's mouth and back of mouth. resident coughed up a piece of food. once food was extracted from throat O2 sat at 98% and clear lung sounds. paramedics assessed resident, resident refused to go to hospital. will continue to monitor resident.."</p> <p>A care plan dated 2/25/16, indicated "Resident #135 has episodes of coughing while eating and will not stop chewing or attempt to empty food from his mouth with encouragement from staff." The interventions include the following: "Notify physician of concerns or changes, observed resident closely for signs of difficulty chewing and/or aspiration, Speech therapy consult as needed."</p> <p>A random dining observation was made on 3/8/16 at 12:10 p.m. Resident #135 was observed making gargling noises and coughing during the course of the lunch meal. During this time, Resident #135 indicated to caregiver that was sitting at his table "something was stuck in his throat". The caregiver encouraged Resident #135 to drink to wash down whatever was stuck in his throat. The staff in the dining room approached Resident #135 and encourage him to</p>		<p><b>following measures.</b></p> <p>DON or designee will audit residents with new incidents of coughing and choking to ensure speech therapy referral and screen completed, audit will be completed Monday through Friday x 4 weeks, then weekly x 5 months</p> <p>Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed</p> <p>Facility Administrator will be responsible for ensuring compliance</p> <p><b>V. Plan of Correction completion date.</b></p> <p>Plan of Completion date is April 8, 2016.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155793	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/10/2016
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	<p>cough to clear his throat. It was observed Resident #135's nose was running at times and drooling during coughing and gagging episodes with face red in color. A random dining observation was made on 3/9/16 at 12:37 p.m. Resident #135 was noted coughing and face had turned red in color. It was observed a staff nurse approached Resident #135 to provide assistance. Resident #135's family member arrived during this time and attempted to help assist resident clear his throat by slapping his back. The staff nurse indicated she would stay with Resident #135, because he was coughing so bad and seems to be getting worse. Resident #135's face returned to normal color and coughing had ceased at 12:49 p.m.</p> <p>A progress note dated, 3/9/16, indicated, "This writer observed resident during lunch meal having a coughing episode in which his face was turning red. Resident was continuing to chew as he was coughing and this writer encouraged resident to expel the food in mouth. Resident expelled ground food particles with thick clear sputum. Resident continued to cough after food was cleared. Resident's wife's (sic) entered dining room and resident began to cough again. Resident's wife began to pat resident on his back and this writer educated wife that this was not</p>			

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	<p>appropriate to do so. When resident's coughing episode has stopped and this writer asked resident if he would like to finish his meal. Resident took a sip of thickened fluid and resident decided he was finished. Resident was assisted back to his room by wife. This writer reported resident's coughing episode to the staff nurse on duty to assess resident".</p> <p>An interview was conducted with Speech Therapist #8 on 3/10/16 at 10:12 a.m. She indicated Resident #135 had completed his speech therapy. She indicated she was unaware of Resident #135's choking incident that had occurred on February 19th, and the staff should have notified speech of the occurrence to evaluate. Speech therapist #8 indicated screening residents after receiving a recommendation usually took about a day. She indicated as of right now she does not have a recommendation to screen Resident #135.</p> <p>An interview was conducted with the Director of Nursing on 3/10/16 at 10:46 a.m. She indicated the staff should have recommended a screening to be done regarding Resident #135 choking on a piece of food in February. She indicated the staff did not initiate a recommendation for screening, because this was a one time occurrence.</p> <p>3.1-23 (a)(1)</p>			

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F 0411 SS=D Bldg. 00	<p>483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care.</p> <p>A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist.</p> <p>Based on observation, interview, and record review, the facility failed to consider a dental consult for a resident that did not consistently wear their top denture for 1 of 3 residents reviewed for dental services (Resident #65).</p> <p>Findings include:</p> <p>The clinical record for Resident #65 was reviewed on 3/9/16 at 11:45 a.m. The diagnoses for Resident #65 included, but were not limited to, hemiplegia/hemiparesis, dysphagia, heart failure and chronic obstructive pulmonary disease.</p> <p>During an interview with Family Member #7, on 3/7/16 at 11:36 a.m., Family</p>	F 0411	<p><b>I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.</b></p> <p>Resident # 65 was offered a dental consult and it was completed 3/18/16 with no changes or recommendations, resident # 65 continues to refuse dentures but wants no changes in dentures.</p> <p><b>II. The facility will identify other residents that may potentially be affected by the deficient practice.</b></p> <p>Residents with dentures have the</p>	04/08/2016	

