

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/25/2016
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NAME OF PROVIDER OR SUPPLIER ROSEGATE COMMONS ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 7525 ROSEGATE DRIVE INDIANAPOLIS, IN 46237
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R 0000 Bldg. 00	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: May 23, 24, and 25, 2016</p> <p>Facility number: 012936 Provider number: 012936 AIM number: N/A</p> <p>Census bed type: Residential: 75 Total: 75</p> <p>Sample: 7</p> <p>These State findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Q.R. completed by 14466 on June 01, 2016.</p>	R 0000		
R 0090 Bldg. 00	<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: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the</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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	<p>welfare, safety, or health of a resident.</p> <p>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;</p> <p>(B) poisonings;</p> <p>(C) fires; or</p> <p>(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</p> <p>(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 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 record review and interview,</p>	R 0090	<u>R0090 – June 15,</u>	06/15/2016

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	<p>the facility failed to implement their elopement risk protocol for a resident at risk for elopement as indicated by current facility policy for 1 of 2 residents reviewed for elopement. (Residents #24).</p> <p>Findings:</p> <p>The clinical record review for Resident #24 was completed on 5/23/16 at 11:10 a.m. Diagnoses included, but not limited to, dementia.</p> <p>Review of ASC (American Senior Communities Corporation) Elopement Risk Assessment dated 5/24/15, indicated Resident #24 was not at risk to elope.</p> <p>Nurses Note dated 4/11/2016 at 9:50 p.m., indicated, "Found res [Resident #24] out in hall with some of belongings, crying confused. Not knowing where to put belongs when she [Resident #24] leaves. Called daughter, she came and talked to mother for a long time. Ativan given helped for awhile, later res [Resident #24] had been put to bed, got herself up was out in hall with only a nightgown and brief on. In her wheel chair looking for outside door, states she [Resident #24] is going to her house. Talked to her [Resident #24] for awhile she [Resident #24] allowed signee to take her to her room. She [Resident #24] did</p>		<p><u>2016completion date</u></p> <p>-</p> <p><i>Itis the common practice of this facility to implement an elopement risk protocolfor a resident at risk for elopement.</i></p> <p>Clinicaldirector and general manager addressed LPN #1 as it related to documentationfor resident #24 regarding nursing note dated April 11, 2016 as it pertained topotential exit seeking behavior. LPN #1was in-serviced regarding correct procedures when following company policy andprocedure as it relates to exit seeking behaviors. Resident #24 has order in place and does weara wander guard 24/7 to monitor any future exit seeking behaviors.</p> <p>OnMay 26, 2016 the interdisciplinary team held an At Risk meeting at 11:00a.m. During this meeting a review of allresidents currently without a wander guard was</p>	

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	<p>not want to go to bed yet. Put her in her recliner, she [Resident #24] then asked were does that (back door) lead to can I get outside? informed daughter of this and ADON [Assistant Director Of Nursing] [LPN #1]. We checked on resident."</p> <p>On 4/15/16, at 930 p.m., Nurses Notes indicated "Resident [Resident #24] was found on neighbors porch when AID [CNA/ Certified Nursing Assistant] went in to do routine care. Redirected back inside. Elopement packet procedures initiated. POA [Power Of Attorney], GM [General Manager], Physician all notified. Order for Wanderguard given. 72 hour f/u [follow up] initiated and wanderguard placed."</p> <p>Review of ASC Elopement Risk Assessment dated 4/15/16, indicated Resident #24 is at risk for elopement. Assessment and implementation of safety initiated after elopement occurred.</p> <p>On 5/23/2016 at 9:15 a.m., GM provided incident report dated 4/15/16, indicated Description of incident: "Resident [Resident #24] found sitting on neighbors porch. Complaints or injuries noted: None. Staff Action: Redirected back into apt." Clinical Director, GM, Physician, Family Notified. Family</p>		<p>discussed to determine anypotential residents with possible elopement risk behaviors. No additionalresidents were identified at this time. Elopement Risk Assessments will continue to be completed upon admission,with any exit seeking behaviors, and with any service plan updates if there isa cognitive diagnosis.</p> <p>OnWednesday, June 15 at 2 p.m. a mandatory in-service will take place for allnursing staff regarding proper protocol when handling possible exit seekingbehaviors. There were revisions made tothe elopement policy and procedure to include verbal exit seeking behavior. All staff will receive a copy of the policyduring the in-service on June 15, 2016. The newly updated policy and procedureis made available in the nurse's station for their review and guidance at alltimes. All staff, including</p>	

