STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	155816		03/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARLINGTON PLACE HEALTH CAMPUS	1635 N ARLINGTON AVE INDIANAPOLIS, IN 46218

(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
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00194455, IN00190144, & IN00193862. Complaint IN00194455 - Substantiated. Federal/State findings cited at F246, F279, F282, and F312. Complaint IN00190144 - Substantiated. Federal/State findings cited at F514. Complaint IN00193862 - Substantiated. Federal/State findings cited at F157 and F323. Survey Dates: March 15, 16, & 17, 2016. Facility number: 013005 Provider number: 155816 AIM number: 201256400 Census bed type: SNF: 56 SNF/NF: 20 Residential: 11 Total: 87 Census payor type: Medicare: 47 Medicaid: 19	F 0000	April1, 2016 Preparation or execution of thisplan of correction does not constitute admission or agreement of provider ofthe truth of the facts alleged or conclusions set forth on the Statement ofDeficiencies. The Plan of Correction isprepared and executed solely because it is required by the position of Federaland State Law. The Plan of Correction issubmitted in order to respond to the allegation of noncompliance cited during acomplaint survey on March 17, 2016. Please accept this plan of correction as the provider's credibleallegation of compliance. The provider respectfullyrequests a desk review with paper compliance to be considered in establishingthat the provider is in substantial compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	Other: 10 Total: 76 Sample: 16 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed 3/19/16 by 29479.			
F 0157 SS=D Bldg. 00	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) 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). The facility must also promptly notify the			

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	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. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.			
	Based on interview and record review, the facility failed to inform a resident's family member/health care representative of a decision to transfer a resident to a scheduled physician's appointment at a location outside the facility. This deficient practice affected 1 of 3 residents reviewed for family notification (Resident Z). Finding includes: During a telephone interview on 3/15/16 at 12:26 p.m., Resident Z's daughter/healthcare representative indicated her mother was transported to a physician's appointment in "January" 2016. She indicated the facility failed to inform her of the appointment. She further indicated she was her mother's health care representative and had always been "very" involved with her mother's care. She indicated she wasn't informed her mother had been transported out of	F 0157	**F 157(D)** **Correctiveactions accomplished for those residents found to be affected by the allegeddeficient practice:** Resident#Z expired 3/5/16. **Identification of other residents havingthe potential to be affected by the same alleged deficient practice andcorrective actions taken**: DHS or designee will review residents withscheduled appointments at a location outside the facility to ensure the familymember/health care representative has been informed and the notification isdocumented in the clinical record. **Measuresput in place and systemic changes made to ensure the alleged deficient practicedoes not recur:** DHS or designeewill re-educate the	04/16/2016

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	the facility to an appointment until the facility called her to inform her that while in the care of the transportation service her mother had fallen out of her wheelchair and was being sent to the emergency room for evaluation and treatment. Resident Z's record was reviewed on 3/15/16 at 1:30 p.m. Resident Z had diagnoses which included, but were not limited to, history of falls, muscle weakness, dementia, and abnormal gait. A Minimum Data Set (MDS) assessment tool, dated 1/15/16, indicated Resident Z had severe cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 3 out of 15. An emergency contact document, indicated Resident Z was not responsible for herself and her daughter was her health care representative. A progress note, dated 12/30/16 at 1:03 p.m., indicated the facility had scheduled an appointment with a nephrologist (kidney doctor) on "Friday" 1/13/16 at 12:00 p.m. Progress notes, dated 12/30/16 through 1/17/16, were reviewed on 3/15/16 at 1:40 p.m. The record lacked indication Resident Z's daughter/healthcare representative was notified of her appointment with the nephrologist.		Licensed Nurses on the following campus guidelines: 1). Responsible Party Notification **How the corrective measures will be monitored to ensure the alleged deficientpractice does not recur:** The following audits for 5 residentswill be conducted by the DHS or designee 2 times per week times 8 weeks, thenmonthly times 2 months to ensure compliance: Residents with scheduled appointments at a location outside the facilityto ensure the family member/health care representative has been informed and thenotification is documented in the clinical record. The results of the audit observations will be reported, reviewedand trended for compliance through the campus Quality Assurance Committee for aminimum of 4 additional months then randomly thereafter for furtherrecommendation.	