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	<p>Member #7 indicated she would've liked Resident #65 to go the dentist because Resident #65's teeth were "not in good shape" and no one at the facility asked her if she would like for Resident #65 to see the dentist. Family Member #7 further indicated Resident #65 does not wear her top denture most likely due to improper fit and it had been quite awhile since she wore the top denture.</p> <p>An Observation Report, created 11/11/15, indicated Resident #65, "...some/all natural teeth lost-does not have or does not use dentures (or partial plates)...."</p> <p>A Dental Consult was not located in the clinical record.</p> <p>The last Dental Consult for Resident #65 was requested from the Director of Nursing, on 3/9/16 at 2:00 p.m.</p> <p>A Dental Verbal Consent Form, dated 9/7/15, indicated Family Member #7 consented to dental services.</p> <p>On 3/9/16 at 2:01 p.m., Speech Therapist (ST) #8 indicated Resident #65 was currently on caseload and Resident #65 does not wear her top denture but she was unsure why.</p> <p>At 2:09 p.m., on 3/9/16, CNA #5</p>		<p>potential to be affected by the alleged deficient practice</p> <p><b>III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.</b></p> <p>Residents with dentures and/or Responsible parties are offered dental services upon admission, upon request, or upon concerns with dentures.</p> <p>Social services reviewed residents with dentures for concerns and offered dental services if not currently receiving dental services.</p> <p>Social services will contact resident and/or responsible party and offer dental services upon concerns expressed with dentures</p> <p><b>IV The facility will monitor the corrective action by implementing the following measures.</b></p> <p>Administrator or designee will conduct random audit on residents with dentures to ensure dental services are offered for</p>		

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	<p>indicated Resident #65 doesn't consistently wear her top denture, but the top denture was in her bathroom. CNA #5 further indicated she thought Resident #65 did not like how the top denture felt. During an observation at the same time with CNA #5, Resident #65 was observed without her top denture in. Resident #65 indicated she did not like wearing her top denture at this time.</p> <p>During an interview with ST #8, on 3/10/16 at 10:06 a.m., ST #8 indicated she also worked with Resident #65 several months ago and ST #8 did not remember Resident #65 wearing her top denture during that timeframe.</p> <p>On 3/10/16, at 10:42 a.m., the Director of Nursing (DON) indicated when she spoke with Resident #65 the previous day, Resident #65 indicated she did not like to wear her top denture because it was uncomfortable so the DON offered Resident #65 to see the dentist and Resident #65 agreed at that time.</p> <p>A Dental Consult was not provided prior to final exit from the facility on 3/10/16.</p> <p>An Admissions Statement, no date, was provided by the DON, on 3/10/16 at 2:28 p.m. It indicated, "...Independent professionals may provide other services.</p>		<p>dental concerns, weekly x 4 weeks, 2 x monthly x 2 months, and then monthly x 3 months.</p> <p>Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.</p> <p>Facility Administrator will be responsible for ensuring compliance.</p> <p>Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.</p> <p><b>V. Plan of Correction completion date.</b></p> <p>Plan of Completion date is April 8, 2016</p>		

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F 0508 SS=D Bldg. 00	<p>The need for these services is determined by our Interdisciplinary Care Planning Team in consultation with you, your family, and your physician. These include: Dental Services...."</p> <p>3.1-24(a)(1)</p> <p>483.75(k)(1) PROVIDE/OBTAIN RADIOLOGY/DIAGNOSTIC SVCS The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. Based on interview and record review, the facility failed to ensure remote pacemaker checks were done, as ordered, for 1 of 5 residents reviewed for unnecessary medications. (Resident #23)</p> <p>Findings include:</p> <p>The clinical record for Resident #23 was reviewed on 3/3/16 at 2:10 p.m. The diagnoses for Resident #23 included, but were not limited to: chronic systolic heart failure, coronary atherosclerosis of native coronary artery, atrial fibrillation, and presence of a defibrillator. Resident #23 was admitted to the facility on</p>	F 0508	<p><b>I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.</b></p> <p>Resident #23 pacemaker check was completed on 3/8/16</p> <p><b>II. The facility will identify other residents that may potentially be affected by the deficient practice.</b></p> <p>Residents with pacemakers have the potential to be affected by the alleged deficient practice</p>	04/08/2016	

