

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 01/31/2013
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NAME OF PROVIDER OR SUPPLIER BRIDGE AT GARDEN PLAZA	STREET ADDRESS, CITY, STATE, ZIP CODE 8614 W 10TH ST INDIANAPOLIS, IN 46234
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R000000	<p>This visit was for State Residential Licensure Survey.</p> <p>Survey dates: January 30 and 31, 2013</p> <p>Facility Number: 005616 Provider Number: 005616 AIM Number: N/A</p> <p>Survey Team: Lora Brettnacher, RN, TC Heather Lay, RN</p> <p>Census bed type: Residential: 88 Total: 88</p> <p>Census payor type: Other: 88 Total: 88</p> <p>Sample: 7</p> <p>These State Residential findings are cited in accordance with 410 IC 16.2.</p> <p>Quality Review completed on 02/06/2012 by Brenda Nunan, RN.</p>	R000000	<p><i>Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law.</i></p>	

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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R000006	<p>410 IAC 16.2-5-0.5(f)(1-5) Scope of Residential Care - Deficiency (f) The resident must be discharged if the resident:</p> <p>(1) is a danger to the resident or others; (2) requires twenty-four (24) hour per day comprehensive nursing care or comprehensive nursing oversight; (3) requires less than twenty-four (24) hour per day comprehensive nursing care, comprehensive nursing oversight, or rehabilitative therapies and has not entered into a contract with an appropriately licensed provider of the resident ' s choice to provide those services; (4) is not medically stable; or (5) meets at least two (2) of the following three (3) criteria unless the resident is medically stable and the health facility can meet the resident ' s needs: (A) Requires total assistance with eating. (B) Requires total assistance with toileting. (C) Requires total assistance with transferring.</p> <p>Based on interview and record review, the facility failed to address service needs to ensure a resident was free from danger to herself for 1 of 7 sampled residents (Resident #1).</p> <p>Findings include:</p> <p>Resident #1's closed record was reviewed on 1/30/13. Resident #1 was admitted to the facility on 8/24/12, and had a diagnosis of dementia; progressive over past three years.</p>	R000006	<p>R006 Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law. A. With Respect to the Specific Residents Cited: Resident #1 is no longer a resident in the community. Resident #1 was identified by the facility as being beyond the scope of Residential Care on 10/24/2013. At this time, facility began working with the family to</p>	02/28/2013			

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	<p>A physician signed admission and history physical dated 8/20/2012, indicated, Resident #1 was an elopement risk due to dementia and memory loss.</p> <p>A document titled, "Nurse's Admission Assessment Record" dated 8/24/2012-4:30 P.M., indicated Resident #1 was admitted to the facility on 8/24/2012, she had dementia, she was alert, her memory recall was limited to her date of birth and birth place, she was cooperative and ambulatory.</p> <p>A document titled, "The Bridge at Garden Plaza Assisted Living-Level of Care Assessment", dated 8/24/2012 indicated, "Psycho/Social Status. . .Frequent interventions and supervision to manage behaviors toward self and others. May need physical assistance in locating areas within the facility. Aggressive or violent behaviors to self or others is above our Assisted Living Criteria. (Wandering without regards to safety of self or others, wandering into other residents rooms, or wandering outside of the facility). Additional Comments-Supervision needed to manage behavior towards others."</p> <p>A nurse's note dated 8/24/2012-8:00</p>		<p>provide a safety companion until there could be a safe transition to a secure environment. Resident #1 was discharged to a secure environment 11/7/12.</p> <p>B. With Respect to How the Facility will Identify Residents with the Potential for the Identified Concern and Take Corrective Action: The Resident Pre-Move-In Assessment will reflect resident history of exit seeking behaviors. The Administrator will review the Pre Move-In Assessment and Healthcare Provider Physician's Report to determine admission approval or denial. Episodes of resident Exit Seeking Behavior will be documented in the resident record and the 24 hour report. The Administrator will communicate the episode and follow up during the Daily Stand Up Meetings including family and healthcare provider notification and the plan to ensure safety of the residents.</p> <p>C. With Respect to What Systemic Measures have been put in place to Address the Stated Concern: A Photograph of residents with a history of exit seeking will be maintained in the resident record and a file at the reception desk. Residents will also receive an identification bracelet with their name, community name, address and phone number. Staff training is scheduled on exit seeking</p>				

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	<p>P.M., indicated, "Resident alert and confused to short term memory...ambulates with walker."</p> <p>A nurse's note dated 8/25/12-11:00 P.M., indicated, Resident #1 was found on the 3rd floor in her T-shirt and underwear. She was redirected back to her apartment.</p> <p>A nurse's note dated 8/26/2012-8:00 P.M., indicated, Resident #1 was redirected back to her apartment six times. Resident #1 indicated to the staff she did not belong there. The nurse in charge was notified.</p> <p>A nurse's note dated 8/31/2012-9:45 A.M., indicated, a housekeeper found Resident #1 in the stairway trying to find her way downstairs. The nurse in charge was notified.</p> <p>A nurse's note dated 8/31/12-1:15 P.M., indicated, Resident #1 was brought back to the Assisted Living (AL) side from the Independent Living (IL) side of the building.</p> <p>A nurse's note dated 8/31/2012-1:15 P.M., indicated, Resident #1 was brought back to the AL side from the IL. She was trying to get inside her old apartment. Staff reminded her she lived in the AL side now.</p>		<p>residents, Elopement policy and communication expectations.</p> <p>D. With Respect to How the Plan of Corrective Measures will be Monitored: The Administrator will review the documentation of the episodes of exit seeking to ensure follow up compliance. DOC: 2/28/2013</p>				

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	<p>Resident indicated to the staff she did not understand why.</p> <p>A nurse's note dated 8/31/2012-230 P.M., indicated, Resident #1 was redirected back to AL after trying to return her door key because she did not live there anymore. The charge nurse was notified.</p> <p>A nurse's note dated 9/2/2012-6:30 P.M., indicated, Resident #1 was escorted back to the AL from the IL because she could not find her way back on her own. The nurse was aware.</p> <p>Nurse's notes dated 9/2/2012-7:12 P.M., 8:20 P.M., 8:54 P.M., and 9:10 P.M., all indicated, Resident #1 had to be assisted back to AL from the IL by staff.</p> <p>Nurse's notes dated 9/5/2012, indicated, at 9:00 A.M., Resident #1 was assisted back to AL from IL. She was trying to get into an apartment. At 10:30 A.M., she was back on IL and indicated to staff she did not know where she lived. At 1:00 P.M., she was found on the IL side and assisted back to her apartment on the AL side. At 1:10 P.M., the resident who lived in room 239 complained to staff because Resident #1 kept</p>						