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	A progress note, dated 1/15/16 at 2:27 p.m., indicated Resident Z was on a leave of absence for an appointment. A progress note, dated 1/15/16 at 3:40 p.m., indicated the supervisor from the transportation service had called the facility to inform them they were sending Resident Z to the emergency room due to complaints of pain after she had fallen out of her wheelchair. During an interview on 3/16/16 at 10:00 a.m., the Director of Nursing indicated documentation which indicated the facility notified Resident Z's daughter of her appointment on 1/15/16 was not available. She indicated Resident Z's daughter usually met her mother at off campus appointments. During an interview on 3/17/16 at 12:40 p.m., the Assistant Director of Nursing (ADON) indicated the progress note, dated 12/30/16 at 1:03 p.m., had a "typo." She indicated the nephrologist appointment date was Friday, January 15, 2015 not 1/13/16. A Responsible Party Notification policy identified as current by Unit Manger #1 on 3/16/16 at 1:37 p.m., indicated, "...To ensure the resident's responsible party is			

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	aware of all diagnostic testing results or change in condition in a timely manner. Procedure...The responsible party should be notified of change in condition or diagnostic testing results in a timely manner...documentation of notification or notification attempts should be recorded in the resident medical record." This Federal tag relates to Complaint #IN00193862. 3.1-5(a)(4)			
F 0246 SS=D Bldg. 00	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Based on observation, interview, and record review, the facility failed to provide an appropriate sized wheelchair for 1 of 3 residents reviewed for accommodation of needs (Resident B). Finding includes:	F 0246	**Correctiveactions accomplished for those residents found to be affected by the allegeddeficient practice:** Resident #B was assessed by therapy and another wheelchairwas ordered to better accommodate the resident's needs. **Identification of other residents havingthe potential**	04/16/2016

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	During an observation on 3/15/16 at 11:10 a.m., and at 1:00 p.m., Resident B was in his room sitting in his wheelchair with the foot pedals up and his feet extending out and resting on the floor. The back of his wheelchair was low on his back and the arm rests were low for him, and he had to slump over to rest his arms on the arm rests. His legs protruded out far beyond the seat of the wheelchair. Record review on 3/15/16 at 2:40 p.m., Resident B's Minimum Data Set (MDS) assessment, dated 3/8/16, indicated he had a Brief Interview for Mental Status (BIMS) score of 13 out of 15. He was identified as extensive assistance of 2 for transfers, and ambulation did not occur. Resident B's MDS indicated he normally used a wheelchair, and required extensive assistance for locomotion in the wheelchair. Diagnosis included but were not limited to muscle weakness, and other abnormalities of gait and mobility. An admission height of 6 foot 5 inches tall and a weight of 218 pounds were documented on 1/13/16. During an interview on 1:10 p.m., Resident B indicated the wheelchair he was sitting in was the wrong size. He indicated he was uncomfortable and moaned as he scooted back in the chair.		**to be affected by the same alleged deficient practice andcorrective actions taken**: The DHS, Therapist or designee will observe residentswho require a wheelchair to ensure the size of the wheelchair is appropriate toaccommodate the resident's needs. **Measuresput in place and systemic changes made to ensure the alleged deficient practicedoes not recur:** DHS or designeewill re-educate the Registered Nurses, Licensed Nurses, Certified NursingAssistants and Therapists regarding the following campus guideline: Resident Rights - Accommodation of Needs **How thecorrective measures will be monitored to ensure the alleged deficient practicedoes not recur:** The following audits for 5 residents will be conducted bythe DHS or designee 2 times per week times 8 weeks, then monthly times 2 monthsto ensure compliance: Residents whorequire a wheelchair to ensure the size of the wheelchair is appropriate to accommodatethe resident's needs. The results of the audit observations will be reported, reviewedand trended for compliance thru the campus Quality Assurance Committee for aminimum of 4 additional months then randomly thereafter for furtherrecommendation.	