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	<p>12/20/15.</p> <p>The 12/20/15 Hospital Discharge Orders indicated she had the following orders/future tests and appointments:</p> <p>1/6/16 at 8:40 a.m. - "Remote Device Check with REMOTE HEART FAILURE" (Name of hospital/heart and vascular clinic, south location)</p> <p>2/8/16 at 7:35 a.m. - "Remote Device Check with REMOTE HEART FAILURE" (Name of hospital/heart and vascular clinic, south location)</p> <p>3/22/16 at 11:30 a.m. - "Remote Device Check with PACEMAKER/ICD" (Name of hospital/heart an vascular clinic, north location)</p> <p>The 12/21/15 care plan for Resident #23 indicated she required a pacemaker related to her atrial fibrillation. The goal was for Resident #23 not to experience signs of pacemaker failure. Interventions were telephone checks as ordered.</p> <p>The 1/6/16 physician's order, created 12/20/15, indicated, "Remote device check with remote heart failuire (sic)." The 2/8/16 physician's order, created 1/25/16, indicated "Remote check. Can do from facility."</p>		<p><b>III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.</b></p> <p>Residents with pacemakers were reviewed and pacemaker checks are done per order</p> <p>Nursing staff were re-educated on procedure for conducting pacemaker checks remotely</p> <p><b>IV The facility will monitor the corrective action by implementing the following measures.</b></p> <p>DON or designee will conduct audits on residents with orders for remote pacemaker checks to ensure check completed, weekly x4 weeks, and then monthly x 5 months</p> <p>Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.</p> <p>Facility Administrator will be responsible for ensuring</p>		

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	<p>There was no information in the clinical record to indicate either of these checks were completed.</p> <p>An interview was conducted with the DON on 3/9/16 at 1:45 p.m. She indicated the 1/6/16 remote pacemaker check was not done, as ordered. She indicated they tried to send her out for the appointment, but the transportation was canceled, and she was unsure as to why it was canceled. She indicated there was no documentation regarding what happened with the 1/6/16 remote pacemaker check.</p> <p>An interview was conducted with the DON (Director of Nursing) on 3/8/16 at 2:15 p.m. She indicated the facility did not have the correct phone line to do the 2/8/16 remote pacemaker check. She indicated this was the first time the facility ever had a problem doing a pacemaker check. She indicated a new part had to be ordered and it still hadn't come in yet. She indicated they did not realize they didn't have the correct line until the 2/8/16 remote check appointment.</p> <p>The DON provided an invoice on 3/9/16 at 10:30 a.m. It indicated a part was ordered for Resident #23 on 2/8/16.</p>		<p>compliance.</p> <p>Results of this audit will bereviewed at the monthly Quality Assurance Committee meeting and frequency andduration of reviews will be adjusted as needed.</p> <p><b>V. Plan of Correction completion date.</b></p> <p>Plan of Completion date is April 8, 2016.</p>	

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	<p>On 3/9/16 at 4:38 p.m., a telephone interview was conducted with the Electrophysiology Therapy Manager for the heart and vascular clinic at which Resident #23's remote pacemaker checks were scheduled. She indicated the standard for pacemaker checks is every 91 days, but since Resident #23 was in heart failure and had a defibrillator, she should have pacemaker checks every 31 days. She indicated Resident #23 had been getting them at that schedule, remotely, for about the past year, and would continue at that schedule, unless the doctor changes it at a future appointment. She indicated Resident #23 was a "no show" for her 1/6/16 remote check, and it looked like there was trouble with the remote recorder for her 2/8/16 remote check. She indicated a remote pacemaker check for Resident #23 was completed the previous day, 3/8/16.</p> <p>An interview was conducted with the DON on 3/10/16 at 10:39 a.m. She indicated she was unable to find any verification as to why the 1/6/16 remote check was not completed. She indicated the part, ordered on 2/8/16, still hadn't come in, so was still unable to do a remote pacemaker check for Resident #23.</p>			