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	<p>comments: Thank you for letting me know.</p> <p>On 5/24/16 at 10:30 a.m., During interview with ADON indicated "I didn't think this [Nurses Notes dated 4/11/16] was considered exit seeking," as explanation for why Elopement Policy was not followed.</p> <p>On 5/25/16 at 1:30 p.m., During interview with Director of Clinical Services indicated Since Resident [Resident #24] was not actively looking for a door, it was not considered exit seeking.</p> <p>On 5/24/2016 at 9:15 a.m., A review of the policy indicated, Elopement (Risk and Missing Resident) policy dated 7/15, indicated current policy. "Policy: It is the policy of this Community that staff who have residents under their care are responsible for knowing the location of those residents and in the case of a missing resident, ensuring appropriate action is taken. Procedure: Residents identified to be at risk or have a history of elopement will be identified as follows: 1. resident identified to be at risk for elopement will be identified as follows: a. The Community will utilize an ELOPEMENT RISK ASSESSMENT to identify residents at risk to leave the</p>		<p>new nursingstaff will be re-educated as to where and how to use this policy effectively atthe in-service on June 15, 2016. Residents at risk for elopement will continue to be reviewed by theInterdisciplinary team at the monthly " At Risk " meetings.</p> <p>ACQI tool entitled "Elopement Risk" will be implemented to ensure all nursingstaff clearly understands the guidelines for monitoring any exit seekingbehaviors and implementing the policy quickly and effectively. The CQI tool will create a preventativemeasure to ensure nursing staff is following proper protocol. Audit will bechosen at random based on changes in condition and new cognitive diagnosis ofcurrent residents. This audit/CQI willbe completed weekly X1 month, then monthly x 2 months. The director of assisted living clinicalservices / designee</p>				

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	<p>Community unattended. b. A list of residents at risk for elopement is maintained in a book with corresponding pictures. (See Resident Elopement Risk Profile.) Social Services/Clinical Director and/or designee will be responsible to keep the list of residents and profiles current. c. Any resident identified as an "Elopement Risk" will be evaluated for the placement of an "electronic monitoring device."</p> <p>On 5/25/16 at 10:00 a.m. GM provided Morning and Clinical Meetings policy dated 4/2014, indicated Policy "It is the policy of this community to review all pertinent Community information as a team to ensure appropriate follow-up and continuity of care. Procedure: The morning meeting will start in the Community specific to the assigned time by the Executive Director/General Manager and should last no longer than 15 minutes. Items to be reviewed: (Included but not limited to) : Behaviors, Resident Change in condition, Concerns or Grievances. Prior to Morning and Clinical Meeting:6. Clinical Director will gather any new orders as well as the 24-hour report and the emergency call log and any incident reports. Clinical Meeting: 2....b. New or worsening behavior review and completion of Nurse's note, service plan and resident</p>		will be responsible to complete these audits.	

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R 0117 Bldg. 00	<p>profile."</p> <p>Review of Evaluation Agreement for residential Healthcare Services dated 4/15/16, indicated Resident #24 Behaviors: interventions required daily to manage episodic behaviors (Wanderguard).</p> <p>410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which</p>			

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	<p>they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure one staff with a current First Aide Certificate was on site in the facility at all times for 75 of 75 residents.</p> <p>Findings include:</p> <p>Review of the personnel files on 05/24/11 at 1:30 p.m., indicated seven (7) of nine (9) employee files reviewed lacked documentation of First Aid Certification.</p> <p>Employee #03-LPN, Start date 05/04/16, lacked documentation of First Aid Certification.</p> <p>Employee #04-Home Health Aid (HHA), Start date: 03/15/16, lacked documentation of First Aid Certification.</p> <p>Employee #11-LPN, Start date: 04/05/16, lacked documentation of First Aid Certification.</p> <p>Employee #25-Server, Start date 01/13/16, lacked documentation of First Aid Certification.</p> <p>Employee #32-Clinical Director, Start date 05/16/16, lacked documentation of</p>	R 0117	<p><u>R0117 – June 3, 2016 completion date</u></p> <p>- <i>It is the common practice of this facility to ensure that at least one staff with a current first aid certificate will be onsite in the facility at all times.</i></p> <p>Clinical Director immediately scheduled a First Aid Certification class that was held on Friday, June 3, 2016 for all identified nursing staff that did not hold certification. Clinical director also verified the current schedule to ensure all shifts were covered with personnel holding first aid certification.</p> <p>Clinical director scheduled a First Aid certification course and it was completed on Friday, June 3, 2016.</p> <p>Clinical director and General Manager in-serviced on Thursday, May 26, 2016 by the director of assisted living</p>	06/03/2016