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	He indicated the wheelchair was too small and it was hard to have his feet on the pedals. When he placed his feet on the pedals his knees hit the bedside table his food tray was on. When his feet were on the pedals his knees were above his hips. During an interview on 3/15/16 at 1:40 p.m., the Physical Therapist Director indicated the wheelchair Resident B was in was a standard wheelchair. She indicated when a resident was sitting in a wheelchair their knees should be at a 90 degree angle. She indicated Resident B was unable to be in that position in the chair he was in. She indicated he would need a custom chair for his size, and it would need to be ordered. During an interview on 3/15/16 at 1:45 p.m., Licensed Practical Nurse (LPN) #4 indicated the resident had the wheelchair he was in since he was admitted on 1/1/16. During an interview on 3/15/16 at 1:55 p.m., Occupational Therapist #2 observed Resident B in his wheelchair and indicated it was not the correct size for him. She indicated the seat of the wheelchair should be deeper for his long legs and his knees should be at a 90 degree angle when sitting in the chair,			

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	and the back of his knees should be 2 inches from the end of the seat. She indicated it was not possible for him to be in that position in the current chair he was in. During an interview on 3/15/16 at 2:00 p.m., the Director of Nursing (DON) indicated no recommendations of wheelchairs for Resident B had been made by therapy. The DON observed Resident B in his wheelchair and indicated the wheelchair looked to small for him. During an interview on 3/15/16 at 2:10 p.m., Physical Therapist #5 indicated she was Resident B's regular therapist and indicated she was responsible for making wheelchair recommendations but had not made a recommendation for Resident B. She then assessed him and indicated Resident B should use a deeper seat and a taller chair for his size. This Federal tag relates to complaint IN00194455. 3.1-3(v)(1)			
F 0279	483.20(d), 483.20(k)(1)			

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SS=D Bldg. 00	DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).			
	Based on observation, interview and record review, the facility failed to develop a care plan for activities of daily living related to eating assistance for 1 of 3 residents reviewed for activities of daily living related to eating assistance (Resident B). Findings include: Resident B's record was reviewed on 3/15/16 at 2:40 p.m. Resident B's Minimum Data Set (MDS) assessment, dated 3/8/16, indicated he had a Brief Interview for Mental Status score of 13	F 0279	**Correctiveactions accomplished for those residents found to be affected by the allegeddeficient practice:** Resident #B was observed for eating assistance and theresidents ADL care plan and profile was updated. **Identification of other residents havingthe potential to be affected by the same alleged deficient practice andcorrective actions taken**: The DHS or designee will observe residentsfor eating assistance and their ADL care plans and profile will be reviewed andupdated accordingly.	04/16/2016

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	out of 15. He was identified to need extensive assistance of 2 for transfers, and ambulation did not occur. Resident B was identified as needing, "Limited assistance of one person" for eating. Diagnoses included but were not limited to muscle weakness, other abnormalities of gait and mobility, chronic obstructive pulmonary disease, and dysphasia. The record lacked indication of a care plan for activities of daily living related to eating assistance. On 3/15/16 at 1:00 p.m., Resident B was observed eating lunch. He had pork loin that was chopped for him, rice, vegetables, a dessert of key lime pie, and a glass of thickened water. He was observed to be having trouble eating with a fork in his left hand, he was unable to get the food to his mouth. He switched to his right hand and was able to get some food to his mouth with the fork in his right hand and using his left hand to stabilize the fork. He had shaking in his hands and dropped food 3 times. At one time he had a piece of pork loin hanging from his lip and was unaware that it was there and took a drink of his water and the pork loin fell to his lap. He became fatigued and drifted to sleep. He ate 2 bites of pork loin and had 2 drinks of water. At 1:35 p.m., Certified Nursing Assistant (CNA) #6 came in and woke		**Measuresput in place and systemic changes made to ensure the alleged deficient practicedoes not recur:** DHS or designeewill re-educate the Nurse Leaders and MDS Coordinator regarding the followingcampus guideline: Interdisciplinary Team Care Plan **How the corrective measures will be monitored to ensure the alleged deficientpractice does not recur:** The following audits for 5 residentswill be conducted by the DHS or designee 2 times per week times 8 weeks, thenmonthly times 2 months to ensure compliance: Resident ADL care plan in place related to eating assistance. The results of the audit observations will be reported, reviewedand trended for compliance thru the campus Quality Assurance Committee for aminimum of 4 additional months then randomly thereafter for furtherrecommendation.	