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F 9999  Bldg. 00	<p>An interview was conducted with the DON on 3/10/16 at 1:29 p.m. She indicated she spoke with the Rehabilitation Unit Manager who informed her they were able to take Resident #23 to a different nurse's station on 3/8/16 to complete the remote pacemaker check. She indicated she was unsure whether they attempted to utilize a different nurse's station for her previously scheduled remote checks.</p> <p>The Lab and Diagnostic Test Results Clinical Protocol policy was provided by the DON on 3/10/16 at 2:30 p.m. It indicated, "The staff will process test requisitions and arrange for tests."</p> <p>3.1-49(g)</p> <p>3.1-14 Personnel (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method. (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall</p>	F 9999	<p><b>I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.</b></p> <p>LPN# 1 has completed her annual dementia training requirement.</p> <p>Dietary Aide # 4 second step tuberculin skin test was completed.</p>	04/08/2016			

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	<p>be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step.</p> <p>(u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personal assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to ensure annual dementia training was completed for 1 of 10 staff members reviewed. The facility also failed to ensure a staff member's second step tuberculin skin test was completed for 1 of 5 staff members</p>		<p><b>II. The facility will identify other residents that may potentially be affected by the deficient practice.</b></p> <p>Employees who are employed at Hamilton Trace of Fishers have the potential to be affected by the alleged practice.</p> <p><b>III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.</b></p> <p>The Human Resources Director will be educated regarding requirements for dementia-specific training and tuberculosis skin tests for new hires and current employees.</p> <p>New employees will complete 6 hours of dementia-specific training within 30 days of employment.</p> <p>Employees will complete 3 hours of dementia-specific training annually after initial dementia-specific training has been completed.</p> <p>New employees will have a physical examination within 1</p>	

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	<p>reviewed for second step tuberculin skin testing (LPN #1, Dietary Aide #4).</p> <p>Findings include:</p> <p>Employee personnel files were reviewed on 3/10/16 at 10:00 a.m. The Employee Records form indicated the following start dates: LPN #1: 7/12/12 Dietary Aide #4: 2/3/16</p> <p>The employee personnel file for LPN #1 indicated the last annual training for dementia was 1/10/15.</p> <p>During an interview with the Human Resources (HR) Manager, on 3/10/16 at 1:40 p.m., she indicated the facility was not able to locate any annual dementia training in 2016 for LPN #1.</p> <p>A document was provided by the HR Manager on 3/10/16 at 2:45 p.m. The document indicated LPN #1 worked 463 hours since 1/10/16.</p> <p>During an interview with the Director of Nursing, on 3/10/16 at 2:27 p.m., she indicated staff were expected to complete 3 hours annually of dementia training.</p> <p>The employee personnel file for Dietary Aide #4 indicated the first step tuberculin</p>		<p>month prior to employment. The examination will include a tuberculin skin test, using the Mantoux method. At the time of employment, or within 1 month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities will be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding 12 months, the baseline tuberculin skin testing will employ the two-step method. If the first step is negative a second test will be performed 1 to 3 weeks after the first step.</p> <p><b>IV The facility will monitor the corrective action by implementing the following measures.</b></p> <p>The Administrator or designee will audit new employee files weekly X 60 days, monthly X 90 days, and then quarterly for a total of 12 months for the required dementia-specific training.</p> <p>The Administrator or designee will audit new employee files weekly X 60 days, monthly X 90 days, and then quarterly for a</p>		

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R 0000  Bldg. 00	<p>skin test was completed on 2/1/16. A second step tuberculin skin test was not located in the personnel file.</p> <p>During an interview with the HR Manager, on 3/10/16 at 11:41 a.m., she indicated a second step tuberculin skin test was not completed until 3/9/16.</p> <p>A Time Card Report was received from the HR Manager on 3/10/16 at 1:41 p.m. The Report indicated Dietary Aide #4 worked 64 hours since 2/23/16 (3 weeks after 2/1/16) .</p> <p>A policy titled, Infection Control, was received by the DON, on 3/10/16 at 2:27 p.m. The policy indicated, "...PPD [tuberculin skin testing] testing will be completed on associates upon hire in a two-step process and annually thereafter...."</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-5.</p>	R 0000	<p>total of 12months for the required tuberculin skin test.</p> <p>Results of this audit will bereviewed at the monthly Quality Assurance Committee meeting and frequency andduration of reviews will be adjusted as needed</p> <p>Facility Administrator will be responsible forensuring compliance</p> <p><b>V. Plan of Correction completion date.</b></p> <p>Plan of Completion date is April 8, 2016.</p> <p>March 28, 2016</p> <p>Kim Rhoades, Director Long-Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204</p>	