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	<p>coming into her apartment. The charge nurse was notified. At 3:00 P.M., she had to be redirected to her apartment. At 4:30 P.M., Resident #1 indicated to staff she did not live there and wanted to know how to get downstairs. The nurse was aware.</p> <p>Nurse's notes dated 9/6/2012, indicated, at 9:00 A.M., Resident #1 told staff she was leaving and she did not live there. She was redirected to her apartment. At 12:30 P.M., she was redirected from the IL side to the AL side. At 2:00 P.M., she was found on the IL side. Resident #1 indicated to staff she did not live there and was waiting on friends to come and pick her up. She was redirected to the AL side.</p> <p>A nurse's note dated 9/6/2012-8:00 P.M., indicated, Resident #1 had been redirected back to her apartment four times during the shift. Resident #1 was confused and indicated she did not live there.</p> <p>Nurse's notes dated 9/7/2012-9:00 A.M., Resident #1 could not find her apartment and had to be redirected. At 10:30 A.M., she was found on the IL side looking for her apartment. At 11:15 A.M. she was trying to get into another resident's apartment. At 2:00</p>			
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	<p>P.M., staff found her in the parking lot. At 5:00 P.M., she was found trying to get into room 213 because she indicated she lived there.</p> <p>An un-timed nurse's note dated 9/9/2012, indicated, Resident #1 was confused and non-compliant.</p> <p>A nurse's note dated 9/10/2012-10:00 A.M., indicated, Resident #1 was confused and looking for her apartment all morning even after being directed and taken there several times.</p> <p>Nurse's notes dated 9/14/2012, indicated, at 9:00 A.M., Resident #1 was escorted back to the AL side from the IL side. At 12:30 P.M., she was again returned to the AL side from the IL side. At 7:00 P.M., a nurse's note indicated, she had been escorted back from the IL side five times by staff during the shift. The nurse had been notified.</p> <p>Nurse's notes dated 9/19/2012 indicated at 2:00 P.M., 3:30 P.M., and 4:00 P.M., Resident #1 was found on the IL side and escorted back to the AL side.</p> <p>An untimed nurse's note dated, 9/20/2012 indicated, Resident #1 had</p>						

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	<p>been escorted back from the IL side twice because she could not find her apartment.</p> <p>Nurse's notes dated 9/21/2012 indicated, at 10:00 A.M., 12:00 P.M., 3:30 P.M., 6:00 P.M., and 7:00 P.M., Resident #1 had been found on the IL side and had to be redirected back to her room on the AL side.</p> <p>Nurse's notes dated 9/28/2012, indicated, at 2:30 P.M., Resident #1 was brought back from IL. At 9:50 P.M., staff were called to the IL side to get her because she was very upset and agitated. She refused to return to AL.</p> <p>A nurse's note dated 10/5/2012-8:00 P.M., indicated Resident #1 was found outside in the rain.</p> <p>A nurse's note dated 10/21/2012-6:45 P.M., indicated, "Staff found resident outside the building by back door. Wondering back of the building. Staff redirected res. (resident) but res. was not cooperative to go back to the building. After attempted multiple times res. came to in building...."</p> <p>A nurse's note dated 10/25/2012-3:00 P.M., indicated, Resident #1 was found walking down the hallway with</p>						

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	<p>her pants falling down. When staff offered to assist her she became agitated and started "elbowing" the staff.</p> <p>A nurse's note dated 10/29/2013-9:00 A.M., indicated, another resident found Resident #1 in the stairway by her room. This resident assisted Resident #1 back to the floor were she lived.</p> <p>A nurse's note dated 11/6/12-5:00 P.M., indicated, "Resident became very delusional and stated that she thought a kid had [sic] stole something. Very aggressive because the staff at "this place" wasn't doing anything about it. She hit 3 staff members including her personal caregiver with her walker. In addition, a nurse's note dated 11/7/2012, indicated, "late entry for 11/6/12- Resident hitting kicking multiple staff during evening shift redirected several times. Resident would not cooperate nurse sit [sic] with resident until sleep. DON (Director of Nursing) notified."</p> <p>A nurse's note dated 11/7/2012-12:00 P.M., indicated Resident #1 would be sent out to a hospital for evaluation and treatment.</p> <p>During an interview on 1/30/13-3:11</p>			

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	<p>P.M., The General Manager (GM) stated, "We would not consider her going outside an unusual occurrence. It was nice weather." When asked if she was aware the admission History and Physical indicated she was an elopement risk, she replied, "No." At this time, the following documentation was requested from the GM: 1) A a service plan (from Resident #1's admission date of 8/24/2012) which indicated Resident #1 had been identified as an elopement risk, including what interventions were in place to keep her safe. 2) The facility's policy on admission requirements. 3) The facility's policy on elopement. 4) The facility's policy on reporting unusual occurrences.</p> <p>During an interview with the ADON (Assistant Director of Nursing and the GM, on 1/31/2013 at 10:00 A.M., the GM indicated she began working at this facility in October 2012. She questioned whether Resident #1 was appropriate for the building but the son was adamant about keeping her there. She provided a copy of an email conversation between her and Resident #1's son. This email indicated, "I talked to you on 10/24/12 about your mother's increased wandering. She is wandering into other resident's apartments, and into</p>						

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	<p>the independent living building. When she gets over to the independent living building, she needs their assistance getting back over to our building by wheelchair because her knee hurt [sic], and she is very tired. Our company's national director of resident care has been with us this week, and she is very concerned that (Resident #1 named) dose {sic} not meet guidelines to remain in assisted living as we cannot ensure her safety. We are suggesting a few possibilities: A 24 hour care giver would allow your mother to remain here in this environment... If your mother could be admitted to the hospital for 3 days, she might be able to utilize skilled care (likely for strengthening if she is having issues with her knee) under Medicare. I am unsure if a hospital would admit her for 3 days though, as her overall health seems stable...."</p> <p>Review of Resident #1's Service Plan dated 8/24/2012, failed to contain any issues regarding her risk of elopement. A monthly service plan update, dated September 2012, indicated, Resident did wander from building to building. It did not indicate she also wandered outside the building. The update did not contain interventions the facility would put in</p>						

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	<p>to place to keep her safe. Even though documentation indicated Resident #1 was confused and not aware of her surroundings, the current service plan dated 8/24/2012, indicated she was alert , oriented to self, time, and immediate surroundings.</p> <p>Review of the facility's current policy titled, "Guidelines for Assisted Living", indicated, "...The purpose of this level of care is to provide a physical and social environment that will extend the time span during which a resident can live independently. Our intent is to provide the best quality of life for each individual resident. Services provided: Services provided will be based upon resident Assessment and the Service Plan for each individual resident. . .Criteria for admission... Must have minimal difficulty with orientation of time/place/person. Must be free from long term behavioral symptoms that may cause disruption to the residential community. Residents who are forgetful or slightly confused can be cared for as long as their ability to function and their safety is not in jeopardy... Must not be a safety risk to self or others... If a prospective or a current resident has difficulty with one or more of the above criteria, an</p>						

