

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/30/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00129879.</p> <p>Complaint IN00129879 - Substantiated. Federal/state deficiencies related to the allegations are cited at F309, F329 and F514.</p> <p>Survey dates: July 22, 23, 24, 25, 26, 29 & 30, 2013.</p> <p>Facility number: 004700 Provider number: 155741 AIM number: 100266630</p> <p>Survey team: Marcy Smith, RN-TC Dinah Jones, RN (July 22, 23, 24, 25, & 26, 2013) Patti Allen, SW (July 22, 23, 24, 25, & 29, 2013) Leia Alley, RN (July 22, 23, 24, 25, 26, & 29, 2013)</p> <p>Census bed type: SNF/NF: 38 Total: 38</p> <p>Census payor type: Medicare: 4</p>	F000000	<p>This plan of correction is the center's credible allegation of compliance. Preparation and/or completion of this plan of correction does not constitute admission or agreement by the provider of the facts alleged of the conclusion set forth the in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by state and federal law.</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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/30/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Medicaid: 31 Other: 3 Total: 38</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on August 06, 2013; by Kimberly Perigo, RN.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/30/2013	
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F000225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p>	F000225	Corrective actions will be	08/29/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/30/2013	
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Based on record review and interview, the facility failed to report an allegation of abuse immediately to the facility administrator as indicated by facility policy. (Resident #37, #48 and LPN #1)</p> <p>Findings Include:</p> <p>A facility Reporting Information form dated July 8th, 2013; was reviewed on 7/25/13 at 3:00 p.m. The report indicated Resident #37 and Resident #48 were in a Resident to Resident altercation. Resident #37 was alleged to have pushed Resident #48, who was in a self propelled wheel chair, into a fence with an electric wheel chair.</p> <p>The report indicated, "The incident occurred on Friday July 5th, 2013, and was reported to the administrator on Monday July 8th, 2013 by [Resident #48's initials] at noon. When the administrator asked [Resident #48's initials] why she did not report it sooner, [Resident #48's initials] stated she told Nurse K [Licensed Practical Nurse, [LPN] #1] and Called [name of activities director]. Administrator spoke with K and K stated that she did not report to her that Resident #37 backed her into the fence but she did report that</p>		<p>accomplished for those residents found to have been effected by the deficient practice; The residents were separated. An attempt to discuss the incident residents # 48 and # 37 was set up and Resident # 37 declined. A conference was held and no further incidents have occurred. LPN # 1 was re-educated on reporting allegations of abuse immediately. LPN #1 also received counseling. Failure to report any further allegations of abuse immediately will not be tolerated and could lead to suspension up to and including termination. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken. All of the residents have the potential to be affected. The facility will re-educate the staff in the importance of reporting an allegation immediately and policy and procedure will be reviewed. New hires will be educated during the orientation process. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur. The staff will sign a statement of understanding any violation of the policy will not be tolerated. Violation of the policy could result in disciplinary action, suspension up to and including termination. All allegations of abuse and reports of any abuse will be</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/30/2013
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Resident #37 was playing that 'n-----' music."</p> <p>A review of a facility Employee Counseling Form for LPN #1, One on One Inservice, dated 7/8/13, indicated a Statement by Employee: "Resident #48 stated she thought [Resident #37's name] was trying to run into her. When writer asked [Resident #37's name] about event, [Resident #37's name] stated that this event didn't occur and was not true. Writer came to conclusion because both residents are sound of mind that no validity was found in this statement from [Resident #48's name]. Writer took steps to complete whether or not this was actual and factual incident there fore not deemed to be reported to supervisor."</p> <p>A review on 7/26/13 at 2:00 p.m., of a facility document titled, Abuse Prohibition Policy/Procedure, dated 8/2/05 and recently revised on 7/22/13, indicated, "Policy. It is the policy of [name of facility] to keep its residents free from abuse, neglect, involuntary seclusion, and misappropriation of property. In the event of an incident, the following procedure will be followed. Procedure. 1. All staff members are responsible to intervene on behalf of</p>		submitted to Quality Assurance for review. Addendum: The monitoring of the systemic changes will be ongoing. Date of Completion- August 29, 2013		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/30/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>the resident. 2. The incident must be reported to the Administrator Immediately."</p> <p>During an interview on 7/26/13 at 2:30 p.m., the facility Administrator indicated she gave LPN #1 a disciplinary write up notice for not reporting an allegation of Resident to Resident abuse immediately to her.</p> <p>3.1-28(e)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/30/2013	