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			<p>Re: Allegation of Compliance</p> <p>Dear Ms. Rhoades:</p> <p>Please find enclosed the Plan of Correction to the annual Recertification and State Licensure Survey conducted on March 10, 2016. This letter is to inform you that the plan of correction attached is to serve as Hamilton Trace of Fishers credible allegation of compliance. We allege compliance April 8, 2016. We are requesting a desk review for this plan of correction.</p> <p>If you have any further questions, please do not hesitate to contact me at 317-813-4444.</p> <p>Sincerely,</p> <p>Benjy Grzych H.F.A. Administrator Hamilton Trace of Fishers</p> <p>Submission of this plan of correction in no way constitutes</p>	

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R 0033  Bldg. 00	410 IAC 16.2-5-1.2(h)(1-2) Residents' Rights - Noncompliance (h) The facility must furnish on admission the following: (1) A statement that the resident may file a complaint with the director concerning resident abuse, neglect, misappropriation of resident property, and other practices of the facility. (2) The most recently known addresses and		an admission by Hamilton Traceof Fishers or its management company that the allegations contained in thesurvey report is a true and accurate portrayal of the provision of nursing careor other services provided in this facility. The Plan of Correction is prepared and executed solely because it isrequired by Federal and State Law. ThePlan of Correction is submitted in order to respond to the allegation ofnoncompliance cited during the Annual Recertification and State LicensureSurvey on March 10, 2016. Please accepthis plan of correction as Hamilton Trace of Fishers credible allegation ofcompliance by April 8, 2016  Thisstatement of deficiencies and plan of correction will be reviewed at the March QualityAssurance/Assessment Committee meeting.		

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	<p>telephone numbers of the following: (A) The department. (B) The office of the secretary of family and social services. (C) The ombudsman designated by the division of disability, aging, and rehabilitation services. (D) The area agency on aging. (E) The local mental health center. (F) Adult protective services. The addresses and telephone numbers in this subdivision shall be posted in an area accessible to residents and updated as appropriate.</p> <p>Based on observation, interview, and record review, the facility failed to post, in an area accessible to residents, the addresses and phone numbers of the department, the area agency on aging, the local mental health center, and the adult protective services. This had the potential to affect 29 residents who reside in the facility.</p> <p>Findings include:</p> <p>An environmental tour of the facility was conducted with the Maintenance Director and Environmental Services Director on 3/9/16 at 1:45 p.m. No posting of the addresses and phone numbers of the department, the area agency on aging, the local mental health center, and the adult protective services was observed in the facility. A binder at the entrance of the facility indicated "State Advocacy</p>	R 0033	<p><b>I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.</b></p> <p>There was nota specific resident affected by the deficient practice.</p> <p><b>II. The facility will identify other residents that may potentially be affected by the deficient practice.</b></p> <p>Residents who reside on the residential unit of Hamilton Trace of Fishers have the potential to be affected by the alleged practice.</p> <p><b>III. The facility will put into place the following systematic changes to ensure that the deficient practice does not</b></p>	04/08/2016	

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	<p>Information" on the front of the binder. There was no state advocacy information inside of the binder.</p> <p>An interview was conducted with Administrator on 3/10/16 at 12:00 p.m. He indicated the advocacy information was in the binder when he checked a week earlier, so someone must have removed it.</p>		<p><b>recur.</b></p> <p>A copy of the required information of the following has been posted: resident rights, names, addresses and telephone numbers of all pertinent State client advocacy groups, the Medicaid Fraud control unit, and a statement regarding how to apply for and use Medicare and Medicaid benefits, and how to receive funds. Residents and families will be educated upon admission where this information can be located. In addition, each unit has a posting detailing the location of these documents within the facility.</p> <p><b>IV The facility will monitor the corrective action by implementing the following measures.</b></p> <p>Administrator or designee will audit monthly X 6 months.</p> <p>Locations of resident rights, state advocacy groups and applying and use of Medicare and Medicaid will be reviewed in resident council monthly 3 months then quarterly thereafter</p>	