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	<p>assistance/service plan to meet his/her needs will be developed with resident, staff, family, and home health agency involvement. If the needs cannot be met with the services available, then the prospective resident would not qualify for residency...."</p> <p>Review of a current facility policy titled, "Exit -Seeking Residents and Elopement", provided by the GM on 1/31/2013, indicated,... The community will identify exit-seeking residents to minimize resident safety risks. Definition of Elopement: An incident in which a resident leaves community grounds without staff knowledge, and the resident has impaired decision-making abilities and is unaware of his/her own safety needs... Upon Move-in. Residents will be assessed at move-in to determine if they are at risk for exit-seeking activity. This will be accomplished by inquiry of family of past behaviors and observation during first week of residency... Residents who have been identified to be at risk for exit-seeking behaviors will be given an identification bracelet with their name, name of community and community's phone number...."</p>						

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R000036	<p>410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment.</p> <p>Based on record review and interview, the facility failed to notify a resident's physician after a resident's daughter failed to take the resident to the emergency department for treatment as ordered by the physician [Resident #7] and failed to notify a resident's physician prior to administering a lower insulin dose than ordered [Resident #5]. This deficient practice affected 2 of 2 residents reviewed for failure to notify the physician in a sample of 7 residents reviewed.</p> <p>Findings include:</p> <p>1. On 1/30/13 at 11:15 A.M., Resident #7's record was reviewed. Diagnoses included, but were not limited to, dementia, hypertension, insomnia, and a history of colon cancer.</p>	R000036	<p>R036: Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law. A. With Respect to the Specific Residents Cited: Residents # 5 and #7 did not experience a negative outcome. A healthcare provider clarification order was obtained for Resident #5. B. With Respect to How the Facility will Identify Residents with the Potential for the Identified Concern and Take Corrective Action: A protocol for execution of physician orders was implemented, including documentation of resident/responsible party refusal to follow the physician's order. The 24 hour report will reflect residents with new and changed physician orders. The Resident</p>	02/28/2013			

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	<p>A "Nurse's Notes" dated 11/26/12 at 5:20 P.M., included, but was not limited to, "Resident [#7] having increased confusion and also complains of bilateral hand weakness... Order received from [physician] to transfer resident [Resident #7] to hospital of choice..."</p> <p>A "Nurse's Notes" dated 11/26/12 at 9:00 P.M., included, but was not limited to, "[Resident #7's] family would not be taking resident [Resident #7] to hospital but would make an appointment tomorrow..."</p> <p>There was no documentation in Resident #7's clinical record that indicated the resident's physician was notified of the family's refusal to take her to the local hospital for evaluation.</p> <p>On 1/31/13 at 2:00 P.M., in an interview, the General Manager and Assistant Director of Nursing indicated they were unable to provide any further documentation of physician notification.</p> <p>2. On 1/30/13 at 1:35 P.M., Resident #5's record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus and hypertension.</p> <p>A "Physician's Orders" dated 11/7/12,</p>		<p>Care Director and the Administrator will review the followup needs and resolution during Daily Stand Up Meetings.</p> <p>C. With Respectto What Systemic Measures have been put in place to Address the Stated Concern: Training was conducted for the LPN/QMA associates to review policy, procedures and expectations for Physician Orders, Medication Management and Medication Errors. D. With Respect to How the Plan of CorrectiveMeasures will be Monitored: Resident Care Director/Designee will conduct daily randomly review the follow through of new physician orders and follow up to address discrepancies. DOC: 2/28/2013</p>				

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	<p>included, but was not limited to, "Humalog [insulin] inject 14 units subcutaneous [under the skin] three time per day with meals with sliding scale insulin..."</p> <p>A "Physician's Orders" dated 12/17/12, included, but was not limited to, "Increase Humalog [insulin] to 18 units with each meal plus sliding scale [insulin]..."</p> <p>A "Medication Administration Record" dated 12/1/12, indicated the scheduled dose of "Humalog 18 units" was not given as ordered on 12/17/12. Instead a note on the "Medication Administration Record" indicated the 12 P.M. dose of 18 units was decreased to 8 units related to Resident #5's blood sugar being 95.</p> <p>There was no documentation in Resident #5's record regarding an order to decrease the dose of insulin on 12/17/12 at 12 P.M. or notification of Resident #5's physician.</p> <p>On 1/31/12 at 2:30 P.M., in an interview, the General Manager and Assistant Director of Nursing indicated they were unable to provide further documentation related to the insulin dose given on 12/17/12. In addition, the Assistant Director of</p>						

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	Nursing indicated the physician should have been notified for orders to change the resident's dose of insulin.						

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R000090	<p>410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency</p> <p>(g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following:</p> <p>(1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to:</p> <p>(A) epidemic outbreaks; (B) poisonings; (C) fires; or (D) major accidents.</p> <p>If the division cannot be reached, a call shall be made to the emergency telephone number published by the division.</p> <p>(2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative.</p> <p>(3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility.</p> <p>(4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the:</p> <p>(A) employee's full name; and (B) dates and hours worked during the past twelve (12) months.</p> <p>(5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any</p>			

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	<p>subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability.</p> <p>(6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request</p> <p>Based on interview and record review, the facility failed to inform the division within 24 hours of becoming aware of an unusual occurrence that directly threatened the safety or health of a resident for 2 residents reviewed for reporting of unusual occurrences in a total sample of 7 (Resident #1 and Resident #2).</p> <p>Findings include:</p> <p>Resident #1's closed record was reviewed on 1/30/13. Resident #1 was admitted to the facility on 8/24/12, and had a diagnosis of dementia; progressive over past three years.</p> <p>A physician signed admission history and physical, dated 8/20/2012, indicated Resident #1 was an elopement risk due to her dementia and memory loss.</p> <p>A nurse's note dated 9/4/2012-6:30 P.M., indicated, Resident #1 was</p>	R000090	<p>R090: Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law. With Respect to the Specific Residents Cited: Resident #1 & #2 are no longer residents in the community and were discharged prior to this regulatory survey. With Respect to How the Facility will Identify Residents with the Potential for the Identified Concern and Take Corrective Action: A review of the Reportable Incidents Regulation was completed by the Administrator. An audit of resident incident and accident reports was completed to ensure reporting compliance. The 24 hour report will reflect residents transported to the hospital and the clinical status upon return. The AI Administrator and Resident Care Director will review the 24 hour report and communicate the follow up needs including regulatory reportable</p>	02/28/2013

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	<p>noted to have bleeding to her head. She had a small wound to the left top side of her head with a moderate amount of bleeding. She was sent out to the ER to be evaluated. She returned with three staples intact to the laceration.</p> <p>Nurse's notes dated 9/6/2012, indicated, at 9:00 A.M., Resident #1 told staff she was leaving and she did not live there. She was redirected to her apartment. At 12:30 P.M., she was redirected from the IL side to the AL side. At 2:00 P.M., she was found on the IL side. Resident #1 indicated to staff she did not live there and was waiting on friends to come and pick her up. She was redirected to the AL side.</p> <p>Nurse's notes dated 9/7/2012- 2:00 P.M., indicated, staff found Resident #1 in the parking lot. Staff escorted her back to her apartment and notified the nurse.</p> <p>A nurse's note dated 10/4/2012-10:30 A.M., indicated, "Writer found resident laying on her bedroom floor beside her bed. Res (resident) alert but can't say how she fell. Laceration noted to right side of head, moderate amount of bleeding. 0 [no] c/o (complaints) of pain, denies being dizzy. ROM</p>		<p>incidents during the daily stand up meetings. The Administrator will receive notification of Unusual Occurrences when identified by the associates. With Respect to What Systemic Measures have been put in place toAddress the Stated Concern: In-service education has been scheduled for the Resident Care Associates to review Reporting Unusual Occurrences and the communication expectations. The General Manager or designee will inform ISDH of an unusual occurrence that threatens the welfare, safety, or health of a resident using the Indiana Division of Long Term Care Reportable Unusual Occurrences Policy as a guideline. With Respect to How the Plan of Corrective Measures will be monitored The Resident Care Director and the Administrator will review the Resident Incidents, Accidents and Unusual Occurrences monthly with a documented plan to address trends and patterns. DOC: 2/28/2013</p>				