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F000226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to implement their policy and procedure in regard to reporting an allegation of abuse for 1 of 2 allegations of abuse reviewed for policy and procedure implementation. (Resident #37, #48 and LPN #1)</p> <p>Findings Include:</p> <p>A facility Reporting Information form dated July 8th, 2013; was reviewed on 7/25/13 at 3:00 p.m. The report indicated Resident #37 and Resident #48 were in a Resident to Resident altercation. Resident #37 was alleged to have pushed Resident #48, who was in a self propelled wheel chair, into a fence with an electric wheel chair.</p> <p>The report indicated, "The incident occurred on Friday July 5th, 2013 and was reported to the administrator on Monday July 8th, 2013, by [Resident #48's initials] at noon. When the</p>	F000226	<p>Corrective actions will be accomplished for those residents found to have been effected by the deficient practice; The residents were separated. An attempt to discuss the incident residents # 48 and # 37 was set up and Resident # 37 declined. A conference was held and no further incidents have occurred. LPN # 1 was re-educated on reporting allegations of abuse immediately. LPN #1 also received counseling. Failure to report any further allegations of abuse immediately will not be tolerated and could lead to suspension up to and including termination. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken. All of the residents have the potential to be affected. The facility will re-educate the staff in the importance of reporting an allegation immediately and policy and procedure will be reviewed. New hires will be educated during the orientation process. What measures will be put into place or what systemic changes will be made to ensure that the deficient</p>	08/29/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/30/2013	
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>administrator asked [Resident #48's initials] why she did not report it sooner, [Resident #48's initials] stated she told Nurse K [Licensed Practical Nurse, [LPN] #1] and Called [name of activities director]. Administrator spoke with K and K stated that she did not report to her that Resident #37 backed her into the fence but she did report that Resident #37 was playing that 'n-----' music."</p> <p>A review of a facility Employee Counseling Form for LPN #1, One on One Inservice, dated 7/8/13, indicated a Statement by Employee: "Resident #48 stated she thought [Resident #37's name] was trying to run into her. When writer asked [Resident #37's name] about event, [Resident #37's name] stated that this event didn't occur and was not true. Writer came to conclusion because both residents are sound of mind that no validity was found in this statement from [Resident #48's name]. Writer took steps to complete whether or not this was actual and factual incident there fore not deemed to be reported to supervisor."</p> <p>A review on 7/26/13 at 2:00 p.m., of a facility document titled, Abuse Prohibition Policy/Procedure, dated 8/2/05, and recently revised on</p>		<p>practice does not occur. The staff will sign a statement of understanding any violation of the policy will not be tolerated. Violation of the policy could result in disciplinary action, suspension up to and including termination. All allegations of abuse and reports of any abuse will be submitted to Quality Assurance for review. Addendum: The monitoring of the systemic changes will be ongoing. Date of Completion- August 29, 2013</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/30/2013
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>7/22/13, indicated, Policy. It is the policy of [name of facility] to keep its residents free from abuse, neglect, involuntary seclusion, and misappropriation of property. In the event of an incident, the following procedure will be followed. Procedure. 1. All staff members are responsible to intervene on behalf of the resident. 2. The incident must be reported to the Administrator Immediately."</p> <p>During an interview on 7/26/13 at 2:30 p.m. the facility Administrator indicated she gave LPN #1 a disciplinary write up notice for not reporting an allegation of Resident to Resident abuse immediately to her.</p> <p>3.1-28(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/30/2013	
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to ensure a physician was notified regarding the possibility of a resident being allergic to a medication which had been prescribed and administered and medications were given according to the residents plan of care. This had the potential to affect 1 of 3 residents reviewed for receiving unnecessary medications in a sample of 11. (Resident #A)</p> <p>Findings include:</p> <p>The closed clinical record of Resident #A was reviewed on 7/29/13 at 9:00 a.m.</p> <p>Diagnoses for Resident #A included, but were not limited to pneumonia, Parkinson's disease, anxiety, congestive heart failure and paranoid schizophrenia.</p> <p>Resident #A was admitted to the facility on 11/19/07, was discharged</p>	F000309	<p>Corrective actions will be accomplished for those residents found to have been effected by the deficient practice; Resident #A as stated in the 2567 the pharmacist was notified of allergy to macrolides. The resident had taken the antibiotic without any adverse reactions. Resident A did receive the medications as stated in the 2567 from another nurse. However the nurse did not initial on the Medication Administration Record. Resident # A has since RHC'd. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken Any resident with an Allergy has the capacity to be affected. All medical records will be reviewed and allergies written on the spine of the medical record the Medication Administration Record will be reviewed for all allergies and documented if not. All residents with allergies or responsible party will be interviewed regarding type of allergic reactions resident sustains from allergy to</p>	08/29/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/30/2013