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R 0187 Bldg. 00	<p>410 IAC 16.2-5-1.6(k) Physical Plant Standards - Deficiency (k) Hot water temperature for all bathing and hand washing facilities shall be controlled by an automatic control valve. Water temperature at point of use must be maintained between one hundred (100) degrees Fahrenheit and one hundred twenty (120) degrees Fahrenheit.</p> <p>Based on observation, interview, and record review, the facility failed to ensure water temperatures were maintained between 100 and 120 degrees, at point of contact, for 5 of 29 residents whose water temperatures were retrieved. (Residents #3, 10, 23, 30, and 31)</p> <p>Findings include:</p>	R 0187	<p>totaling 12 months.</p> <p>Results of this audit will bereviewed at the monthly Quality Assurance Committee meeting and frequency andduration of reviews will be adjusted as needed</p> <p>Facility Administrator will be responsible forensuring compliance</p> <p><b>V. Plan of Correction completion date.</b></p> <p>Plan of Completion date is April 8, 2016.</p> <p><b>I. The corrective actions to be accomplished forthose residents found to have been affected by the deficient practice.</b> TheMaintenance Director immediately adjusted the water temperatures to be withinthe required range of 100 degrees Fahrenheit and 120 degrees Fahrenheit. Resident# 10, # 3, # 23, # 30, and # 31 all</p>	04/08/2016

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	<p>An environmental tour of the facility was conducted with the Maintenance Director and Environmental Services Director on 3/9/16 at 1:45 p.m.</p> <p>The following water temperatures were retrieved from the following resident's rooms:</p> <p>Resident #10 - kitchen sink @ 130 degrees Fahrenheit, bathroom sink @ 127.1 degrees Fahrenheit</p> <p>Resident #3 - kitchen sink @ 128.1 degrees Fahrenheit, bathroom sink @ 126.6 degrees Fahrenheit</p> <p>Resident #23 - kitchen sink @ 128.2 degrees Fahrenheit, bathroom sink @ 126.1 degrees Fahrenheit</p> <p>Residents #30 and #31 - kitchen sink @128.2 degrees Fahrenheit, bathroom sink @ 126.6 degrees Fahrenheit</p> <p>Resident #10 indicated he could not get his shower to cool down once, a couple of months ago, so he forwent his shower that day.</p> <p>Resident #31 indicated the water was "pretty hot", but they would adjust it down.</p>		<p>have their water temperatures within therequired range of 100 degrees Fahrenheit and 120 degrees Fahrenheit. <b>II. The facility will identify other residents thatmay potentially be affected by the deficient practice.</b> Residents who reside on the residential unit ofHamilton Trace of Fishers have the potential to be affected by the allegedpractice. <b>III. Thefacility will put into place the following systematic changes to ensure thatthe deficient practice does not recur.</b> The Maintenance Director and the AssistantMaintenance Director will be educated regarding appropriate water temperaturesfor the residential resident rooms. The Maintenance Director will audit randomresidential rooms weekly for temperatures to be in the required range of 100degrees Fahrenheit and 120 degrees Fahrenheit. The facility has added a task to the TELS routinemaintenance program to audit residential rooms for compliance of the regulatedtemperatures between 100 degrees Fahrenheit and 120 degrees Fahrenheit. <b>IV Thefacility will monitor the corrective action by implementing the followingmeasures.</b> The Administrator or designee will audit residential room water</p>		

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	<p>The Maintenance Director indicated water temperatures was his assistant's responsibility, and he was unsure if he'd been keeping water temperature logs.</p> <p>An interview was conducted with the Maintenance Director on 3/9/16 at 2:50 p.m. He indicated the water temperature logs did not include resident room water temperatures for the residential side of the facility.</p> <p>The Administrator provided water temperature logs on 3/10/16 at 11:41 a.m. The logs did not include water temperatures for residential resident rooms.</p> <p>An interview was conducted with the Maintenance Director on 3/10/16 at 2:35 p.m. He indicated water temperatures were to be maintained between 100 to 120 degrees Fahrenheit.</p>		<p>temperatures weekly X 60 days. Results of this audit will bereviewed at the monthly Quality Assurance Committee meeting and frequency andduration of reviews will be adjusted as needed Facility Administrator will be responsible forensuring compliance <b>V. Plan of Correction completion date.</b> Plan of Completion date is April 8, 2016</p>	