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	Resident B, she asked him if he was done eating, he indicated he was and she removed the tray. During an interview on 3/16/16 at 1 p.m., CNA #6 indicated Resident B required set up assistance for meals. During an interview on 3/16/16 at 1:10 p.m., License Practical Nurse (LPN) #4 indicated information about individual resident care needs was found on Care Tracker. Staff had to log in to view it and it could be printed. She indicated Resident B required set up assistance for meals and was independent with eating. During an interview on 3/16/16 at 2:00 p.m., the MDS Coordinator indicated Resident B was coded as needing limited assistance of one staff person for eating. She indicated limited assistance of one staff would be staff cutting up food, cueing, handing the resident items. She indicated it is more than just setting the tray down and leaving the resident alone. She further indicated when the need for assistance was identified on the MDS the Unit Manager should be informing their staff of the need and a care plan should be developed for the resident. She indicated she missed creating a care pan for Resident B and he should have had a care plan created for activities of daily			

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	living related to eating assistance. During an interview on 3/17/16 at 10:00 a.m., Director of Nursing (DON) indicated they lacked a care plan policy. This Federal tag relates to complaint IN00194455. 3.1-35(a)			
F 0282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview, and record review the facility failed to ensure a resident received prescribed gastrointestinal feeding tube (G-tube) feedings for 1 of 2 residents reviewed for following the plan of care related to G-tube feedings (Resident B). Finding includes: Resident B's record was review on 3/15/16 at 2:40 p.m. Resident B had diagnosis which included, but was not	F 0282	**Correctiveactions accomplished for those residents found to be affected by the allegeddeficient practice:** Resident #B orders were clarified and transcribed to theEMAR. **Identification of other residents havingthe potential to be affected by the same alleged deficient practice andcorrective actions taken**: The DHS or designee will review allresidents with prescribed gastrointestinal feeding tube	04/16/2016

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	limited to, dysphasia (difficulty with speech). A Minimum Data Set (MDS) assessment, dated 3/8/16, indicated he had a Brief Interview for Mental Status score of 13 out of 15 and required limited assistance of one staff for eating, and had feeding tube. During an observation on 3/15/16 on 1:00 p.m., Resident B ate 2 bites of pork loin for lunch, no G tube feeding was administered. A care plan for nutrition, dated 1/21/16, indicated a goal to meet nutritional and hydration needs through tube feedings and oral diet to support overall metabolic demands. An approach indicated tube feedings and oral diet would be administered as ordered by physician. A care plan for artificial feeding and having a percutaneous endoscopic gastrostomy tube (PEG tube), dated 1/4/16, indicated an approach to administer Jevity, a concentrated calorie nutrition for tube-fed patients to maintain healthy weight, per current MD order, and to record intake every shift. A physician order, dated 2/3/16, indicated an order for Jevity 1.5 bolus 1 can administered when Resident B consumed less than 50% of a meal.		orders to ensure theorder is transcribed to the EMAR and the resident is receiving as ordered. **Measuresput in place and systemic changes made to ensure the alleged deficient practicedoes not recur:** DHS or designeewill re-educate the Registered and Licensed Nurses on the following campusguidelines: Trilogy Guide to Physician Order Entry and Trilogy Guide to Categories,Flow sheets, and Point of Care **How the corrective measures will be monitored to ensure the alleged deficientpractice does not recur:** The following audits for 5 residentswill be conducted by the DHS or designee 2 times per week times 8 weeks, thenmonthly times 2 months to ensure compliance: Residents with prescribed gastrointestinal feeding tube orders to ensurethe order is transcribed to the EMAR and the resident is receiving as ordered. The results of the audit observations will be reported, reviewedand trended for compliance thru the campus Quality Assurance Committee for aminimum of 4 additional months then randomly thereafter for furtherrecommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155816	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 03/17/2016
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	Consumption records, dated February and March 2016, indicated Resident B consumed less than 50% of his lunch meal on 2/19/16, 2/24/16, 3/6/16, 3/10/16, 3/15/16, and breakfast meal on 2/14/16, and 2/17/16... During an observation on 3/15/16 on 1:00 p.m., Resident B ate 2 bites of pork loin for lunch, no G tube feeding was administered. During an interview on 3/16/16 at 1:10 p.m., Licensed Practical Nurse (LPN) #4 indicated Resident B did not have an order for G-tube feedings. During an interview on 3/16/16 at 1:05 p.m., Unit Manager #1 indicated Resident B had a current order for bolus G-tube feedings if he ate less than 50% of a meal. He indicated the order was not showing up on the Electronic Medication Administration Record (E MAR). He indicated Resident B should have reviewed the bolus tube feedings when he ate less than 50% of his meal. During an interview on 3/16/16 at 2:15 p.m., the Medical Records Director indicated if the physician's order did not flow to the E MAR the nurses would not see the order and sign off on it. She further indicated Resident B had never received a bolus feeding for intake less			