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>to a local hospital on 5/4/13 and died at the hospital on 5/12/13.</p> <p>1. A physician's order, dated 4/17/13, indicated Resident #A was supposed to start receiving ZPack (azithromycin - an antibiotic) as directed for an upper respiratory infection. The resident received the first dose on 4/17/13.</p> <p>Recapitulated physician's orders for January, February, March and April, 2013, indicated the resident was allergic to Macrolides. Azithromycin is one of the drugs in this classification.</p> <p>During an interview with Resident #A's sister on 7/28/13 at 7:15 p.m., she indicated LPN (Licensed Practical Nurse) #4 had contacted her on 4/18/13 and told her the physician had ordered azithromycin for Resident #A. The sister indicated at that time she told LPN #4 that Resident #A could not have azithromycin, that he was allergic to it. She indicated LPN #4 told her he would get a different antibiotic ordered.</p> <p>Medication Administration Records for Resident #A, for April, 2013, indicated he received azithromycin on</p>		<p>medication and this information will be documented in the medical record. All residents with that refuse medications from one nurse will be re-approached and the medication will be offered again. If resident continues to refuse another nurse will approach the resident to offer the medication. All medications administered or refused will be documented on the Medication Record as indicated by initialing medication and circling it and documenting the reason for refusal on the back of the Medication Administration Record. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur. All residents with allergies will be reviewed weekly for appropriate documentation. All physicians' new orders will be reviewed in morning meeting to assure that residents are not allergic to medications ordered for them. The Medication records will be audited on a daily basis until compliance is made then will be audited 3 times a week. The nurses were reeducated on the process of proper documentation on refusals of medications and if needed to request another nurse to give the medications. How the corrective actions will be monitored to ensure the deficient practice will not recur, ie what quality assurance program will be put into place The results of the</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/30/2013	
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>4/17, 4/18, 4/19, 4/20, 4/21 and 4/22, 2013.</p> <p>During an interview with LPN on 7/29/13 at 4:00 p.m., he indicated after Resident #A's sister told him the resident was allergic to azythromycin, he had called the pharmacy, and the pharmacist told him Resident #A had taken this antibiotic before. LPN #4 indicated he did not call Resident #A's physician to see if the physician still wanted to prescribe this medication, even though the resident's sister said he was allergic to it and signed physician orders indicated the resident was allergic to drugs in the class of macrolides.</p> <p>2. Recapitulated orders for April, 2013, indicated Resident #A was supposed to receive multiple medications, including the following:</p> <p>Xanax 1mg. BID (twice a day) This is an anti-anxiety medication. Aspirin 81 mg daily Sinemet 10-100mg BID (this is an anti-Parkinson's medication_ Celexa 20 mg BID (this is an antidepressant) Synthroid 50 micrograms daily (a medication for thyroid conditions) Glucophage 1000 mg. BID (a medication to treat high blood sugar)</p>		findings will be reported to the QA Committee on a monthly basis this will be on going. Addendum: In the event a resident refuses a medication, the nurse will ask for a reason for the refusal, and explain risks and benefits to resident. This will be documented on the back of the Medication Administration Record. By what date the systemic changes will be completed Date of Completion- August 29, 2013				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/30/2013
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Seroquel 150mg. BID (this is an anti-psychotic medication)</p> <p>The Medication Administration Record for Resident #A, for April, 2013 indicated:</p> <p>He did not receive his Xanax on 4/6/13 at 8:00 p.m. 4/14/13 at 8:00 a.m. and 4/19/13 at 8:00 p.m.</p> <p>He did not receive his aspirin on 4/14/13.</p> <p>He did not receive his Sinemet on 4/14 13 at 8:00 a.m., and 4/19/13 at 8:00 p.m.</p> <p>He did not receive his Celexa on 4/14/13 at 8:00 a.m.</p> <p>He did not receive his Synthroid on 4/23/13, 4/27,13 and 4/28/13.</p> <p>He did not receive his Glucophage on 4/14/13 at 8:00 a.m.</p> <p>He did not receive his Seroquel on 4/14/13 at 8:00 a.m.</p> <p>There was no documentation in Resident A's record which indicated why he did not receive these medications.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/30/2013