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	<p>(range of motion) is WNL (within normal limits). Son (named) requested res.[resident] be sent to ER via ambulance upon speaking with him. Ambulance called. Res sitting up by bed with cloth held over laceration." The note did not indicate the size of the laceration. The resident was sent to the ER per the family's request. A nurse's note dated 10/4/2012-3:00 P.M., indicated, "Resident returned to facility via ambulance. Laceration is clean, 0 [no] sutures. N.O.[new order] for Amoxil [antibiotic] 875 mg tab 1 po (by mouth) BID (twice a day) X [for] 5 days for UTI (urinary tract infection)..." This note did not indicate the size of the laceration.</p> <p>A nurse's note dated 10/5/2012-8:00 P.M., indicated Resident #1 was found outside in the rain.</p> <p>A nurse's note dated 10/21/2012-6:45 P.M., indicated, "Staff found resident outside the building by back door. Wondering back of the building. Staff redirected res. (resident) but res. was not cooperative to go back to the building. After attempted multiple times res. came to in building..."</p> <p>A nurse's note dated 10/4/2012-10:30 A.M., indicated, "Writer found resident</p>			

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	<p>laying on her bedroom floor beside her bed. Res (resident) alert but can't say how she fell. Laceration noted to right side of head, moderate amount of bleeding. 0 c/o (complaints) of pain, denies being dizzy. ROM (range of motion) is WNL (within normal limits). Son (named) requested res. be sent to ER via ambulance upon speaking with him. Ambulance called. Res sitting up by bed with cloth held over laceration." The note did not indicate the size of the laceration. The resident was sent to the ER per the family's request. A nurse's note dated 10/4/2012-3:00 P.M., indicated, "Resident returned to facility via ambulance. Laceration is clean, 0 sutures. N.O. for Amoxil 875 mg tab 1 po (by mouth) BID (twice a day) X 5 days for UTI (urinary tract infection) ..." This note did not indicate the size of the laceration.</p> <p>During an interview, 1/30/13-3:11 P.M., The General Manager (GM) was asked if she reported Resident #1 being found in the parking lot on 9/7/2012 at 200 P.M., when she was found outside in the rain on 10/5/2012 at 8:P.M., and when she was found wandering outside the back of the building on 10/21/12 at 6:45 P.M. to the Indiana State Department of Health, She replied, "We would not</p>						

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	<p>consider her going outside an unusual occurrence. It was nice weather." When asked if she was aware the admission History and Physical indicated she was an elopement risk, she replied, "No." The GM was asked if she reported Resident #1's injury of unknown origin (laceration) which occurred on 9/4/2012. She indicated she did not work at the facility at that time but she would look to see if it was reported. At this time, the GM was asked to provide the facility's policy on reporting unusual occurrences. She indicated the facility did not have a policy on reporting unusual occurrences. During an interview on 1/31/2013-3:00 P.M., The GM indicated she could not find documentation that Resident #1's unwitnessed injuries were reported to the state.</p> <p>2) Resident #2's closed record was reviewed on 1/31/2013. Resident #2 was originally admitted to the facility on 3/6/2013. She was readmitted on 6/8/2012, 8/14/2012, 10/29/12, and 11/19/12. Resident #2 had diagnoses which included: History of falls, Alzheimer's dementia, anxiety, expressive aphasia with previous history of multiple strokes, chronic kidney disease,.congestive heart</p>			

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	<p>failure, atrial fibrillation, and depression.</p> <p>A document dated 3/14/12, titled "Aid and Attendance Needs for VA (Veterans Administration) Application for coverage for AID and Attendance Benefits", indicated, Resident #1 had memory problems and therefore required supervision for safety purposes.</p> <p>A document dated, 3/6/2012, titled, "Nurses Admission/Assessment Record", indicated, Resident #2 was alert, oriented x 3, at times had intermittent confusion.</p> <p>A nurse's note dated 8/14/2012-4:00 P.M., indicated, "Res arrived accompanied by daughter in wheelchair. Res (resident) came from rehab (rehabilitation). Res pleasant and alert to person and place but has intermittent confusion. Bruising to face and neck from fall. Right wrist and arm bruised . Also skin tear to knee. Skin pale. Pedal pulse present. LSCTA (lung sounds clear to auscultation). 0 [no]s/s (signs and symptoms of SOB (shortness of breath) at this time. Res being transported in wheelchair. 0 [no] complaints pain/discomfort. Family with res."</p>						

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	<p>A nurse's note dated 8/5/12-4:00 P.M., indicated, "Resident c/o [complained] right arm pain. Family took her to [hospital named] for eval [evaluation] and treat [treatment].</p> <p>A nurse's note dated 8/16/2012-2:00 P.M. and 3:30 P.M., indicated Resident #2 returned from the hospital with a hard cast and received pain medication for a broken right arm.</p> <p>An admission nurse's note dated 10/29/2012-5:00 P.M., indicated Resident #2 returned from the hospital again. She was alert but confused. She was unable to state the year she was born or the current year. She was unable to identify where she was. She ambulated with a walker and had a history of falls.</p> <p>The next nurse's note dated, 11/3/2012-6:00 A.M., indicated, "Nurse went to res (resident) room to check BS (blood sugar). Found resident in bed blood everywhere. Res. stated 'I fell in bathroom then got myself up.' Res has skin tear on Left wrist and Left elbow also c/o (complained) pain when res move left arm. also bruises on left side face... Sent to (hospital named)."</p>			

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	<p>A nurse's note dated, 11/3/2012-1 P.M., indicated, Resident #2 returned from the hospital with a broken left arm and stitches.</p> <p>During an interview, 1/30/13-3:11 P.M., The General Manager (GM) was asked if she reported the 8/16/12 incident of unknown origin (Resident #1's broken bone) to the state. She indicated they assumed it was from a fall that occurred at the skilled facility. She didn't think it was unusual for someone to have a broken bone from a fall. She did not have documentation regarding an incident of a fall that occurred while the resident was at the skilled facility. Resident #1 was not diagnosed or assessed to have complaints of pain to that arm when she was admitted back to them. She was asked if she reported the broken bone to the other arm from the incident on 11/3/2013. She indicated no, she did not because the resident told the staff she fell. The GM was asked at this time if it was her practice to report unwitnessed injuries of confused residents. She indicated she did not report broken bones unless it was to a dependant resident.</p>						