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	than 50% since the order was written. During an interview on 3/17/16 at 9:47 a.m., the DON indicate they lacked a policy to ensure physician's orders were coded into the E MAR. This Federal tag relates to Complaint IN00194455. 3.1-35(g)(2)			
F 0312 SS=D Bldg. 00	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, interview, and record review, the facility failed to ensure staff provided assistance with activities of daily living related to eating assistance for 1 of 3 residents reviewed for activities of daily living (Resident B). Finding includes: Resident B's record was reviewed on 3/15/16 at 2:40 p.m., Resident B's	F 0312	**Correctiveactions accomplished for those residents found to be affected by the allegeddeficient practice:** Resident #B observed and is being assisted with feeding. **Identification of other residents havingthe potential to be affected by the same alleged deficient practice andcorrective actions taken**: The DHS or designee will observe residentsduring meal	04/16/2016

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	Minimum Data Set (MDS) assessment dated 3/8/16, indicated he had a Brief Interview for Mental Status score of 13 out of 15. He was identified as extensive assistance of 2 for transfers, and ambulation did not occur. Resident B was identified as needing "Limited assistance of one person" for eating. Diagnosis included, but were not limited to muscle weakness, other abnormalities of gait and mobility, chronic obstructive pulmonary disease, and dysphasia. The record lacked indication of a care plan for activities of daily living related to eating assistance. On 3/15/16 at 1:00 p.m., Resident B was observed eating lunch. He had pork loin that was chopped for him, rice, vegetables, a dessert of key lime pie and a glass of thickened water. He was observed to be having trouble eating with a fork in his left hand, he was unable to get the food to his mouth. He switched to his right hand and was able to get some food to his mouth with the fork in his right hand and using his left hand to stabilize the fork. He had shaking in his hands and dropped food 3 times. At one time he had a piece of pork loin hanging from his lip and was unaware that it was there and took a drink of his water and the pork loin fell to his lap. He became fatigued and drifted to sleep. He ate 2 bites of pork loin and had 2 drinks of		time to ensure staff is providing assistance with activities ofdaily living related to eating assistance. **Measuresput in place and systemic changes made to ensure the alleged deficient practicedoes not recur:** DHS or designeewill re-educate the Nursing staff on the following campus expectation: Assistancewith activities of daily living related to eating assistance. **How the corrective measures will be monitored to ensure the alleged deficient practicedoes not recur:** The following audits for 5 residents will be conducted bythe DHS or designee 2 times per week times 8 weeks, then monthly times 2 monthsto ensure compliance: Observe residentsduring meal time to ensure staff is providing assistance with activities ofdaily living related to eating assistance. The results of the audit observations will be reported, reviewedand trended for compliance thru the campus Quality Assurance Committee for aminimum of 4 additional months then randomly thereafter for furtherrecommendation.	

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	water. At 1:35 p.m., Certified Nursing Assistant (CNA) #6 came in and woke Resident B, she asked him if he was done eating, he indicated he was and she removed the tray. During an interview on 3/16/16 at 1 p.m., CNA #6 indicated Resident B required set up assistance for meals. During an interview on 3/16/16 at 1:10 p.m., Licensed Practical Nurse (LPN) #4 indicated information about individual resident care needs was found on Care Tracker. Staff had to log in to view it and it could be printed. She indicated Resident B required set up assistance for meals and was independent with eating. During an interview on 3/16/16 at 2:00 p.m., the MDS coordinator indicated Resident B was coded as needing limited assistance of one staff person for eating. She indicated limited assistance of one staff would be staff cutting up food, cueing, and handing the resident items. She indicated it was more than just setting the tray down and leaving the resident alone. She further indicated when the need for assistance was identified on the MDS the Unit Manager should be informing their staff of the need and a care plan should be developed for the resident. She indicated she missed			