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	<p>First Aid Certification.</p> <p>Employee #46-LPN, Start date 12/12/05, lacked documentation of First Aid Certification.</p> <p>Employee #47-Receptionist, Start date 07/18/08, lacked documentation of First Aid Certification.</p> <p>Review of the "Two Week as Worked Schedule " from the week of 05/01/16 to 05/22/16, indicated on 05/15/16, 05/17/16, 05/18/16 and 05/20/16, staff person with First Aid Certification was not scheduled to be on-site for the second shaft.</p> <p>On 05/15/16, second shift, Employee #39 -LPN, Employee #48 LPN only two (2) employees on the schedule, both lacked First Aid Certification.</p> <p>On 05/17/16, second shift, Employee #39 -LPN, Employee #48 LPN only two (2) employees on the schedule, both lacked First Aid Certification.</p> <p>On 05/18/16, second shift, Employee #24-LPN, only employee on the schedule, lacked First Aid Certification.</p> <p>On 05/20/16, second shift, Employee #39-LPN, only employee on the</p>		<p>clinical services that all nursing staff upon hire are to be first aide certified or scheduled to participate in the next available class. If nursing personnel is hired without first aide certification, he or she will only be scheduled with personnel that hold certification until such time that he/she obtain certification. Clinical director and general manager were also re-educated on the importance of routine validation of personnel certification for first aide expiration dates. Clinical director and/or general manager will audit every six months to ensure all certifications for first aide are compliant. Current staff schedules will now reflect the certification status of each nurse per shift.</p> <p>ACQI tool entitled "First Aide Certification" will be implemented to ensure all nursing staff upon hire are first aide certified or</p>	

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R 0349 Bldg. 00	<p>schedule, lacked First Aid Certification.</p> <p>The Administrator acknowledged during interview on 05/25/16 at 2:45 p.m. there were some shifts on second shift that had no First Aid Certified employees scheduled/or worked. The following dates 05/15/16, 05/17/16, 05/18/16 and 05/20/16, a staff person with First Aid Certification was not scheduled to be on-site for the second shift.</p> <p>410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.</p> <p>Based on record review and interview, the facility failed to ensure a clinical record was accurately documented for 1 of 7 residents clinical records reviewed. (Resident #60)</p> <p>Findings include:</p> <p>The clinical record review for Resident #60 was reviewed on 5/23/16 at 1:09 p.m. Diagnoses included, but were not</p>	R 0349	<p>scheduled to participant inthe next available class. Audit willalso ensure that the current schedule validates all shifts are covered withpersonnel holding first aide certification. This audit will be conducted every month for six months by the directorof assisted living clinical services and/or designee.</p> <p><u>R0349 – June 15, 2016 completiondate</u></p> <p><i>- Itis the common practice of this facility to ensure that clinical records areaccurately documented.</i></p> <p>Resident#60 and the physician order for Xanax</p>	06/15/2016

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	<p>limited to, anxiety and chronic pain. The clinical record indicated an admission date of 5/16/16.</p> <p>A review of an admission medication list signed by a physician on 5/3/16, indicated an order for Xanax (a medication used to treat anxiety) 0.5 milligrams (mg), 1/2 tablet to 1 tablet orally twice a day.</p> <p>A review of the Medication Administration Record (MAR) dated 5/16/16 through 5/31/16, indicated an order for Xanax 0.5 mg, 1/2 tablet to 1 tablet orally twice a day.</p> <p>The orders lacked documentation indicating the specific indications for each dose.</p> <p>During an interview on 5/25/16 at 11:55 a.m., LPN (Licensed Practical Nurse) #1 indicated the Xanax order for Resident #60 should have been clarified upon admission and written as 2 separate orders, 1 order for each dose and an indication listed for each dose.</p> <p>On 5/25/16 at 3:00 p.m., LPN #1 indicated a call had been placed to Resident #60's physician to clarify the order.</p>		<p>0.5 mg, 1/2 tablet to one tablet orally, twice a day was submitted to the physician for an order clarification to direct the resident when it is acceptable to take the 0.5mg dose and when to take the 1 tablet dose. On May 27, 2016, we received the order clarification signed and back from physician. The order clarification was documented within the MAR and communicated to resident #60.</p> <p>All residents and their current physician orders for medication have been reviewed by the clinical director and assistant clinical director to ensure that all orders on the MAR are documented accurately. This audit was completed on June 7, 2016. Any identified orders requiring clarification were submitted to his/her physician immediately and documented within the MAR.</p> <p>A mandatory nursing</p>				

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	On 5/25/16 at 3:20 p.m., the Clinical Director provided a policy titled, Telephone Orders/Physician Orders, and indicated it was the current policy used by the facility. The policy indicated, "...Nursing managers and/or designated nurses will review physician orders for accuracy, order omissions, and obtain any necessary order clarifications from Physician or Nurse Practitioner...."		in-service will be held on June 15, 2016 to review the telephone orders/physician orders policy. Clinical director and/or designee will continue to ensure that each month during the pharmacy reconciliation of each residents ordered medications are reviewed for accuracy and signed by two nurses. Clinical director and/or designee will review all new orders and changes in orders at least three times per week for accuracy. ACQI tool entitled "Physician Orders" will be implemented to ensure accuracy of current orders. This tool will be monitored weekly times one month, then monthly times two months. Director of assisted living clinical services and/or designee will be responsible to complete this CQI audit.	