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>During an interview with Resident #A's sister on 7/28/13 at 7:15 p.m., she indicated the resident would sometimes refuse his medications. She indicated she had spoken with facility staff in February, 2013, and thought they had agreed to get a different nurse to try and administer the medications when he was refusing. There was no documentation in the resident's record which indicated a different nurse had been requested to try and administer the above medications.</p> <p>On 4/17/13, a care plan was created which indicated, "Hx [history] of refusing...medicines especially if given by a male..." Interventions included, "Let female staff member who has the best relationship with the resident approach him when he is resistant."</p> <p>This Federal tag relates to Complaint IN00129879</p> <p>3.1-37(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/30/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure nurses observed and documented the reasons for giving an as needed anti-anxiety medication and it's effectiveness and alternative interventions were offered prior to giving the medication. This had the potential to affect 1 of 11 residents reviewed for unnecessary medications. (Resident #A)</p> <p>Findings include:</p>	F000329	<p>Corrective actions will be accomplished for those residents found to have been effected by the deficient practice; Resident A RHC How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken All other residents have the capacity to be affected. Medication Administration records will be audited 5 days a week for accuracy. Any nurse found non-compliant disciplinary actions will be taken after being</p>	08/29/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/30/2013	
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>The closed clinical record of Resident #A was reviewed on 7/29/13 at 9:00 a.m.</p> <p>Diagnoses for Resident #A included, but were not limited to pneumonia, Parkinson's disease, anxiety, congestive heart failure and paranoid schizophrenia.</p> <p>Resident #A was admitted to the facility on 11/19/07, was discharged to a local hospital on 5/4/13 and died at the hospital on 5/12/13.</p> <p>A physician's order, dated 4/17/13, indicated Resident #A could receive Ativan, (an anti-anxiety medication) 1 mg. (milligram) every 8 hours as needed for anxiety and/or agitation.</p> <p>Medication Administration Records for April, 2013, indicated Resident #A received Ativan on 4/18 and 4/22, 2013.</p> <p>A Controlled Drug Use Record indicated Resident #A was given Ativan twice on 4/29, and one time on 4/30, 5/1, 5/2, 5/3 and 5/4, 2013. These administrations were not documented on the Medication Administration Records for April and May, 2013.</p>		<p>reeducated. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur. All nurses will be reeducated in regards to appropriate documentation of as needed medications. All controlled drug use records will be audited against Medication Administration Records 5 days a week for compliance. If not in compliance the nurse will be reeducated and disciplinary actions will be given appropriately. The results of the audits will be discussed in the next morning meeting. How the corrective actions will be monitored to ensure the deficient practice will not recur, ie what quality assurance program will be put into place. The results of the audits will be taken to the next morning meeting and monthly to QA meeting. The disciplinary process of the nurse found not in compliance will also be discussed in the morning meeting and at QA to assure efficacy. Addendum: The monitoring of the systemic changes will be ongoing. By what date the systemic changes will be completed. Date of Completion- August 29, 2013</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/30/2013
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Resident #A's record did not indicate why the as needed medication was given or if it was effective, or if any alternative interventions were attempted prior to giving it.</p> <p>A care plan for Resident #A, dated 4/17/13, indicated, "Risk for side effects from...Ativan prn [as needed]..." A goal was, "Will not have any side effects from medication." Interventions included, "Monitor behaviors and report to MD [medical doctor] to assure lowest therapeutic dose given."</p> <p>The resident's record did not indicate any behaviors, anxiety, or agitation; for the above days; when he received the prn Ativan.</p> <p>During an interview with the Director of Nursing on 7/30/13 at 9:30 a.m., she indicated the nurses are supposed to document on the back of the Medication Administration record why the prn medications were given, if they were effective and what alternative interventions were attempted prior to giving the medication.</p> <p>This Federal tag relates to Complaint IN00129879.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/30/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-48(a)(6)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/30/2013	
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F000441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview, and</p>	F000441	Corrective actions will be accomplished for those residents	08/29/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/30/2013