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	creating a care pan for Resident B and he should have had a care plan created for activities of daily living related to eating assistance. During an interview on 3/17/16 at 10:00 a.m., Director of Nursing (DON) indicated they lacked a care plan policy. A current policy titled "ELECTRONIC ADL DOCUMENTATION GUIDELINES" lacked indication of how staff would access information about a residents ADL needs. This Federal tag relates to complaint IN00194455. 3.1-38(a)(3)			
F 0323 SS=G Bldg. 00	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to ensure the safety of a cognitively impaired resident who was sent to the doctor's office without	F 0323	**Correctiveactions accomplished for those residents found to be affected by the allegeddeficient practice:** Resident Z expired	04/16/2016

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	supervision resulting in the resident going to the emergency room for evaluation of pain in the hip and knee after falling out of the wheelchair for 1 of 3 residents reviewed for accidents (Resident Z). Finding includes: During a telephone interview on 3/15/16 at 12:26 p.m., Resident Z's daughter/healthcare representative indicated her mother was transported to a physician's appointment in "January" 2016 She indicated the facility failed to send staff along with her mother or notify her of the appointment so she could have gone. She indicated, while with the transportation service, her mother fell out of the wheelchair and had to be evaluated and treated at the emergency room for complaints of pain in her knees and hips. Resident Z's record was reviewed on 3/15/16 at 1:30 p.m. A document titled "Face Sheet," dated 10/1/14, indicated Resident Z was not responsible for herself and her daughter was her responsible party. Resident Z had diagnoses which included, but were not limited to, history of falls, muscle weakness, dementia, and abnormal gait. A Minimum Data Set (MDS) assessment tool, dated 1/15/16, indicated Resident Z		March 5, 2016. **Identification of other residents havingthe potential to be affected by the same alleged deficient practice andcorrective actions taken**: The DHS ordesignee will review scheduled appointments at a location outside the facility,for residents who are cognitively impaired or requiring physicalassistance, to ensure the familymember/health care representative have been notified to ensure they will be able to attend thescheduled appointment with the resident and the notification is documented in the clinicalrecord. **Measuresput in place and systemic changes made to ensure the alleged deficient practicedoes not recur:** DHS or designeewill re-educate the Licensed Nurses on the following campus guidelines: 1). Falls management program 2). Scheduledappointments at a location outside the facility will be communicated to thefamily member/health care representative to ensure they will be able to attendthe scheduled appointment if the resident is cognitively impaired or requiresphysical assistance and the notification is documented in the clinicalrecord. **How the corrective measures will be monitored to ensure the alleged deficientpractice does not recur:** The following audits for 5 residentswill be conducted	

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	required extensive assistance of two staff for transfers, was not steady and only able to stabilize with staff assistance during transitions and walking, and had severe cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 3 out of 15. A current care plan, dated 9/25/15, indicated Resident Z had a history of falls and was at risk for falling due to weakness, unsteady gait, and memory impairment. A goal indicated she would remain free from injuries from falls. A progress note, dated 12/30/16 at 1:03 p.m., indicated the facility had scheduled an appointment with a nephrologist (kidney doctor) on "Friday" 1/13/16 at 12:00 p.m. Progress notes, dated 12/30/16 through 1/17/16, were reviewed on 3/15/16 at 1:40 p.m. The record lacked indication Resident Z's daughter/healthcare representative was notified of her appointment with the nephrologist. A progress note, dated 1/15/16 at 2:27 p.m., indicated Resident Z was on a leave of absence for an appointment. A progress note, dated 1/15/16 at 3:40 p.m., indicated the supervisor from the transportation service had called the facility to inform them they were sending		by the DHS or designee 2 times per week times 8 weeks, thenmonthly times 2 months to ensure compliance: Review scheduled appointments at a location outside the facility, forresidents who are cognitively impaired or requiring physical assistance, to ensure the family member/health care representativehave been notified to ensure they will be able to attend the scheduledappointment with the residentand the notification is documented in the clinical record. The results of the audit observations will be reported, reviewedand trended for compliance thru the campus Quality Assurance Committee for aminimum of 4 additional months then randomly thereafter for furtherrecommendation.	

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	Resident Z to the emergency room due to complaints of pain after she had fallen out of her wheelchair. An emergency room document, dated 1/15/16, indicated Resident Z was evaluated in the emergency for complaints of right hip pain and left knee pain secondary to a fall. The note indicated she fell while transferring herself from her wheelchair in which she leaned over and fell forward to the ground. The note indicated her right hip pain was mild to moderate and her left knee pain was moderate in quality. The note further indicated x-rays were obtained and were negative and Resident Z was sent back to the facility in stable condition. During an interview on 3/16/16 at 9:20 a.m., Transportation Service Employee #1 indicated if a resident required assistance for transfers and/or was cognitively impaired, facility staff or family was required to accompany them to appointments. She indicated they could not leave a cognitively impaired resident alone in an office for an appointment. She indicated there was not a written form of communication which indicated such information that was exchanged at the time of the transfer. She indicated it was implied when a			

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	facility called for transportation. She indicated if a resident could not transfer without assistance or were cognitively impaired the facility should order "stretcher" transportation. Otherwise, they should order "wheelchair" service. She further indicated if they ordered a stretcher EMTs (Emergency Medical Technicians), who were trained in transfer techniques, would accompany the driver and the resident during transportation. She indicated the transportation service only provided transportation to and from appointments. She indicated when wheel chair service was ordered trained staff were not available to monitor cognitively impaired residents or provide physical assistance with transfers. During an interview on 3/16/16 at 10:00 a.m., the Director of Nursing (DON)indicated documentation which indicated the facility notified Resident Z's daughter of her appointment on 1/15/16 was not available. She indicated Resident Z's daughter usually met her mother at off campus appointments. During an interview on 3/16/16 at 10:05 a.m., Unit Manager #1 indicated if a resident was cognitively impaired and family was not available to attend the scheduled appointment, "if possible" the			

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	appointment should be rescheduled to accommodate the family or staff should go with the resident to the appointment. He indicated the transportation services would not allow "stretcher" service unless it was medically necessary. During an interview on 3/17/16 at 12:40 p.m., the Assistant Director of Nursing (ADON) indicated the progress note, dated 12/30/16 at 1:03 p.m., had a "typo." She indicated the nephrologist appointment date was Friday, January 15, 2015 not 1/13/16. During an interview on 3/17/16 at 1:59 p.m., the DON indicated the facility did not have a policy regarding transportation of residents to appointments. She indicated the procedure was to notify family when a resident required transport service. She indicated family was informed the facility would not send a caregiver and were given the option to ride with the resident or meet the resident at their appointment. She further indicated when facility staff ordered transportation for residents they had to indicate whether the resident required a wheel chair or stretcher. She indicated if the resident required stretcher services, the facility was required to provide documentation which indicated the medical necessity for stretcher services.			

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	She indicated she was unaware of what the criteria was for requesting wheel chair verses stretcher services. She indicated the facility did not have a policy which indicated what the criteria was for obtaining stretcher verses wheelchair service. During an interview on 3/17/16 at 2:40 p.m., the Executive Director indicated the facility did not have a policy regarding transportation services. She indicated transportation services would only provide stretcher service if it was medically necessary based on Medicare guidelines. She was unable to indicate what those guidelines were. During an interview on 3/17/16 at 3:00 p.m., the Director of Nursing indicated staff did not go with residents to appointments. She indicated families were notified of appointments so they could be present at the appointment to monitor and assist cognitively impaired residents and/or residents that required physical assistance with transfers. A Falls Management Program policy identified as current by the Executive Director on 3/17/16 at 3:15 p.m., indicated, "Purpose...Trilogy health Services (THS) strives to maintain a hazard free environment, mitigate fall			

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	risk factors and implement preventative measures. THS recognizes even the most vigilant efforts may not prevent all falls and injuries. In those cases, intensive efforts will be directed toward minimizing or preventing injury...." This Federal tag relates to Complaint #IN00193862. 3.1-45(a)(2)			
F 0514 SS=E Bldg. 00	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview, the facility failed to ensure State Preadmission Screening Notification forms were signed by the resident or responsible person for 4 of 7 residents	F 0514	**Correctiveactions accomplished for those residents found to be affected by the allegeddeficient practice:** ResidentZ expired March 5, 2016.	04/16/2016

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	reviewed for documentation of preadmission screening notifications (Residents M, L, F, and H). Findings include: 1. On 3/16/16 at 12:12 p.m., Resident M's closed record was reviewed. The form titled, "Application for Long-Term Care Services: State Form 45943," dated 11/20/15, lacked Resident M's signature under the section titled, "PREADMISSION SCREENING NOTIFICATION." The "Resident Face Sheet," dated 11/21/15, indicated Resident M was responsible for himself and admitted on 11/21/15. Resident M's admission Minimum Data Set (MDS) assessment, dated 11/28/15, indicated he had a Brief Interview for Mental Status (BIMS) score of 12 out of 15 and had moderate cognitive impairment. 2. On 3/16/16 at 1:17 p.m., Resident L's closed record was reviewed. The "Resident Face Sheet," dated 11/19/15, indicated Resident L was admitted on 11/19/15, was not responsible for herself, and her spouse was her responsible party.		**Identification of other residents havingthe potential to be affected by the same alleged deficient practice andcorrective actions taken**: The DHS ordesignee will review scheduled appointments at a location outside the facility,for residents who are cognitively impaired or requiring physicalassistance, to ensure the familymember/health care representative have been notified to ensure they will be able to attend thescheduled appointment with the resident and the notification is documented in the clinicalrecord. **Measuresput in place and systemic changes made to ensure the alleged deficient practicedoes not recur:** DHS or designeewill re-educate the Licensed Nurses on the following campus guidelines: 1). Falls management program 2). Scheduledappointments at a location outside the facility will be communicated to thefamily member/health care representative to ensure they will be able to attendthe scheduled appointment if the resident is cognitively impaired or requiresphysical assistance and the notification is documented in the clinicalrecord. **How the corrective measures will be monitored to ensure the**	

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(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
	Resident L's closed record lacked documentation of the form titled, "Application for Long-Term Care Services: State Form 45943." During an interview on 3/16/16 at 2:54 p.m., the Executive Director indicated she was unable to find the form titled, "Application for Long-Term Care Services: State Form 45943," for Resident L. 3. On 3/16/16 at 1:59 p.m., Resident F's closed record was reviewed. The form titled, "Application for Long-Term Care Services: State Form 45943," dated 11/20/15, lacked Resident F's signature under the section titled, "PREADMISSION SCREENING NOTIFICATION The "Resident Face Sheet," dated 11/22/15, indicated Resident F was admitted on 11/22/15 and was responsible for himself. Resident F's 14-day Minimum Data Set (MDS) assessment, dated 12/6/15, indicated he had a Brief Interview for Mental Status (BIMS) score of 11 out of 15 and had moderate cognitive impairment. 4. On 3/16/16 at 2:37 p.m., Resident H's		**alleged deficientpractice does not recur:** The following audits for 5 residentswill be conducted by the DHS or designee 2 times per week times 8 weeks, thenmonthly times 2 months to ensure compliance: Review scheduled appointments at a location outside the facility, forresidents who are cognitively impaired or requiring physical assistance, to ensure the family member/health care representativehave been notified to ensure they will be able to attend the scheduledappointment with the residentand the notification is documented in the clinical record. The results of the audit observations will be reported, reviewedand trended for compliance thru the campus Quality Assurance Committee for aminimum of 4 additional months then randomly thereafter for furtherrecommendation.	

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	closed record was reviewed. The form titled, "Application for Long-Term Care Services: State Form 45943," dated 11/13/15, lacked Resident H's signature under the section titled, "PREADMISSION SCREENING NOTIFICATION The "Resident Face Sheet," dated 11/13/15, indicated Resident H was admitted on 11/13/15 and was responsible for himself. Resident H's 30-day Minimum Data Set (MDS) assessment, dated 12/11/15, indicated he had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 and was cognitively intact. During an interview on 3/16/16 at 2:15 p.m., the Customer Services Specialist indicated the Application for Long-Term Care Services form was supposed to be signed by the resident or responsible person under the section titled, "PREADMISSION SCREENING NOTIFICATION." The Customer Services Specialist indicated many of the forms were not signed by the residents or the responsible party prior to her starting in February. She indicated the facility preferred to have the Pre-Screening form signed prior to admission or within 24 hours of admission, and the State			

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	required the form to be signed within five days of admission. During an interview on 3/17/16 at 12:41 p.m., the Assistant Director of Nursing (ADON) indicated the information on residents' face sheets was usually entered within 24 to 48 hours of admission and would have been accurate on a resident's date of discharge. During an interview on 3/17/16 at 2:48 p.m., the Executive Director indicated they had problems with the former staff person responsible for getting signatures from the residents or responsible person on the Application for Long-Term Care Services. During an interview on 3/17/16 at 3:10 p.m., the Executive Director indicated there was no policy related to obtaining signatures on the Application for Long-Term Care Services. This Federal tag relates to complaint IN00190144. 3.1-50(f)(4)			