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R000092	<p>410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on record review and interview, the facility failed to perform fire and disaster drills quarterly on each shift and failed to attempt fire and disaster drills at least every 6 months with the local fire department. This deficient practice had the potential to affect 88 of 88 residents currently residing in the facility.</p> <p>Findings include:</p>	R000092	<p>R092: Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law. With Respect to the Specific Residents Cited: No specific residents cited. Residents did not experience a negative outcome. With Respect to How the Facility will</p>	02/28/2013			

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	<p>On 1/30/13 at 12:00 P.M., the General Manager provided the facility fire drills that included, but were not limited to, fire drills for 2012.</p> <p>There was no documentation of the facility performing fire and disaster drills on the 3rd shift for the first and second quarters in 2012 [11 P.M. to 7 A.M.] and no documentation of attempted fire and disaster drills with the local fire department.</p> <p>On 1/31/13 at 10:00 A.M., in an interview, the General Manager indicated she was unable to provide documentation of facility fire and disaster drills on the 3rd shift for the first and second quarters in 2012.</p> <p>On 1/31/13 at 2:05 P.M., in an interview, the General Manager indicated she was unable to provide 2 attempted drills with the local fire department. At that time, she provided a written statement from the local fire department that indicated 1 fire and disaster drill was completed in conjunction with the local fire department on 4/25/12. However, in an interview at that time, the General Manager indicated she was unable to provide additional attempts with the local fire department.</p>		<p>Identify Residents with the Potential for the Identified Concern and Take Corrective Action: The regulatory requirement for fire drills was reviewed by the Administrator. A Fire Drill and Disaster Drill schedule was completed. With Respect to What Systemic Measures have been put in place to Address the Stated Concern: An in- service training was held with the Maintenance department to review quarterly fire drill requirements, and the requirement for facility shall attempt to hold a fire and disaster drill with the fire department every 6 months. These activities will be scheduled and put on a grid in the fire drill book, and in the maintenance office. With Respect to How the Plan of Corrective Measures will be Monitored The General Manager will check the fire drill book to ensure the fire drill or fire and disaster drill had been carried out per the schedule by the 25th of each month. DOC: 2/28/2013</p>				

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R000121	<p>410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following:</p> <p>(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 be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. 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. The frequency of repeat testing will depend on the risk of infection with tuberculosis.</p> <p>(2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.</p> <p>(3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings.</p> <p>(4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out.</p>			

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	<p>Based on record review and interview, the facility failed to ensure a health screen which included ensuring a tuberculin skin test was administered to employees prior to having contact with residents for 1 of 5 employees reviewed (CNA (Certified Nursing Assistant) #1.</p> <p>Employee records were reviewed on 1/31/2013 at 9:30 A.M. CNA #1 was hired on 1/28/13. His file did not contain documentation of a tuberculin skin test to rule out the possibility of tuberculosis prior to having contact with residents.</p> <p>During an interview on, 1/31/2013-9:45 A.M., the GM (General Manager) indicated she could not find documentation which indicated it was done.</p>	R000121	<p>R121: Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law. With Respect to the Specific Employee Cited: The results of Employee #1's PPD skin test was documented in the employees personnel file. With Respect to How the Facility will Identify Residents with the Potential for the Identified Concern and Take Corrective Action: The New Hire Checklist will be used and reviewed by the Administrator prior to new direct care employee resident contact. The Administrator will approve the new hire start date. A tracking tool has been implemented to ensure Annual compliance. With Respect to What Systemic Measures have been put in place to Address the Stated Concern: In-service training is scheduled for department managers to review the PPD and communicable disease regulatory requirements, including the community communication and documentation expectations. With Respect to How the Plan of Corrective Measures will be monitored The Administrator will report compliance monthly to the</p>	02/28/2013			

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			General Manager and the community Quality Assurance meeting minutes will reflect compliance and the follow up plan for discrepancies.	

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R000214	<p>410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident.</p> <p>Based on record review and interview, the facility failed to complete an evaluation of a resident prior to admission to the facility. This deficient practice affected 2 of 6 residents reviewed for pre-admission evaluations in a sample of 7 residents reviewed [Residents #5 and #6].</p> <p>Findings include:</p> <p>1. On 1/30/13 at 1:35 P.M., Resident #5's record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus and hypertension. Resident #5 was admitted to the facility on 10/9/12.</p> <p>There was no documentation in Resident #5's record regarding an evaluation prior to admission to the facility.</p> <p>2. On 1/30/13 at 1:00 P.M., Resident #6's record was reviewed. Diagnoses included, but were not limited to, end stage renal disease, hypertension,</p>	R000214	<p>R214: Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law. A. With Respect to the Specific Residents Cited: Residents # 5 and 7 did not experience a negative outcome. A current assessment for Residents # 5 and 7 was completed and placed in the resident record. B. With Respect to How the Facility will Identify Residents with the Potential for the Identified Concern and Take Corrective Action: The requirement for pre-Move-In Assessments was reviewed by the Administrator and the Resident Care Director. The Administrator will review resident Pre-Move-In Assessments and Re-Admission assessments prior to resident move-in or return. C. With Respect to What Systemic Measures have been</p>	02/28/2013			

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	<p>and syncope. Resident #6 was admitted to the facility on 11/10/12.</p> <p>There was no documentation in Resident #6's record regarding an evaluation prior to admission to the facility.</p> <p>On 1/31/13 at 2:00 P.M., in an interview, the General Manager indicated she was unable to provide an evaluation for Residents #5 and #6 prior to their admission dates. At that time, she indicated an evaluation needed to be completed prior to admission to the facility.</p>		<p>put in place to Address the Stated Concern: In-service training was conducted for the Licensed Nurses and the Community Sales team to review Admissions and Pre-Assessment policy, procedures and expectations for Pre-Move-In and re-admission requirements. D. With Respect to How the Plan of Corrective Measures will be Monitored: Resident Care Director/Designee will ensure completion of and provide the Pre-Move-In Assessment to the Administrator prior to the resident moving into the facility or their re-admission. DOC:2/28/2013</p>	

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R000217	<p>410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows:</p> <p>(1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident.</p> <p>(2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review.</p> <p>(3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request.</p> <p>(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.</p> <p>(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.</p> <p>Based on record review and interview, the facility failed to obtain a signature on a service plan and failed to identify/revise services to be provided to residents with significant change/risk to self for 2 of 7 residents reviewed for service plans [Resident #7 and Resident #1].</p>	R000217	<p>R217: Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law. With Respect to the</p>	02/28/2013			

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	<p>Findings include:</p> <p>1. On 1/30/13 at 11:15 A.M., Resident #7's record was reviewed. Diagnoses included, but were not limited to, dementia, hypertension, insomnia, and a history of colon cancer.</p> <p>A "Resident Service Plan" dated 7/19/12, included, but was not limited to, "Fall Prevention: Not a fall risk... no falls since last assessment... Staff will check on resident 2 times per shift... resident has a pendant... Nutrition and Meals: Feeds self independently... Dressing and Grooming: Needs minimal assist... Cognition: Resident [#7] is alert and oriented to person, time, and immediate surroundings... Staff will reorient to current situation as needed... Mood: Resident [#7] is pleasant with others..."</p> <p>A "Nurse's Notes" dated 10/11/12 at 2:00 P.M., included, but was not limited to, "Resident [#7] found in another resident's apartment... states she is lost..."</p> <p>A "Nurse's Notes" dated 11/24/12 at 5:25 P.M., included, but was not limited to, "Resident [#7] pushed</p>		<p>Specific Residents Cited: Resident #1 no longer residents in the community and was discharged prior to this regulatory survey. Resident # 7 did not experience a negative outcome. The Service Plan and Assessment for Resident #7 was reviewed and updated to reflect the resident's clinical status. With Respect to How the Facility will Identify Residents with the Potential for the Identified Concern and Take Corrective Action: A review of the Service Plan Policy was completed by the Resident Care Director and Administrator. An audit of resident service plans was completed to ensure compliance. A Service Plan review schedule has been implemented. The 24 hour report will reflect residents change in condition. The Resident Care Director will review the 24 hour report and make the appropriate changes in the resident service plan. Service Plan updates will be reviewed and signed by resident/responsible parties. With Respect to What Systemic Measures have been put in place to Address the Stated Concern: In-service education has been scheduled for the Resident Care Associates and Assisted Living support associates to review service plan requirements and the communication of resident needs</p>				

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	<p>pendant... was found sitting on floor..."</p> <p>A "Nurse's Notes" dated 11/26/12 at 5:20 P.M., included, but was not limited to, "Resident [#7] having increased confusion and also complaining of bilateral hand weakness... Order received from [physician] to transfer resident to hospital..."</p> <p>A "Nurse's Notes" dated 12/12/12 at 10:00 A.M., included, but was not limited to, "Resident [#7] complains of not being able to dress herself and having a hard time lifting and holding things..."</p> <p>A "Nurse's Notes" dated 12/13/12 at 12:00 P.M., included, but was not limited to, "Resident [#7] having trouble feeding self and getting very irritable and frustrated with staff..."</p> <p>A "Resident Service Plan" dated 12/13/12, included, but was not limited to, "Fall Prevention: Not a fall risk... Staff will check on resident 2 times a shift... Resident has a pendant... Nutrition and Meals: Resident [#7] needs assistance with filling out menu... needs assistance with utensils... Staff will assist with utensils... Dressing and Grooming:</p>		<p>and changes. With Respect to How the Plan of Corrective Measures will be monitored General Manager will randomly review resident service plans monthly based on the assessment schedule to ensure they reflect current services, and are signed and dated by the resident/responsible party. Administrator will review service plans for 6 months. DOC: 2/28/2013</p>				

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	<p>Resident [#7] needs assistance... Cognition: Resident [#7] is alert and oriented to person, time, and immediate surroundings... Staff will reorient resident to current situation as needed... Mood: Resident [#7] is pleasant with others..."</p> <p>The 12/13/12 service plan failed to address Resident #7's significant change in condition related to falls, impaired cognition, generalized weakness, and change in mood/behavior.</p> <p>The service plan, dated 12/13/12 was not signed by the resident or the resident's legal representative.</p> <p>2) Resident #1's closed record was reviewed on 1/30/13. Resident #1 was admitted to the facility on 8/24/12, and had a diagnosis of dementia; progressive over past three years.</p>						

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	<p>A physician signed admission and history physical dated 8/20/2012, indicated, Resident #1 was an elopement risk due to dementia and memory loss.</p> <p>A document titled, "Nurse's Admission Assessment Record" dated 8/24/2012-4:30 P.M., indicated Resident #1 was admitted to the facility on 8/24/2012, she had dementia, she was alert, her memory recall was limited to her date of birth and birth place, she was cooperative and ambulatory.</p> <p>A nurse's note dated 8/24/2012-8:00 P.M., indicated, "Resident alert and confused to short term memory...ambulates with walker."</p> <p>A nurse's note dated 8/25/12-11:00 P.M., indicated, Resident #1 was found on the 3rd floor in her T-shirt and underwear. She was redirected back to her apartment.</p> <p>A nurse's note dated 8/26/2012-8:00 P.M., indicated, Resident #1 was redirected back to her apartment six times. Resident #1 indicated to the staff she did not belong there. The nurse in charge was notified.</p>						

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	<p>A nurse's note dated 8/31/2012-9:45 A.M., indicated, a housekeeper found Resident #1 in the stairway trying to find her way downstairs. The nurse in charge was notified.</p> <p>A nurse's note dated 8/31/12-1:15 P.M., indicated, Resident #1 was brought back to the Assisted Living (AL) side from the Independent Living (IL) side of the building.</p> <p>A nurse's note dated 8/31/2012-1:15 P.M., indicated, Resident #1 was brought back to the AL side from the IL. She was trying to get inside her old apartment. Staff reminded her she lived in the AL side now. Resident indicated to the staff she did not understand why.</p> <p>A nurse's note dated 8/31/2012-230 P.M., indicated, Resident #1 was redirected back to AL after trying to return her door key because she did not live there anymore. The charge nurse was notified.</p> <p>A nurse's note dated 9/2/2012-6:30 P.M., indicated, Resident #1 was escorted back to the AL from the IL because she could not find her way back on her own. The nurse was aware.</p>						

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	<p>Nurse's notes dated 9/2/2012-7:12 P.M., 8:20 P.M., 8:54 P.M., and 9:10 P.M., all indicated, Resident #1 had to be assisted back to AL from the IL by staff.</p> <p>A nurse's note dated 9/4/2012-6:30 P.M., indicated Resident #1 had a small wound to the left top of her head with a moderate amount of bleeding . She was sent to the emergency room and returned with staples intact to the laceration.</p> <p>Nurse's notes dated 9/5/2012, indicated, at 9:00 A.M., Resident #1 was assisted back to AL from IL. She was trying to get into an apartment. At 10:30 A.M., she was back on IL and indicated to staff she did not know where she lived. At 1:00 P.M., she was found on the IL side and assisted back to her apartment on the AL side. At 1:10 P.M., the resident who lived in room 239 complained to staff because Resident #1 kept coming into her apartment. The charge nurse was notified. At 3:00 P.M., she had to be redirected to her apartment. At 4:30 P.M., Resident #1 indicated to staff she did not live there and wanted to know how to get downstairs. The nurse was aware.</p> <p>Nurse's notes dated 9/6/2012,</p>						

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	<p>indicated, at 9:00 A.M., Resident #1 told staff she was leaving and she did not live there. She was redirected to her apartment. At 12:30 P.M., she was redirected from the IL side to the AL side. At 2:00 P.M., she was found on the IL side. Resident #1 indicated to staff she did not live there and was waiting on friends to come and pick her up. She was redirected to the AL side.</p> <p>A nurse's note dated 9/6/2012-8:00 P.M., indicated, Resident #1 had been redirected back to her apartment four times during the shift. Resident #1 was confused and indicated she did not live there.</p> <p>Nurse's notes dated 9/7/2012-9:00 A.M., Resident #1 could not find her apartment and had to be redirected. At 10:30 A.M., she was found on the IL side looking for her apartment. At 11:15 A.M. she was trying to get into another resident's apartment. At 2:00 P.M., staff found her in the parking lot. At 5:00 P.M., she was found trying to get into room 213 because she indicated she lived there.</p> <p>An un-timed nurse's note dated 9/9/2012, indicated, Resident #1 was confused and non-compliant.</p>						

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	<p>A nurse's note dated 9/10/2012-10:00 A.M., indicated, Resident #1 was confused and looking for her apartment all morning even after being directed and taken there several times.</p> <p>Nurse's notes dated 9/14/2012, indicated, at 9:00 A.M., Resident #1 was escorted back to the AL side from the IL side. At 12:30 P.M., she was again returned to the AL side from the IL side. At 7:00 P.M., a nurse's note indicated, she had been escorted back from the IL side five times by staff during the shift. The nurse had been notified.</p> <p>Nurse's notes dated 9/19/2012 indicated at 2:00 P.M., 3:30 P.M., and 4:00 P.M., Resident #1 was found on the IL side and escorted back to the AL side.</p> <p>An untimed nurse's note dated, 9/20/2012 indicated, Resident #1 had been escorted back from the IL side twice because she could not find her apartment.</p> <p>Nurse's notes dated 9/21/2012 indicated, at 10:00 A.M., 12:00 P.M., 3:30 P.M., 6:00 P.M., and 7:00 P.M., Resident #1 had been found on the IL side and had to be redirected back to</p>			

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	<p>her room on the AL side.</p> <p>Nurse's notes dated 9/28/2012, indicated, at 2:30 P.M., Resident #1 was brought back from IL. At 9:50 P.M., staff were called to the IL side to get her because she was very upset and agitated. She refused to return to AL.</p> <p>A nurse's note dated 10/5/2012-8:00 P.M., indicated Resident #1 was found outside in the rain.</p> <p>A nurse's note dated 10/21/2012-6:45 P.M., indicated, "Staff found resident outside the building by back door. Wondering back of the building. Staff redirected res. (resident) but res. was not cooperative to go back to the building. After attempted multiple times res. came to in building...."</p> <p>A nurse's note dated 10/25/2012-3:00 P.M., indicated, Resident #1 was found walking down the hallway with her pants falling down. When staff offered to assist her she became agitated and started "elbowing" the staff.</p> <p>A nurse's note dated 10/29/2013-9:00 A.M., indicated, another resident found Resident #1 in the stairway by her room. This resident assisted</p>			

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	<p>Resident #1 back to the floor were she lived.</p> <p>A nurse's note dated 11/6/12-5:00 P.M., indicated, "Resident became very delusional and stated that she thought a kid had [sic] stole something. Very aggressive because the staff at "this place" wasn't doing anything about it. She hit 3 staff members including her personal caregiver with her walker. In addition, a nurse's note dated 11/7/2012, indicated, "late entry for 11/6/12- Resident hitting kicking multiple staff during evening shift redirected several times. Resident would not cooperate nurse sit [sic] with resident until sleep. DON (Director of Nursing) notified."</p> <p>A nurse's note dated 11/7/2012-12:00 P.M., indicated Resident #1 would be sent out to a hospital for evaluation and treatment.</p> <p>Resident #1's Service Plan dated 8/24/2012, failed to contain any issues regarding her risk of elopement. A monthly service plan update, dated September 2012, indicated, Resident did wander from building to building. It did not indicate she also wandered outside the building. The update did not contain interventions the facility would put in</p>						

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	<p>to place to keep her safe. Even though documentation indicated Resident #1 was confused and not aware of her surroundings, the current service plan dated 8/24/2012, indicated she was alert , oriented to self, time, and immediate surroundings. The service plan also indicated Resident #1 was not a fall risk.</p> <p>During an interview on 1/30/13-3:11 P.M., The General Manager (GM) was asked to provide a service plan (from Resident #1's admission date of 8/24/2012) which indicated Resident #1 had been identified as an elopement risk, including what interventions were in place to keep her safe and a service plan addressing Resident #1's falls and fall risk.</p> <p>During an interview with the ADON (Assistant Director of Nursing and the GM, on 1/31/2013 at 10:00 A.M., the GM indicated she began working at this facility in October 2012. She questioned whether Resident #1 was appropriate for the building but the son was adamant about keeping her there. She provided a copy of an email conversation between her and Resident #1's son. This email indicated, "I talked to you on 10/24/12</p>						

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	<p>about your mother's increased wandering. She is wandering into other resident's apartments, and into the independent living building. When she gets over to the independent living building, she needs their assistance getting back over to our building by wheelchair because her knee hurt [sic], and she is very tired. Our company's national director of resident care has been with us the this week, and she is very concerned that (Resident #1 named) dose {sic} not meet guidelines to remain in assisted living as we cannot ensure her safety. We are suggesting a few possibilities: A 24 hour care giver would allow your mother to remain here in this environment... If your mother could be admitted to the hospital for 3 days, she might be able to utilize skilled care (likely for strengthening if she is having issues with her knee) under Medicare. I am unsure if a hospital would admit her for 3 days though, as her overall health seems stable...."</p> <p>The GM indicated she was unable to provide service plans which addressed the risk of falls or elopement.</p> <p>Review of a current facility policy titled, "Exit -Seeking Residents and Elopement", provided by the GM on</p>			

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	1/31/2013, indicated,... The community will identify exit-seeking residents to minimize resident safety risks. Definition of Elopement: An incident in which a resident leaves community grounds without staff knowledge, and the resident has impaired decision-making abilities and is unaware of his/her own safety needs... Upon Move-in. Residents will be assessed at move-in to determine if they are at risk for exit-seeking activity. This will be accomplished by inquiry of family of past behaviors and observation during first week of residency... Residents who have been identified to be at risk for exit-seeking behaviors will be given an identification bracelet with their name, name of community and community's phone number...."						

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R000273	<p>410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24.</p> <p>Based on observation, record review, and interview, the facility failed to properly store and label food in 1 of 1 kitchen. This deficient practice had the potential to affect 88 of 88 residents who received food from the kitchen.</p> <p>Findings include:</p> <p>On 1/30/13 at 10:00 A.M., sanitation tour of the kitchen was initiated with the Assistant Dining Service Director. At that time, the following was observed:</p> <p>Refrigerator #1:</p> <p>A. 1 tray of individual bowls of jello without a preparation date or covering.</p> <p>B. 1 tray of individual bowls of apple sauce without a preparation date or covering.</p> <p>C. 1 tray of individual bowls of mixed vegetables without a preparation date.</p>	R000273	<p>R273: Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law. With Respect to the Specific Residents Cited: The bowls of jello without a preparation date were removed from the refrigerator and discarded. The bowls of applesauce without a preparation date were removed from the refrigerator and discarded. The bowls of mixed vegetables without a preparation date were removed from the refrigerator and discarded. The bowls of cottage cheese without a preparation date were removed from the refrigerator and discarded. The bowls of peaches without a preparation date were removed from the refrigerator and discarded. The bowls of lettuce without a preparation date were removed from the refrigerator and discarded. The large bowl of croutons that was next to a container of "Sani-Wipes" was removed and discarded. The</p>	02/28/2013			

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	<p>D. 1 tray of individual bowls of cottage cheese without a preparation date or covering.</p> <p>E. 1 tray of individual bowls of peaches without a preparation date or covering.</p> <p>F. 1 tray of individual bowls of mixed lettuce without a preparation date.</p> <p>Counter located near exit to dining room:</p> <p>G. 1 large bowl of croutons with loose plastic wrap covering the bowl placed next to a container of "Sani-Wipes [disinfectant]."</p> <p>H. 2 reusable squeeze bottles of salad dressing without lids, sealed packets of butter and packets of jelly placed less than an inch from 2 small buckets of quaternary solution [disinfectant].</p> <p>Walk-In Refrigerator:</p> <p>J. A 14 pound unopened container of fruit salad stored on the floor.</p> <p>K. Thawing meat [with liquid noted on the tray from thawing] on a rack above left-over, cooked meatloaf.</p>		<p>Sani-Wipes were stored properly. The two reusable squeeze bottles of salad dressing without lids, sealed packets of butter and packets of jelly were removed and discarded. The 14 pound unopened container off fruit was removed from the floor and stored properly. The meatloaf under the thawing meat was removed from the walk-in refrigerator and discarded. The 3 gallon plastic containers of unopened ice cream was removed from the floor and stored properly. The 3 trays of cake type dessert with fruit without a preparation date was removed from the refrigerator and discarded. The large bowl of coconut pudding without a preparation date was removed from the refrigerator and discarded. The 6 wet stacked rectangle metal pans were removed, cleaned and dried properly. The 5 wet stacked rectangle pans were removed, cleaned, dried and stored properly. The 2 wet small skillets were moved, cleaned, dried and stored properly. With Respect to How the Facility will Identify Residents with the Potential for the Identified Concern and Take Corrective Action: A review of the Product Rotation, & Pull and Prep Policies was completed by the Dining Service Director & Assistant Dining Service Director. A drying rack for pans was purchased.</p>	

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	<p>Walk-In Freezer:</p> <p>L. Three, 3 gallon plastic containers of unopened ice cream stored on the floor.</p> <p>Refrigerator #2:</p> <p>M. 3 trays of cake type dessert with fruit. 1 of 3 trays without a preparation date and 2 of 3 trays without covering.</p> <p>N. 1 large bowl of coconut pudding without a preparation date.</p> <p>Drying Rack:</p> <p>O. 6 rectangle, metal pans stacked on top of one another, wet.</p> <p>P. 5 rectangle, metal pans stacked on top of one another, wet.</p> <p>Q. 2 small skillet stacked on top of one another, wet.</p> <p>On 1/31/13 at 9:45 A.M., the General Manager provided the following policy and procedures for the kitchen:</p> <p>A "Product Rotation" policy and procedure, dated 1/31/11, included, but was not limited to, "Label Food:</p>		<p>Review of the Dietary Chemical use and storage Policy and Procedures was reviewed. The Dining Service Director/Designee will conduct daily random monitoring to review food labeling and storage compliance and chemical storage compliance. The dietary daily task assignment was reviewed and updated. The process for ensuring follow up and compliance checks was established. With Respect to What Systemic Measures have been put in place to Address the Stated Concern: In-service education has been scheduled for the kitchen and dining room associates to review sanitation, food thawing, storage, labeling, drying and chemical use, storage policies, procedures and expectations. With Respect to How the Plan of Corrective Measures will be Monitored The Food Service Director/Designee will perform random compliance follow up daily for 30 days and report findings and follow up to the Administrator weekly. Random compliance audits will then be completed and a monthly review will be made by the FSD to the administrator regarding random round compliance findings and follow up.</p>				

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	<p>All potentially hazardous, ready to eat food prepared on site that have been held for longer than 24 hours must be labeled. The label must include name of food and date by which it is to be discarded... Container Transfer: Transfer items between containers properly. If food is removed from its original package, put in a clean, sanitized container and cover it. The new container must be labeled with item name and use by date from original container... Storage Locations: Store food in designated areas. Do not store food near chemicals or cleaning supplies. Food cannot be stored in locker rooms, furnace rooms, janitor closets, restrooms, vestibules or under stairways or pipes..."</p> <p>A "Pull and Prep" policy and procedure, dated 12/8/09, included, but was not limited to, "Thawing: The best choice for thawing is by allowing a slow defrost in refrigerator..."</p> <p>On 1/31/13 at 10:10 A.M., in an interview, the Dining Service Director indicated he was aware of the need for more staff education regarding related to the above deficient practices.</p>			

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R000410	<p>410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents 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 within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.</p> <p>Based on record review and interview, the facility failed to ensure a tuberculin skin test was completed on a resident within 3 months prior to admission or upon admission to the facility. This deficient practice affected 1 of 6 residents reviewed for admission tuberculin skin testing [Resident #5].</p> <p>Findings include:</p> <p>On 1/30/13 at 1:35 P.M., Resident #5's record was reviewed. Diagnoses included, but were not limited to,</p>	R000410	<p>R410: Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law. With Respect to the Specific Residents Cited: Residents #5 did not experience a negative outcome. With Respect to How the Facility will Identify Residents with the Potential for the Identified Concern and Take Corrective Action: A review of the Resident</p>	02/28/2013			

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	<p>diabetes mellitus and hypertension. Resident #5 was admitted to the facility on 10/9/12.</p> <p>A "Vaccine-Immunization Record" included, but was not limited to, "PPD [tuberculin skin test]... date given [first step] 10/10/12... date read 10/12/12... 0 millimeters [negative]..."</p> <p>On 1/31/13 at 2:00 P.M., in an interview, the General Manager indicated she was unable to provide evidence that tuberculin skin testing for Resident #5 had been completed prior to admission to the facility. She indicated she was aware the skin testing must be completed prior to the first day of admission.</p>		<p>PPD admission PPD requirements and Communicable Disease Policy was completed by the Resident Care Director and the Administrator. An audit of resident records was conducted to determine admission PPD completion and compliance. New Resident PPD completion/compliance will be reviewed during Daily Stand Up meetings. Healthcare provider orders will be obtained for new residents to receive PPD skin tests upon admission or healthcare provider documentation of PPD within the past three months. With Respect to What Systemic Measures have been put in place to Address the Stated Concern: In-service education has been scheduled for the Licensed Nurse and Sales Associates to review PPD admission requirements. With Respect to How the Plan of Corrective Measures will be Monitored The Resident Care manager will communicate PPD Compliance to the Administrator after each resident admission. DOC: 2/28/2013</p>				