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>record review, the facility failed to ensure implementation of contact isolation precautions as indicated by facility policy, by all staff. (Social Service Director and Resident #65)</p> <p>Findings Include:</p> <p>During an observation of medication administration on 7/26/13 at 4:25 p.m., and in the presence of Licensed Practical Nurse (LPN) #1, the facility's Social Services Director was sitting in Resident #65's wheel chair, and passing a pen back and forth with the resident to sign papers, with no gown around her body or gloves on her hands.</p> <p>The clinical record for Resident #65 was reviewed on 7/29/13 at 10:30 a.m.</p> <p>Diagnoses for Resident #65 included but were not limited to, MRSA (antibiotic resistant strain of staph bacteria) in the nares (nostrils).</p> <p>A physician's order dated 7/25/13 indicated, "DC [discontinue] droplet isolation, continue contact precautions for MRSA [of the] Nares."</p> <p>During an interview with the facility Administrator on 7/29/13 at 10:00</p>		<p>found to have been effected by the deficient practice; Resident # 65 was discharged from the facility. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken No other residents are in isolation for MRSA at present. The Social Service Director was inserviced. Staff will be reeducated on the isolation procedures. Any staff member found not to be compliant with isolation precautions will be disciplined.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur.</p> <p>Anyone on Isolation will be discussed in Morning Meeting. All staff will be reeducated on proper Isolation Precautions for each resident as indicated. All staff during rounds will be monitored for appropriate actions with someone on isolation. The results of rounds will be discussed in Morning Meeting and staff member will be reeducated on proper actions and disciplinary actions if indicated. How the corrective actions will be monitored to ensure the deficient practice will not recur, ie what quality assurance program will be put into place The results of the findings reviewed in Morning Meeting will be taken to the QA Committee for review. Reeducation will occur if needed.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/30/2013	
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>a.m., she indicated she spoke to the Social Services Director and the Social Services Director indicated she was so focused on her task that she didn't notice Resident #65 had precautions in regard to contact isolation, and she failed to see the sign and the equipment outside Resident #65's room.</p> <p>A review on 7/29/13 at 10:14 a.m., of a facility policy titled, Infection Control Policy/Procedure (undated) indicated, "POLICY. The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of diseases and infection. PROCEDURE. ... (2) Decides what procedures (such as isolation) should be applied to an individual resident, including, but not limited to, written, current infection control program policies and procedures for an isolation/precautions system to prevent the spread of infection that isolates the infectious agent and includes full implementation of universal precautions."</p> <p>3.1-18(b)(1)</p>		<p>Addendum: The monitoring of the systemic changes will be ongoing. By what date the systemic changes will be completed. Date of Completion- August 29, 2013</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/30/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/30/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000514 SS=D	<p>483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to ensure physician ordered oxygen saturation checks were documented for a resident receiving oxygen. (Resident #A)</p> <p>Findings include:</p> <p>The closed clinical record of Resident #A was reviewed on 7/29/13 at 9:00 a.m.</p> <p>Diagnoses for Resident #A included, but were not limited to pneumonia, Parkinson's disease, anxiety, congestive heart failure and paranoid schizophrenia.</p> <p>A physician's order for April, 2013, indicated Resident #A was to receive</p>	F000514	<p>Corrective actions will be accomplished for those residents found to have been effected by the deficient practice;</p> <p>Resident # A RHC</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken</p> <p>Any Resident on Oxygen with the orders to keep Oxygen levels at a given percent have the capacity to be affected. All residents Medical Records and Medication Administration records will be audited to indicate that the oxygen saturation was documented.</p> <p>What measures will be put into place or what systemic changes will</p>	08/29/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/30/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>oxygen at 2 - 4 liters per nasal cannula. Staff could adjust the amount of oxygen he was receiving, in order to keep his oxygen saturation level over 90%. Oxygen saturation checks were ordered to be done every shift.</p> <p>A Medication Administration Record for April, 2013, indicated the oxygen saturation (O2) checks were done every shift as evidenced by staff putting their initials in the correct space for the date and shift. Of 90 opportunities to enter the results of the O2 saturation checks, only 17 spaces contained a percentage. The rest of the 73 spaces contained initials only.</p> <p>During an interview with the Director of Nursing on 7/30/13 at 9:30 a.m., she indicated the nurses are supposed to document the O2 saturation percentage each time they check it. She indicated she had talked with the nurses about this.</p> <p>This Federal tag relates to Complaint IN00129879.</p> <p>3.1-50(a)(1)</p>		<p>be made to ensure that the deficient practice does not occur.</p> <p>Nurses will be inserviced on the importance of documenting the Oxygen levels and proceed appropriately if not within the parameters given by the physician. The Medication Administration Record will be audited and results taken to the Morning Meeting.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur, ie what quality assurance program will be put into place</p> <p>The results of the audits and any noncompliance actions will be discussed at QA.</p> <p>By what date the systemic changes will be completed.</p> <p>Date of Completion- August 29, 2013</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/30/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE