

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 02/23/2015 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260 |
|--|--|

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

| | | | | |
|-----------------------|--|-------|---|--|
| F 000 Bldg. 00 | <p>This visit was for a Recertification and State Licensure Survey. This visit included the investigation of Complaint IN00164763.</p> <p>Complaint IN00164763: Substantiated. No deficiencies to the allegations are cited.</p> <p>Survey dates: February 15, 16, 17, 18, 19, 20, 21, 22 and 23, 2015.</p> <p>Facility number: 000195 Provider number: 155298 AIMS: 100267690</p> <p>Survey Team: Sandra Nolder, RN--TC (February 15, 16, 17, 18, 19, 20, 22 and 23, 2015) Michelle Hosteter, RN (February 15, 16, 17, 18, 19, 20 and 23, 2015) Gloria Bond, RN (February 15, 16, 17, 18, 19, 20, 21 and 23, 2015) Mary Jane Fisher, RN (February 23, 2015)</p> <p>Census bed type: SNF: 8 SNF/NF: 47 Total: 55</p> | F 000 | <p>This plan of correction is the facility's credible allegation of compliance. Preparation and/or execution of this plan of corrections does not constitute 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 and/or executed solely because it is required by the provisions of federal and state 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: 155298 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 02/23/2015 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260 |
|--|--|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---------------------------|--|---------------|---|----------------------|
| F 155 SS=B Bldg. 00 | <p>Census payor type: Medicare: 5 Medicaid: 47 Other: 3 Total: 55</p> <p>Sample: 6</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review was completed by Tammy Alley RN on March 2, 2015.</p> <p>483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> | | | |

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 02/23/2015 |
|--|---|---|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260 |
|--|--|

| (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 interview and record review, the facility failed to ensure there was adequate CPR (CardioPulmonary Resuscitation) certified staff to cover all shifts. This deficient practice had the potential to affect 55 of 55 residents residing in the facility. (RN #1, RN #2, RN #3, RN #4, LPN #5, LPN #6, LPN #7, LPN #8, LPN #9, LPN #10, LPN #11, LPN #12, LPN #13, LPN #14, LPN #15, LPN #16, LPN #17, LPN #18, LPN #19 and LPN #20)</p> <p>Findings include:</p> <p>The employee records were reviewed on 2/23/15 at 10:00 A.M. The records indicated the facility had 8 out of 28 scheduled nurses certified in CPR. The nurses who were not CPR certified were RN #1, RN #2, RN #3, RN #4, LPN #5, LPN #6, LPN #7, LPN #8, LPN #9, LPN #10, LPN #11, LPN #12, LPN #13, LPN #14, LPN #15, LPN #16, LPN #17, LPN #18, LPN #19 and LPN #20.</p> <p>The employee schedule as worked for 2/3/15 through 2/15/15, was reviewed. The schedules indicated there were no CPR certified nurses working for the following shifts: 2/03/15--10:00 p.m.-6:30 a.m. 2/05/15--10:00 p.m.-6:30 a.m. 2/06/15--2:00 p.m.-10:30 p.m.</p> | F 155 | <p>1. What correction actions will be accomplished for those residents found to have been affected by the deficient practice? No residents were identified for the alleged deficient practice, therefore no corrective action can be accomplished for a specific resident Employee records have been audited to identify what nurses need CPR training</p> <p>2. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken? Residents residing in the facility have the potential to be affected by the alleged deficient practice CPR training to be provided by American Red Cross on 3/24/15 for nurses that do not have an up to date CPR certification</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that deficient practice does not recur? Director of Nursing will train the Director of Staff Development on requirements for nurse CPR certification Director of Staff Development will track all CPR certification expiration dates and will schedule further training as needed</p> <p>4. How will the corrective actions be monitored to ensure the deficient practice will not recur? Director of Nursing or designee will monitor certification</p> | 03/25/2015 |

| | | | | | |
|--|--|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 02/23/2015 |
| NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| F 156 SS=A Bldg. 00 | <p>10:00 p.m.-6:30 a.m. 2/07/15--2:00 p.m.-10:30 p.m. 10:00 p.m.-6:30 a.m. 2/08/15--2:00 p.m.-10:30 p.m. 2/09/15--10:00 p.m.-6:30 a.m. 2/13/15--2:00 p.m.-10:30 p.m. 2/14/15--10:30 p.m.-6:30 a.m. 2/15/15--10:30 p.m.--6:30 a.m.</p> <p>During an interview on 2/23/15 at 2:00 p.m., the Human Resource Manager indicated she did not have any further CPR certifications to provide at that time.</p> <p>3.1-4(f)(8)</p> <p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are</p> | | monthly for 6 months, results will be submitted to the QA Committee for review and follow up, non compliance with facility procedures may result in re-education and/or progressive disciplinary action | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 02/23/2015 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260 |
|--|--|

| (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>included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State</p> | | | |

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 02/23/2015 |
|--|---|---|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260 |
|--|--|

| (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>licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>Based on interview and record review, the facility failed to inform residents their skilled nursing services had ended in a timely manner for 2 of 3 residents reviewed for Notice of Medicare Non-Coverage. (Residents #30 and #34)</p> <p>Findings include:</p> <p>1. A "Telephonic Notification" notice dated 1/26/15 indicated Resident #30's legal representative was notified by telephone and appeal rights and the timeframe was explained</p> <p>A copy of the notice was dated 1/28/15,</p> | F 156 | <p>1. What correction actions will be accomplished for those residents found to have been affected by the deficient practice? Residents #34, 30: no longer reside in the facility No current residents were identified for the alleged deficient practice, therefore no corrective action could be accomplished</p> <p>2. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken?</p> <p>Residents who receive skilled services have the potential to be affected by the alleged deficient practice Social Services Director, Business Office, Admissions</p> | 03/25/2015 |

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 02/23/2015 |
|--|---|---|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260 |
|--|--|

| (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>indicated.the "Notice of Medicare Non-Coverage" notice, which indicated, "The Effective Date Coverage of Your Current Skilled Nursing Services Will End: [date]... Please sign below to indicate you received this notice. I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting my QIO [Quality Improvement Organization]...." lacked a signature and date by the resident's legal representative. The notice and resident's medical record lacked documentation the facility had attempted three times to get the notice signed by the resident's legal representative.</p> <p>Resident #30's record was reviewed on 2/20/15 at 4:36 p.m. Diagnoses included, but were not limited to, persistent mental disorders, generalized pain, osteoporosis, atrial fibrillation, dementia and Alzheimers disease.</p> <p>During an interview on 2/20/15 4:05 p.m., the SSD (Social Service Director)indicated the Non-coverage notice for Resident #30's service end date was 1/28/15, and was her ending date of service for therapy services. She indicated she was being discharged on 1/29/15. She indicated she would not</p> | | <p>Director were in-serviced by the corporate nurse consultant on 2/27/15 for timely notification to POA/resident of Notice of Medicare Non Coverage letters 3. What measures will be put into place or what systemic changes will be made to ensure that deficient practice does not recur? Social Service Director, Business Office Manager, Assistant Business Office Manager, and Admissions Director were in-serviced by corporate nurse consultant on 2/27/15 on timely notification to POA/resident of Notice of Medicare non coverage letters Social Service Director will complete Notice of Medicare Non Coverage tracking tool for discharges of residents with skilled services 4. How will the corrective actions be monitored to ensure the deficient practice will not recur? Social Service Director will submit Non Coverage Notification of Medicare tracking tool monthly for 6 months to the QA Committee for review and follow up, non compliance with facility procedures may result in re-education and/or progressive disciplinary action</p> | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 02/23/2015 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260 |
|--|--|

| (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>necessarily see the family when they came into the facility because the resident resided on the second floor and the SSD's office was on the third floor and she did not get the notice signed.</p> <p>2. A "Telephonic Notification" notice dated 9/14/14 indicated Resident #34's legal representative was notified by telephone and appeal rights and the timeframe was explained</p> <p>A copy of the notice was dated 9/18/14, indicated the "Notice of Medicare Non-Coverage" notice, which indicated, "The Effective Date Coverage of Your Current Skilled Nursing Services Will End: [date]... Please sign below to indicate you received this notice. I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting my QIO [Quality Improvement Organization]..." lacked a signature and date by the resident's legal representative. The notice and resident's medical record lacked documentation the facility had attempted three times to get the notice signed by the resident's legal representative.</p> <p>Resident #34's record was reviewed on 2/20/15 4:25 p.m. Diagnoses included,</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 02/23/2015 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260 |
|--|--|

| (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>but were not limited to, depressive disorder, acute myocardial infarction (heart attack), diabetes mellitus, insomnia, and UTI.</p> <p>During an interview on 2/20/15 4:05 p.m., the SSD indicated Resident #34's service end date was 9/18/14, and was for therapy services, She indicated the resident was discharged on 9/19/14. The SSD indicated the resident's son was in and out of the facility often and she did not know when he was going to be in the facility to get the Non-Coverage letter signed, so she did not get the notice signed.</p> <p>At that time the SSD indicated she was responsible for giving all the Non-Coverage notices. She indicated she had not realized if she gave a telephone notification of the Non-Coverage notice, she had to follow up with getting the Non-Coverage notice signed. She indicated after she gave a telephone notification of the Non-Coverage notices, then the Business Office sent a copy of the notices to the families by certified mail. The SSD indicated she had not known if the business office sent a letter with the Non-Coverage notice asking the responsible party to sign the Non-Coverage notice, then send it back or if the business office sent the notice as</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 02/23/2015 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260 |
|--|--|

| (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 copy for follow up to the phone notification.</p> <p>During an interview on 2/20/15 5:00 p.m., the BOM (Business Office Manager) indicated there were three ways the facility tried to contact the responsible party for the Non-Coverage notices to notify them their skilled services were ending. The first attempt to get the notice signed was while the responsible party was in the facility visiting the resident, the second attempt was a phone notification, then the notice was sent by certified mail to have it signed by the responsible party. The BOM indicated she was not sure if the SSD told the responsible party to sign the Non-Coverage notice and send it back when she discussed the Non-Coverage notice on the telephone. However, the BOM indicated the Business Office had not sent letters with the Non-Coverage notices to explain to the responsible parties the Non-Coverage notices needed to be signed and sent back to the facility. The BOM indicated she assumed unless the SSD told her otherwise, the SSD had told the family to sign the notices, then send them back to the facility.</p> <p>3.1-4(f)(3)</p> | | | |

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 02/23/2015 |
|--|---|---|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260 |
|--|--|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---------------------------|--|---------------|---|----------------------|
| F 221 SS=D Bldg. 00 | <p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>Based on observation, interview and record review, the facility lacked an assessment for a physical restraint for 1 of 2 residents being reviewed for physical restraints. (Resident #21)</p> <p>Findings include:</p> <p>On 2/16/15 at 9:33 a.m., Resident #21 was observed with her seatbelt fastened around her waist, attached to the wheelchair, with the back of the Tilt-N-Space wheelchair leaned back. At that time, LPN #20 indicated the resident was unable to release her seatbelt, but the seatbelt was not considered a restraint. She indicated therapy had the seatbelt on her for positioning because she thrust her hips forward and it was for safety to prevent her from falling out of the chair.</p> <p>Resident #21's record was reviewed on 2/19/15 at 11:16 a.m. Diagnoses included, but were not limited to, abnormal posture, legally blind, muscle weakness and debility.</p> | F 221 | <p>1. What correction actions will be accomplished for those residents found to have been affected by the deficient practice? Resident #21: medical record was reviewed, seat belt assessment and consent were obtained, and care plan was updated. 2. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken? Residents who utilize seat belts have potential to be affected by the alleged deficient practice Residents with restraints were reviewed to ensure assessments and consents were obtained Occupational Therapy evaluated residents with seat belts for proper positioning devices 3. What measures will be put into place or what systemic changes will be made to ensure that deficient practice does not recur? Therapy department was in-serviced on requirements/definition of restraints and positioning devices by corporate nurse consultant Interdisciplinary team will review</p> | 03/25/2015 |

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 02/23/2015 |
|--|---|---|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260 |
|--|--|

| (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's Physician orders dated February 2015, included, but were not limited to, the following orders: 2/9/15--"Resident to wear seatbelt in wheelchair to facilitate proper positioning due to poor trunk control. To wear seatbelt when up in wheelchair, check every hour, release every two hours and to be off at meals."</p> <p>The "OT [Occupational Therapist] Progress & Discharge Summary" dated 6/19/14, indicated "...Analysis of Functional Outcome/Clinical Impression: Caregiver/POA [Power of Attorney] recommends continued use of seatbelt for pt [patient] safety and understands it is considered a restraint...Patient / Caregiver Training since Last Report...Pt POA educated regarding purpose of seatbelt and it being considered a restraint...."</p> <p>The "Occupational Therapy Plan of Care" note dated 11/11/14, indicated "...Reason for Therapy... was referred to therapy for evaluation for restraint reduction while seated in w/c [wheelchair]. Therapy Necessity: Therapy necessary for trial and assessment of w/c positioning devices and modifications for potential for positive restraint reduction. Without therapy patient at risk for continued use of physical restraint while up in w/c...."</p> | | <p>residents with restraints/positioning devices during quarterly resident review to ensure assessments and consents are in place 4. How will the corrective actions be monitored to ensure the deficient practice will not recur? Director of Nursing or designee will complete IDT Walking Rounds (quarterly resident review) QA tool monthly for 6 months, results will be submitted to the QA Committee, non compliance with facility procedures may result in re-education and/or progressive disciplinary action</p> | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 02/23/2015 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260 |
|--|--|

| (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 "OT-Therapist Progress & Discharge Summary" note dated 12/10/14, indicated "... Analysis of Functional Outcome / Clinical Impression: Pt referred for restraint reduction... Summary of Skilled Services Provided since SOC [Start of Care]: Skilled services provided since start of care included w/c management and positioning for restraint reduction assessment...."</p> <p>The resident's record lacked a restraint assessment and a signed consent form from her responsible party for the lap seatbelt being used as a physical restraint for positioning.</p> <p>On 2/20/15 11:16 a.m., a restraint assessment, signed consent and restraint policy and procedure was requested from the DON (Director of Nursing).</p> <p>On 2/20/15 12:04 p.m., the DON had no Restraint assessment or consent to provide.</p> <p>An "Interdisciplinary Assessment and Progress Note" dated 2/12/15, indicated "... If Safety Issues Identified, Evaluate Risk / CP [Care Plan]:...Has seatbelt in w/c for positioning d/t [due to] moves frequently causing sliding in w/c. Repositioned frequently...."</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 02/23/2015 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260 |
|--|--|

| (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 on 2/20/15 at 11:16 a.m., OT #24, with the DON present, indicated Resident #21's seat belt was considered used for positioning to keep her safe and in the chair because she slid in her wheelchair constantly and had to be repositioned frequently by the nursing staff. OT #24 indicated she had called the seatbelt a restraint in June 2014, because she was taught anytime a seatbelt was used it was called a restraint, but the Nursing staff educated her that when a seatbelt was used for positioning, it was not called a restraint.</p> <p>During the same interview, at that time, the DON indicated the resident could not release the seatbelt and she could not ambulate. The DON indicated the OT's used the wrong verbiage in their notes when they addressed the seatbelt and the seatbelt was not considered a restraint because it was used for positioning.</p> <p>A current policy titled "Restraint Devices Physical" provided by the DON on 2/20/15 at 12:04 p.m., indicated "...Purpose:...To prevent the resident from injuring himself or others, Restraints of any type will not be used as punishment or as a substitute for more effective medical and nursing care or for the convenience of the facility staff...To</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 02/23/2015 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260 |
|--|--|

| (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>treat resident's medical symptoms... PHYSICAL RESTRAINTS are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body... Procedure:... 1. Assess resident's need for restraint device use. 2. Obtain informed consent for restraint device use. 3. Obtain physician's order for restraint device. 4. Develop or review resident care plan for type of restraint device, reason for use, alternate methods to be used and method of application. List medical symptoms to be treated and methods to reduce and eliminate the restraint device... Documentation Guidelines:... Assessment for restraint device use. Consent for restraint device use... Type of restraint device use. Monitoring resident..Condition of the area restrained. Condition of the resident while restrained... Reposition, exercise and toileting of the resident... Steps for Assessment...4. Evaluate whether the resident can easily and voluntarily remove the restraint, continue with the assessment to determine whether the device restricts freedom of movement or the resident's access to his or her own body...Clarifications: 'Removes easily' means that the manual method, device,</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 02/23/2015 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260 |
|--|--|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---------------------------|--|---------------|---|----------------------|
| F 226 SS=D Bldg. 00 | <p>material or equipment can be removed intentionally by the resident in the same manner as it was applied by the staff (e.g...,buckles are intentionally unbuckled...) considering the resident's physical condition and ability to accomplish his or her objective... 'Freedom of movement' means any change in place or position for the body or any part of the body that the person is physically able to control or access...."</p> <p>3.1-26(a) 3.1-26(b) 3.1-26(q)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to implement their abuse prevention and investigation policy and procedure related to doing a thorough investigation for an allegation of verbal and physical abuse and for an allegation of a resident's money being taken. This deficient practice affected 2 of 3 residents' abuse investigations reviewed.</p> | F 226 | <p>1. What correction actions will be accomplished for those residents found to have been affected by the deficient practice? Residents #59, 61: reportable files were reviewed 2. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken?</p> | 03/25/2015 |

| | | | | | | | |
|--|---|---|--|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 02/23/2015 | |
| NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260 | | | |
| (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 #59 and #61)</p> <p>Findings include:</p> <p>1. During an interview on 2/16/2015 at 10:22 a.m., Resident #59 indicated that on a weekend, "someone was hurrying and grabbed me and I consider that abuse. I reported it to the head nurse...." The resident was not specific on exactly when it occurred and indicated there should be a record of it for specifics.</p> <p>On 2/16/2015 at 10:30 a.m., Resident #59's record was reviewed. Diagnoses included, but were not limited to, CKD (Chronic Kidney Disease) and hypertension. The residents MDS (Minimum Data Set) assessment indicated the resident's BIMS (Basic Interview for Mental Status) was 13 / 15 indicating the resident was cognitively intact.</p> <p>The record of the facility's incident report regarding an allegation similar to what the resident had reported was reviewed on 2/20/2015 at 4 p.m. The report was dated as occurring on 10/29/2014 at 6:01 p.m. The summary of the report indicated Resident #59 reported to one of the nurses that the previous evening a nurse cursed at him and was rough with him. In addition the report indicated the</p> | | <p>Residents residing in the facility have the potential to be affected by the alleged deficient practice Director of Operations in-serviced department heads on abuse investigation and reporting utilizing the Alleged or Suspect Abuse – Investigation Management form/checklist on 3/4/15</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that deficient practice does not recur?</p> <p>Director of Operations in-serviced interim Executive Director on proper investigation process utilizing the Alleged or Suspected Abuse –Investigation Management form/checklist for reportable occurrences on 3/12/15</p> <p>The Alleged or Suspected Abuse –Investigation Management form/checklist will be utilized by Interdisciplinary Team for alleged or suspected abuse</p> <p>4. How will the corrective actions be monitored to ensure the deficient practice will not recur?</p> <p>The Interdisciplinary Team will submit completed Alleged or Suspected Abuse – Investigation Management form/checklist to the QA Committee for review and follow up, non compliance with facility procedures may result in re-education and/or progressive disciplinary actions</p> | | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 02/23/2015 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260 |
|--|--|

| (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 had made similar statements 2 months before. The report indicated that the resident's family member overheard the resident's allegation and indicated that at the time the resident indicated the incident happened she was with him and she did not observe this happening. The record indicated a follow up was conducted on 11/3/2014, and the resident indicated at the time that he felt safe and was glad that someone was taking the time to talk to him.</p> <p>A hand written statement attached to the incident reported on 10/29/2014 indicated the resident reported : "... [family member] left things for me they came and twisted my hand." The resident indicated they were trying to feed him 4 meals and cursed at him about it.</p> <p>The facility's interview / investigative record indicated two staff nurse's were interviewed regarding the resident's allegation. The nurse that was informed of the alleged abuse and a nurse that was working the evening of the alleged incident. No other staff members were interviewed and no cognitively intact residents in the same hall were interviewed.</p> <p>The facility's, "Abuse and Crime Reporting Policies and Procedures /</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 02/23/2015 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260 |
|--|--|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---------------------------|---|---------------|---|----------------------|
| F 250 SS=E Bldg. 00 | <p>Revised September 2011" indicated "Reports shall be thoroughly investigated in a timely manner."</p> <p>2. On 2/20/2015 at 4:30 p.m., the record of the facility's incident report regarding an allegation made by Resident #61 on 1/27/2015, was reviewed on 2/20/2015 at 4 p.m. The brief description of the incident indicated the resident alleged that \$17 had been removed from the resident's drawer. The record indicated a follow up was done on 1/30/2015, and staff involved in the resident's room had been interviewed and no indication that the money was stolen was indicated.</p> <p>The facility's interview / investigative record indicated staff were interviewed regarding the resident's allegation but no interviewable residents were interviewed.</p> <p>The facility's, "Abuse and Crime Reporting Policies and Procedures / Revised September 2011" indicated the purpose was "To protect the physical and emotional well-being and personal possessions of every resident."</p> <p>3.1-28(a)</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> | | | |

| | | | | | | | |
|--|---|---|--|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 02/23/2015 | |
| NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260 | | | |
| (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 facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on interview and record review, the facility failed to ensure residents' need were met for dental care for 1 of 3 residents reviewed for social services (Resident #53) and failed to ensure residents' needs were met for residents who required antipsychotics for 4 of 6 residents who were reviewed for social services. (Residents #13, 21, 65 and 73)</p> <p>Findings include:</p> <p>1. Resident #53's record was reviewed on 2/20/15 at 11:51 p.m. Diagnoses included, but were limited to, dysphagia, depressive disorder and insomnia.</p> <p>During an interview on 2/16/15 at 1:56 p.m., Resident #53 indicated she had trouble chewing some of the meats due to her teeth were loose. She indicated she switched sides while chewing from time to time due to the trouble she had chewing.</p> <p>A Nurses note dated 1/4/15 at 9:00 p.m., indicated the resident complained of tooth pain and she had 2 "bad teeth" The Physician was notified and he ordered a Dental appointment to be set up for the resident. A call was made to the (name</p> | F 250 | <p>1. What correction actions will be accomplished for those residents found to have been affected by the deficient practice? Resident #53: follow up dental appointment was done on 2/25/15 Residents # 73, 13, 65, 21: medications were reviewed for appropriate diagnoses and behaviors to warrant the medication, care plans and behavior monitoring forms were updated 2. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken? Residents on antipsychotic medications and residents who need dental services have the potential to be affected by the alleged deficient practice Social Service Director reviewed residents to ensure proper follow up dental appointments were completed Residents with behaviors were reviewed for proper behavior monitoring and diagnosis 3. What measures will be put into place or what systemic changes will be made to ensure that deficient practice does not recur? During clinical meetings any referral/appointment will be reviewed to ensure follow up is completed by Director of Nursing</p> | 03/25/2015 | | | |

| | | | | | | | |
|--|---|---|---|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 02/23/2015 | |
| NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260 | | | |
| (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>of dental office) and a message was left to return the call to the facility.</p> <p>A Dental progress note dated 1/5/15, indicated the Dentist performed a dental exam on that day. The note indicated Resident #53 had upper and lower teeth decay. The notes indicated "Pt ...pain in 2 areas noted; noted gross decay #6, #28--both nonrestorable. Referral written to oral surgeon for extraction of them both...."</p> <p>A Nurses note dated 1/5/15 at 12:40 p.m., indicated an appointment was made for a Dental appointment for teeth extraction for 1/7/15.</p> <p>A Nurses note dated 1/5/15 at 3:30 p.m., indicated (name of dentist) called the facility and notified the facility the resident's Medicaid was invalid and the facility needed to call the Dental office back to reschedule the appointment with the new Medicaid information.</p> <p>A Nurses note dated 1/8/15 at 3:00 p.m., indicated the resident had another dental appointment for an evaluation at (name of dental office) on 1/12/15 at 4:30 p.m.</p> <p>A Nurses note dated 1/12/15 at 3:30 p.m., indicated the resident was LOA (leave of absence) for her dental appointment.</p> | | <p>or designee Social Services Consultant will in-service new Social Service Director on process for scheduling dental services by 3/25/15 Nursing staff will be in-serviced for behavior management by Director of Staff Development; training initiated on 3/9/15, to be completed by 3/25/15 Interdisciplinary Team will review medical records for proper behavior documentation during quarterly resident review Pharmacist to review resident medication regimen at least monthly Psychiatrist to be routinely consultant for resident on psychotropic medication Behavior Management Team meets monthly to review residents with behaviors and residents on psychotropic medications New Social Service Director has been hired 4. How will the corrective actions be monitored to ensure the deficient practice will not recur? The Interdisciplinary Team will review physician orders for referral/appointment in clinical meetings Monday thru Friday, results will be submitted to the QA Committee for review and follow up Chemical Restraint QA tool will be completed by Director of Nursing or designee monthly for 6 months, results will be submitted to QA committee for review and follow up Non compliance with facility procedures will result in re-education and/or progressive</p> | | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 02/23/2015 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260 |
|--|--|

| (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 Nurses note dated 1/13/15 at 9:00 a.m., indicated the resident was on an antibiotic medication for a tooth abscess.</p> <p>During an interview on 2/20/15 at 12:47 p.m., LPN #20 indicated Resident #53 was seen by (name of dental office) and as far as she knew her teeth had been extracted, but she would have to ask one of the nurses. At that time, LPN #23 indicated Resident #53 had infected teeth and she went to (name of dental office) on 1/12/15, and was prescribed an antibiotic, but (name of dental office) nor (name of Dentist) would do the teeth extractions because her Medicaid was invalid and the dental offices would not treat her until she got valid Medicaid.</p> <p>During an interview on 2/20/15 at 1:48 p.m., the SSD (Social Service Director) indicated she thought Resident #53 had her teeth extracted already. She indicated the facility paid for the resident to go to the Dentist on 1/12/15, for the evaluation and she was placed on an antibiotic. She indicated she will follow up on the teeth extraction appointment.</p> <p>2. On 2/18/2015 at 9:32 a.m., the record for Resident #73 was reviewed. Diagnoses included, but were not limited to, dementia with behavioral disturbance,</p> | | disciplinary action | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 02/23/2015 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260 |
|--|--|

| (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>unspecified schizophrenia, and unspecified psychosis.</p> <p>The physician's order dated 12/19/14, indicated the resident was on Olanzapine (brand name Zyprexa-an antipsychotic medication) 2.5 milligrams daily.</p> <p>The December 2014, Medication Administration Record (MAR) indicated the resident was on Zyprexa for Crying and tearful episodes on 12/19/14. "...List medication: OLANZAPINE For those residents on antipsychotic psychoactive medications, please identify targeted behaviors to be monitored: [X] Delusions [X] Sensory hallucinations (specify): ___ [X] Fear or paranoia [X] Danger Symptoms]- hitting, kicking, slapping (specify):___ [X] Verbally aggressive toward others [X] resists meds/treatments Protocol: Document behavior in comments field using numeric scale, if no behavior, document 0 in comments field Start Date : 3/24/14." When scrolling to the bottom of the screen, it was observed that there were no comments.</p> <p>The January 2015, MAR indicated the resident was on Olanzapine for fear or paranoia as well as physical aggression towards others.</p> <p>There was no description in the January</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 02/23/2015 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260 |
|--|--|

| (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>2015, MAR, which indicated how her behaviors of fear and paranoia were displayed and being monitored.</p> <p>On 2/23/15 at 2:30 p.m., the Social Services Director indicated the resident's medication of Zyprexa was for fear and paranoia. She indicated the behaviors being monitored were fear and paranoia, but the physical aggression was not an appropriate reason for the use of that medication.</p> <p>On 2/23/15 at 3:30 p.m., a request was made to provide more information regarding the specific way in which Resident #73 displayed her fear or paranoia.</p> <p>As of the exit conference on 2/23/15 at 4:27 p.m., no further information was provided.</p> <p>3. Resident #13's record was reviewed on 2/19/15 at 10:51 a.m. Diagnoses included, but were not limited to, lack of coordination, generalized pain, depressive disorder, epilepsy, vascular dementia, alteration of consciousness, senile dementia with delusional features (the person falsely believe something about themselves).</p> <p>The resident's Physician orders dated February 2015, included, but were not</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 02/23/2015 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260 |
|--|--|

| (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>limited to, the following orders: 3/19/14--"Psych Evaluation-Refer to [name of Psych services] for individual therapy and a neuropsychological evaluation to r/o [rule out] cognitive disorder or dementia." 1/27/15--Risperidone (an anti-psychotic medication) 0.25 mg (milligrams) 1 tablet by mouth daily. 1/27/15--"For those residents on antipsychotic psychoactive medications, please identify targeted behaviors to be monitored: [X] Delusions Protocol : Document Behavior in Comments field using numeric scale. If no behavior, document 0 in comments field."</p> <p>The "Resident Medication Administration Record" dated December 2014, and February 2015, indicated there were no specific targeted behaviors identified to monitor for the resident's Risperidone for these months.</p> <p>The "Resident Medication Administration Record" dated February 2015, indicated the specific targeted behaviors identified to monitor for the resident's Risperidone for that month was delusions.</p> <p>There was no description in the February 2015, MAR, which indicated how his behavior of delusions were displayed and</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 02/23/2015 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260 |
|--|--|

| (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>being monitored.</p> <p>During an interview on 2/20/15 at 1:33 p.m., the SSD (Social Service Director) indicated Resident #13's specific targeted behaviors being monitored for delusions. She indicated he had delusions that he had many girlfriends related to staff and he had to protect all the female nursing staff and he made threatening statements in general out loud if he thought someone was arguing or being disrespectful with a female staff member.</p> <p>5. Resident #21's record was reviewed on 2/19/15 at 11:16 a.m. Diagnoses included, but were not limited to, psychosis and dementia with behavioral disturbances.</p> <p>The resident's Physician orders dated February 2015, included, but were not limited to, the following orders: 1/14/15--"Risperdal [Risperidone]: For those residents on antipsychotic psychoactive medications, please identify targeted behaviors to be monitored: [X] Yelling... [X] Fear and paranoia Protocol: Document Behavior In Comments field using numeric scale. If no behavior, document 0 in comments field." 1/26/15--Risperidone 0.25 mg 1 tablet by mouth at bedtime.</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 02/23/2015 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260 |
|--|--|

| (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's "Resident Medication Administration Record" dated September 2014, through February 2015, indicated Resident #21's specific targeted behaviors being monitored for for the Risperdal were continuous yelling/screaming, yelling or crying and Fear or paranoia.</p> <p>There was no description in the September 2014, through February 2015, MARS, which indicated how her behaviors of fear and paranoia were displayed and being monitored.</p> <p>During an interview on 2/20/15 at 1:48 p.m., the SSD indicated the specific targeted behavior being monitored for Resident #21 was delusions. She indicated the resident's delusions were she thought at times there were things happening that were not happening.</p> <p>6. Resident #65's record was reviewed on 2/18/15 at 11:09 a.m. Diagnoses included, but were not limited to, anxiety, depressive disorder, and dementia with psychosis.</p> <p>The resident's Physician orders dated February 2015, included, but were not limited to, the following orders: 10/3/14--Risperidone (an anti-psychotic medication) 0.25 mg 1 tablet by mouth</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 02/23/2015 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260 |
|--|--|

| (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>two times daily</p> <p>1/4/15--"Risperidone: For those residents on antipsychotic psychoactive medications, please identify targeted behaviors to be monitored: Continuous Yelling or Screaming. Protocol: Document Behavior In Comments field using numeric scale. If no behavior, document 0 in comments field."</p> <p>The "Resident Medication Administration Record" dated September 2014, through February 2015, indicated the specific targeted behaviors for her Risperdal for these months were substantial difficulty with ADL's (Activity Daily Living), verbally aggressive toward others, resists medications/treatments, resists care/therapy and continuous yelling or screaming.</p> <p>There was no description in the September 2014, through February 2015, MARS, which indicated how her behavior of substantial difficulty with ADL's and verbally aggressive towards others were displayed and being monitored.</p> <p>During an interview on 2/20/15 at 1:48 p.m. The SSD indicated the specific targeted behavior being monitored for Resident #65's Risperdal was delusions. The SSD indicated her delusions were</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 02/23/2015 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260 |
|--|--|

| (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>she yelled out and she had delusions that she did not know what was going on around her.</p> <p>During an interview on 2/20/15 at 1:33 p.m., the SSD (Social Service Director) with the Consultant HFA (Healthcare Facility Administrator) in attendance indicated the behaviors were being monitored under Sigma care (Medication Record Administration documentation area) in the computer and the nurses monitored the behaviors. She indicated she did not place the specific targeted behaviors into Sigma Care. At that time, the Consultant HFA indicated Clinical (Nursing staff) placed the specific targeted behaviors into SigmaCare. She indicated there were no numbers in the box on the MAR to tell if the behaviors were increasing or decreasing. The SSD indicated she and the nurses talked to the doctor and told the doctor if the residents were having delusions and what kind and number of delusions the residents were having.</p> <p>A current policy titled "A Guide to Understanding and Managing Psychotropics" dated December 2011, provided by the DON (Director of Nursing) on 2/23/15 at 3:35 p.m., indicated "...iii) Without adequate monitoring: It is required to have a</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 02/23/2015 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260 |
|--|--|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---------------------------|---|---------------|---|----------------------|
| F 257 SS=D Bldg. 00 | <p>behavior monitor identified for each psychotropic medication the resident is taking... It is the SSD's role to obtain a behavior monitor when a resident is admitted with a psychotropic medication (see SSD's Role with Psychotropics at Admission and Appropriate Behavior Monitors)...."</p> <p>A current policy titled "Social Worker's Role With Psychotropics at Admission" dated December 2011, provided by the DON on 2/23/15 at 3:35 p.m., indicated "...Remember: A social service assessment is not complete unless we have interviewed the resident's family or responsible party and have obtained a comprehensive picture of the resident. A supporting diagnosis must be found in the H&P [History and Physical], Psychiatric evaluation, or physician progress notes to justify use of the psychotropic. The SSD is the gatekeeper of identifying unnecessary drugs at admission...."</p> <p>3.1-34(a)</p> <p>483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F</p> | | | |

| | | | | | | | |
|--|---|---|---|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 02/23/2015 | |
| NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260 | | | |
| (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 observation and interview, the facility failed to ensure a resident's room temperature was at a comfortable level for 1 of 4 residents' rooms checked for comfortable temperature levels. (Room 327) (Resident #74)</p> <p>Findings include:</p> <p>During a resident interview, on 2/16/15 at 9:47 a.m., Room 327 was observed to be hot. The blower fan knob on the wall was turned to the off position and a box fan was sitting on a table blowing towards Resident #74. During an interview at that time, Resident #74 indicated her room was hot. She indicated she had asked the Nursing staff to adjust her thermostat to cool her room at different times, but they were unable to get her room any cooler. She indicated her family had brought her a box fan to blow on her to try to keep her cool.</p> <p>During an Environmental tour on 2/20/15 at 9:43 a.m., the Maintenance Supervisor was observed obtaining Resident #74's room temperature at 83 degrees Fahrenheit (F). During an interview at that time, the Maintenance Supervisor indicated Resident #74 had complained of her room being to hot in the past, but he had not measured the temperature of her room at that time. He indicated he</p> | F 257 | <p>1. What correction actions will be accomplished for those residents found to have been affected by the deficient practice? Resident room 327 heating/cooling system was checked by Piene Engineering on 2/20/15</p> <p>2. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken? Residents residing inthe facility have the potential to be affected by the alleged deficient practice Residents rooms were checked for proper temperature</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that deficient practice does not recur? Room temperatures will be checked for proper temperature weekly by maintenance</p> <p>4. How will the corrective actions be monitored to ensure the deficient practice will not recur? Temperatures will be checked weekly, results will be submitted to the QA Committee for review and follow up</p> | 03/25/2015 | | | |

| | | | | | | | |
|--|---|---|--|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 02/23/2015 | |
| NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | | | |
| F 323 SS=D Bldg. 00 | <p>told the nursing staff to open her window to cool her room off when she had complained. He indicated he had not had a heating company out to the facility in the past to check the resident's temperature in her room when she complained about her room being to hot.</p> <p>3.1-19(h)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure an appropriate and safe transfer occurred for 1 of 1 residents being observed for transfers. (Resident #65)</p> <p>Findings included:</p> <p>Resident #65's record was reviewed on 2/18/15 at 11:09 a.m. Diagnoses included, but were not limited to, anxiety, depressive disorder, epilepsy and recurrent seizures and chronic pain.</p> <p>On 2/18/15 at 1:11 p.m., Resident #65 was brought to her room by CNA #21. CNA #21 and CNA #22 was observed</p> | F 323 | <p>1. What correction actions will be accomplished for those residents found to have been affected by the deficient practice? Resident #65: CNA's #21, 22 were in-serviced on gait belt usage 2. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken? Residents who need assistance with transfers have the potential to be affected by the alleged deficient practice Nursing staff will be in-serviced on gait belt usage by the Director of Staff Development by 3/25/15 3. What measures will be put into place or what</p> | 03/25/2015 | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 02/23/2015 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260 |
|--|--|

| (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>placing a gait belt around Resident #65's waist looser than two fingers width. Both CNA's had a hold of the gait belt and the back of the resident's pants and had an arm under the resident's arm. When CNA #21 and CNA #22 lifted the resident out of the wheelchair, her pants were pulled up into the middle of her buttocks and the bottom of her pants were raised, so her ankles were exposed. As the CNA's were pulling on the back of her pants, the pants stretched and the resident's bent knees began to lower towards the floor. CNA #21 had furrowed brows and facial grimacing as she and CNA #22 strained to lift the resident onto the side of the bed.</p> <p>The resident's annual MDS (Minimum Data Set) assessment dated 12/9/14, indicated the resident was an extensive assist with a two person physical assist for transfers.</p> <p>During an interview on 2/18/15 at 1:34 p.m., CNA #21 indicated she had to "recover" the resident with her pants during the transfer to keep from dropping her, even though she had a hold of the gait belt. She indicated she had not known why because she had a hold of the gait belt. CNA #21 indicated the gait belt was to be tight enough to get two fingers under it and Resident #65's was applied</p> | | <p>systemic changes will be made to ensure that deficient practice does not recur? CNA's will be in-serviced on transfers with proper with gait belt technique by Director of Staff Development by 3/25/15 Interdisciplinary Team will review utilization of gait belt technique during quarterly resident review</p> <p>4.How will the corrective actions be monitored to ensure the deficient practice will not recur? Interdisciplinary Team will complete Gait Belt QA tool during quarterly resident reviews, results will be submitted to the QA Committee monthly for 6 months for review and follow up, non compliance with facility procedure may result in re-education and/or progressive disciplinary action</p> | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 02/23/2015 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260 |
|--|--|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---------------------------|---|---------------|---|----------------------|
| F 329 SS=E Bldg. 00 | <p>looser than that. CNA #21 indicated "Didn't you see my face when I was trying to lift her, the transfer was not going well."</p> <p>During an interview on 2/18/15 at 5:04 p.m., the DON (Director of Nursing) indicated she expected the CNA's to have used a gait belt with the transfer of Resident #65. She indicated she had expected the gait belt to have fit tightly enough to get two fingers under the gait belt.</p> <p>3.1-45(a)(2)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 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</p> | | | |

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 02/23/2015 |
|--|---|---|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260 |
|--|--|

| (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>receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review, the facility failed to monitor for specific targeted behaviors related to the use of antipsychotic medications for 4 of 6 residents reviewed for unnecessary medications. (Residents #13, 21, 65 and 73)</p> <p>Findings include:</p> <p>1. On 2/18/2015 at 9:32 a.m., the record for Resident #73 was reviewed. Diagnoses included, but were not limited to, dementia with behavioral disturbance, unspecified schizophrenia, and unspecified psychosis.</p> <p>The physician's order dated 12/19/14, indicated the resident was on Olanzapine (brand name Zyprexa-an antipsychotic medication) 2.5 milligrams daily.</p> <p>The December 2014, Medication Administration Record (MAR) indicated the resident was on Zyprexa for Crying and tearful episodes on 12/19/14. "...List medication: OLANZAPINE For those residents on antipsychotic psychoactive medications, please identify targeted behaviors to be monitored: [X] Delusions [X] Sensory hallucinations (specify): ____</p> | F 329 | <p>1. What correction actions will be accomplished for those residents found to have been affected by the deficient practice? Residents # 73, 13, 65, 21: medical records were reviewed for behaviors and psychotropic medication use; care plans and behavior monitoring forms were updated as needed. 2. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken? Residents with behaviors and psychotropic medication use have the potential to be affected by the alleged deficient practice Residents with behaviors were reviewed for proper behavior monitoring 3. What measures will be put into place or what systemic changes will be made to ensure that deficient practice does not recur? Nursing staff will be in-serviced on the behavior management program; initiated by the Director of Staff Development on 3/9/15 and will be completed by 3/25/15 Pharmacist reviews resident medication regimen at least monthly Psychiatrist to be routinely consulted for residents on psychotropic medication Behavior management team</p> | 03/25/2015 |

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 02/23/2015 |
|--|---|---|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260 |
|--|--|

| (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>[X] Fear or paranoia [X] Danger Symptoms]- hitting, kicking, slapping (specify):___ [X] Verbally aggressive toward others [X] resists meds/treatments Protocol: Document behavior in comments field using numeric scale, if no behavior, document 0 in comments field Start Date : 3/24/14." When scrolling to the bottom of the screen, it was observed that there were no comments.</p> <p>The January 2015, MAR indicated the resident was on Olanzapine for fear or paranoia as well as physical aggression towards others.</p> <p>There was no description in the January 2015, MAR, which indicated how her behaviors of fear and paranoia were displayed and being monitored. On 2/23/15 at 2:30 p.m., the Social Services Director indicated the resident's medication of Zyprexa was for fear and paranoia. She indicated the behaviors being monitored were fear and paranoia, but the physical aggression was not an appropriate reason for the use of that medication.</p> <p>On 2/23/15 at 3:30 p.m., a request was made to provide more information regarding the specific way in which Resident #73 displayed her fear or paranoia.</p> | | <p>meets monthly to review residents with behaviors and residents on psychotropic medication. A new Social Service Director has been hired. 4. How will the corrective actions be monitored to ensure the deficient practice will not recur? Chemical Restraint QA Tool will be completed monthly for 6 months, results will be submitted to the QA Committee for review and follow up, non compliance with facility procedures may result in re-education and/or disciplinary action</p> | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 02/23/2015 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260 |
|--|--|

| (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>As of the exit confrence on 2/23/15 at 4:27 p.m., no further information was provided.</p> <p>2. Resident #13's record was reviewed on 2/19/15 at 10:51 a.m. Diagnoses included, but were not limited to, lack of coordination, generalized pain, depressive disorder, epilepsy, vascular dementia, alteration of consciousness, senile dementia with delusional features.</p> <p>The resident's Physician orders dated February 2015, included, but were not limited to, the following orders: 3/19/14--"Psych Evaluation-Refer to [name of Psych services] for individual therapy and a neuropsychological evaluation to r/o [rule out] cognitive disorder or dementia." 1/27/15--Risperidone (an anti-psychotic medication) 0.25 mg (milligrams) 1 tablet by mouth daily. 1/27/15--"For those residents on antipsychotic psychoactive medications, please identify targeted behaviors to be monitored: [X] Delusions Protocol : Document Behavior in Comments field using numeric scale. If no behavior, document 0 in comments field."</p> <p>The "Resident Medication Administration Record" dated December</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 02/23/2015 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260 |
|--|--|

| (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>2014, and February 2015, indicated there were no specific targeted behaviors identified to monitor for the resident's Risperidone for these months.</p> <p>The "Resident Medication Administration Record" dated February 2015, indicated the specific targeted behaviors identified to monitor for the resident's Risperidone for that month was delusions.</p> <p>There was no description in the February 2015, MAR, which indicated how his behavior of delusions were displayed and being monitored.</p> <p>During an interview on 2/20/15 at 1:33 p.m., the SSD (Social Service Director) indicated Resident #13's specific targeted behaviors were being monitored for delusions. She indicated he had delusions that he had many girlfriends related to staff and he had to protect all the female nursing staff and he made threatening statements in general out loud if he thought someone was arguing or being disrespectful with a female staff member.</p> <p>3. Resident #21's record was reviewed on 2/19/15 at 11:16 a.m. Diagnoses included, but were not limited to, psychosis and dementia with behavioral</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 02/23/2015 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260 |
|--|--|

| (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>disturbances.</p> <p>The resident's Physician orders dated February 2015, included, but were not limited to, the following orders: 1/14/15--"Risperdal [Risperidone]: For those residents on antipsychotic psychoactive medications, please identify targeted behaviors to be monitored: [X] Yelling... [X] Fear and paranoia Protocol: Document Behavior In Comments field using numeric scale. If no behavior, document 0 in comments field." 1/26/15--Risperidone 0.25 mg 1 tablet by mouth at bedtime.</p> <p>The resident's "Resident Medication Administration Record" dated September 2014, through February 2015, indicated Resident #21's specific targeted behaviors being monitored for for the Risperdal were continuous yelling/screaming, yelling or crying and Fear or paranoia.</p> <p>There was no description in the September 2014, through February 2015, MARS, which indicated how her behaviors of fear and paranoia were displayed and being monitored.</p> <p>An Interdisciplinary Assessment and Progress note dated 2/12/15, indicated the Risperdal was for Yelling and delusions.</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 02/23/2015 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260 |
|--|--|

| (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>IDT Evaluation of Behavior & or Current Psychotropic Medications indicated "Risperdal non-effective due to dementia is not delusional."</p> <p>An Interdisciplinary Progress note dated 1/23/15, indicated the resident was in the late stage dementia process and legally blind and hypersensitive to noise and the environment. She often answered other peoples conversations or yelled out wanting to know what the noise was or what was going on around her, which made her appear delusional. She was on Risperdal 0.25 mg daily for delusions, which appeared non-effective for yelling/distressed behavior.</p> <p>During an interview on 2/20/15 at 1:48 p.m., the SSD indicated the specific targeted behavior being monitored for Resident #21 was delusions. She indicated the resident's delusions were she thought at times there were things happening that were not happening.</p> <p>4. Resident #65's record was reviewed on 2/18/15 at 11:09 a.m. Diagnoses included, but were not limited to, anxiety, depressive disorder, and dementia with psychosis.</p> <p>The resident's Physician orders dated February 2015, included, but were not</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 02/23/2015 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260 |
|--|--|

| (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>limited to, the following orders: 10/3/14--Risperidone (an anti-psychotic medication) 0.25 mg 1 tablet by mouth two times daily 1/4/15--"Risperidone: For those residents on antipsychotic psychoactive medications, please identify targeted behaviors to be monitored: Continuous Yelling or Screaming. Protocol: Document Behavior In Comments field using numeric scale. If no behavior, document 0 in comments field."</p> <p>The "Resident Medication Administration Record" dated September 2014, through February 2015, indicated the specific targeted behaviors for her Risperdal for these months were substantial difficulty with ADL's (Activity Daily Living), verbally aggressive toward others, resists medications/treatments, resists care/therapy and continuous yelling or screaming.</p> <p>There was no description in the September 2014, through February 2015, MARS, which indicated how her behavior of substantial difficulty with ADL's and verbally aggressive towards others were displayed and being monitored. A Behavior note dated 1/16/15, indicated she had been refusing labs and care and</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 02/23/2015 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260 |
|--|--|

| (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>there had been significant issues in the past. The note indicated on 1/7/15, she was resistant to care and refused labs. The note indicated on 1/6/15, she refused to be evaluated by the Audiologist. The note indicated on 12/16/14, she refused a shower when asked three times.</p> <p>A Social Service note dated 1/23/15, indicated the resident had late stage dementia and yelled related to dementia.</p> <p>A Social Services Psychosocial Concerns/Changes note dated 12/9/14, indicated the resident had vision loss and was unable to identify pain and the need to change positions and her coping method was to yell out for help. The resident's behavior was a verbal behavior.</p> <p>During an interview on 2/20/15 at 1:48 p.m. The SSD indicated the specific targeted behavior being monitored for Resident #65's Risperdal was delusions. The SSD indicated her delusions were she yelled out and she had delusions that she did not know what was going on around her.</p> <p>During an interview on 2/20/15 at 1:33 p.m., the SSD (Social Service Director) with the Consultant HFA (Healthcare Facility Administrator) in attendance, indicated the behaviors were being</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 02/23/2015 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260 |
|--|--|

| (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>monitored under Sigma care (Medication Record Administration documentation area) in the computer and the nurses monitored the behaviors. She indicated she did not place the specific targeted behaviors into Sigma Care. At that time, the Consultant HFA indicated Clinical (Nursing staff) placed the specific targeted behaviors into SigmaCare. She indicated there were no numbers in the box on the MAR to tell if the behaviors were increasing or decreasing. The SSD indicated she and the nurses talked to the doctor and told the doctor if the residents were having delusions and what kind and number of delusions the residents were having.</p> <p>A current policy titled "A Guide to Understanding and Managing Psychotropics" dated December 2011, provided by the DON (Director of Nursing) on 2/23/15 at 3:35 p.m., indicated "...iii) Without adequate monitoring: It is required to have a behavior monitor identified for each psychotropic medication the resident is taking. Behavior monitors cannot be the same for different drugs (i.e. Risperdal [sic] for 'hitting' and Ativan for 'hitting'). It is the SSD's role to obtain a behavior monitor when a resident is admitted with a psychotropic medication (see SSD's Role with Psychotropics at Admission</p> | | | |

| | | | | | |
|--|---|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 02/23/2015 |
| NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| F 371 SS=E Bldg. 00 | <p>and Appropriate Behavior Monitors). iv) Without adequate indications for its use: The documentation in the medical record does not identify any behaviors, however, a new order for Respirdal [sic] was started. The resident does not have a qualifying diagnosis found in the History and Physical, MD progress notes, or mental health notes. It is not appropriate to 'create' a diagnosis to justify the medication. It must be documented. the behavior monitor is not commensurate with the class of drug. For example, 'Respirdal [sic] (an anti-psychotic) for crying' (not a psychotic behavior). The behavior monitor is inappropriate...."</p> <p>A current policy titled "Social Worker's Role With Psychotropics at Admission" dated December 2011, provided by the DON on 2/23/15 at 3:35 p.m., indicated "...Remember:... A supporting diagnosis must be found in the H&P [History and Physical], Psychiatric evaluation, or physician progress notes to justify use of the psychotropic. The SSD is the gatekeeper of identifying unnecessary drugs at admission...."</p> <p>3.1-48(a)(3) 3.1-48(a)(4) 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> | | | | |

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 02/23/2015 |
|--|---|---|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260 |
|--|--|

| (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 facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview and record review, the facility failed to ensure foods stored in the refrigerated were properly labeled with an open date and failed to keep a freezer floor area in a sanitary condition. These deficient practices had the potential to affect 51 of the 55 residents currently residing in the facility and being served from the kitchen.</p> <p>Findings include:</p> <p>1. During an initial sanitation tour of the kitchen with prep Cook # 25 on 2/15/2015 at 2:55 p.m., the walk in refrigerator had a large piece of meat on the bottom of one of the racks. The meat was not labeled or dated.</p> <p>During an interview with Cook #25 at this time, indicated she was not sure what the large piece of meat was but thought it might be beef. She indicated she was a fill in cook and was not sure who placed the meat there or when this was done.</p> <p>During an interview with the CDM (Certified Dietary Manager), on</p> | F 371 | <p>1. What correction actions will be accomplished for those residents found to have been affected by the deficient practice? No residents were identified for the alleged deficient practice, therefore no corrective action can be taken for a specific resident Meat was discarded immediately Small ice cream cup was removed and thrown away The grill was cleaned</p> <p>2. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken? Residents who reside in the facility have the potential to be affected by the alleged deficient practice. Other food items were checked to ensure they were labeled/dated and properly stored Kitchen was deep cleaned by dietary staff Dietary staff were in-serviced by Certified Dietary Manager on proper thawing of food, dating & labeling, and kitchen cleaning schedule.</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that deficient practice does not recur? Dietary staff was in-serviced by Certified</p> | 03/25/2015 |

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 02/23/2015 |
|--|---|---|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260 |
|--|--|

| (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>2/15/2015 at 5:14 p.m., he indicated he would expect the food to be labeled and dated as soon as it was removed from the box in the freezer and put in the refrigerator.</p> <p>2. During an initial sanitation tour of the kitchen with prep Cook #25 on 2/15/2015 at 3 p.m., the walk in freezer was observed with a few items under one of the shelves. Cook #25 was observed picking up the items and throwing all but one small ice cream cup away. The small ice cream cup was put on the shelf and left.</p> <p>During an initial sanitation tour of the kitchen with prep Cook #25 on 2/15/2015 at 3:50 p.m., The grill had a heavy layer of black residue on it.</p> <p>During an interview with the CDM present on 2/15/2015 at 5:14 p.m., he indicated he would expect the ice cream cup picked from underneath the shelves to be thrown away.</p> <p>3.1-21(i)(3)</p> | | <p>Dietary Manger on proper thawing of food, dating & labeling, and kitchen cleaning schedule. Cleaning schedules were revised and dietary staff were in-serviced by Certified Dietary Manager on 3/3/15 The Registered Dietician will review kitchen sanitation during each facility visit. 4. How will the corrective actions be monitored to ensure the deficient practice will not recur? Dietetics Sanitation and Infection Control Surveillance QA tool will be completed weekly by Certified Dietary Manager and monthly by Registered Dietician, results will be submitted to the QA Committee for review and follow up, non compliance with facility procedure may result in re-education and/or progressive disciplinary action.</p> | |

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 02/23/2015 |
|--|---|---|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260 |
|--|--|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---------------------------|--|---------------|---|----------------------|
| F 412 SS=D Bldg. 00 | <p>483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS</p> <p>The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.</p> <p>Based on interview and record review, the facility failed to ensure dental services were provided in a timely manner for 1 of 3 residents reviewed for dental services. (Resident #53)</p> <p>Findings include:</p> <p>Resident #53's record was reviewed on 2/20/15 at 11:51 p.m. Diagnoses included, but were limited to, dysphagia, depressive disorder and insomnia.</p> <p>During an interview on 2/16/15 at 1:56 p.m., Resident #53 indicated she had trouble chewing some of the meats due to her teeth were loose. She indicated she switched sides while chewing from time to time due to the trouble she had chewing.</p> <p>The resident's Physician orders dated February 2015, included, but were not</p> | F 412 | <p>1. What correction actions will be accomplished for those residents found to have been affected by the deficient practice? Resident #53: follow up dental appointment was done on 2/25/15</p> <p>2. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken? Residents needing dental services have the potential to be affected by the alleged deficient practice Social Service Director reviewed residents to ensure proper followup dental appointments were completed</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that deficient practice does not recur? During clinical meeting Monday thru Friday any referral/appointment will be reviewed by the Interdisciplinary</p> | 03/25/2015 |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 02/23/2015 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260 |
|--|--|

| (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>limited to the following orders: 10/22/13--Annual Dental Evaluation 10/22/13--Regular diet 1/12/15--Cephalexin (an antibiotic medication) 500 mg take 1 capsule by mouth every six hours for seven days for tooth infection.</p> <p>A Nurses note dated 1/4/15 at 9:00 p.m., indicated the resident complained of tooth pain and she had 2 "bad teeth" The Physician was notified and he ordered a Dental appointment to be set up for the resident. A call was made to the (name of dental office) and a message was left to return the call to the facility.</p> <p>A Dental progress note dated 1/5/15, indicated the Dentist performed a dental exam on that day. The note indicated Resident #53 had upper and lower teeth decay. The tooth notes indicated "Pt ...pain in 2 areas noted; noted gross decay #6, 28--both nonrestorable. Referral written to oral surgeon for extraction of them both...."</p> <p>A Nurses note dated 1/5/15 at 12:40 p.m., indicated an appointment was made for a Dental appointment for teeth extraction for 1/7/15.</p> <p>A Nurses note dated 1/5/15 at 3:30 p.m., indicated (name of dentist) called the</p> | | <p>Team to ensure follow up is completed by Director of Nursing or designee Social Service Consultant will in-service new Social Service Director on process for scheduling dental services by 3/25/15 4. How will the corrective actions be monitored to ensure the deficient practice will not recur? The Interdisciplinary Team will review physician orders for referral/appointments in clinical meetings Monday thru Friday, results will be reported to QA Committee for review and follow up, non compliance of facility procedure may result in re-education and/or disciplinary action</p> | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 02/23/2015 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260 |
|--|--|

| (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>facility and notified the facility the resident's Medicaid was invalid and the facility needed to call the Dental office back to reschedule the appointment with the new Medicaid information.</p> <p>A Nurses note dated 1/8/15 at 3:00 p.m., indicated the resident had another dental appointment for an evaluation at (name of dental office) on 1/12/15 at 4:30 p.m.</p> <p>A Nurses note dated 1/12/15 at 3:30 p.m., indicated the resident was LOA (leave of absence) for her dental appointment.</p> <p>A Nurses note dated 1/13/15 at 9:00 a.m., indicated the resident was on an antibiotic medication for a tooth abscess.</p> <p>During an interview on 2/20/15 at 12:47 p.m., LPN #20 indicated Resident #53 was seen by (name of dental office) and as far as she knew her teeth had been extracted, but she would have to ask one of the nurses. At that time, LPN #23 indicated Resident #53 had infected teeth and she went to (name of dental office) on 1/12/15, and was prescribed an antibiotic, but (name of dental office) nor (name of Dentist) would do the teeth extractions because her Medicaid was invalid and the dental offices would not treat her until she got valid Medicaid.</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 02/23/2015 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260 |
|--|--|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---------------------------|---|---------------|---|----------------------|
| F 456 SS=E Bldg. 00 | <p>During an interview on 2/20/15 at 1:48 p.m., the SSD (Social Service Director) indicated she thought Resident #53 had her teeth extracted already. She indicated the facility paid for the resident to go to the Dentist on 1/12/15, for the evaluation and she was placed on an antibiotic. She indicated she will follow up on the teeth extraction appointment.</p> <p>3.1-24(a)</p> <p>483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. Based on observation, interview and record review, the facility failed to maintain a clean grill and working oven. This deficient practice had the potential to affect 51 of the 55 residents currently residing in the facility and being served from the kitchen.</p> <p>Findings include:</p> <p>1. During an initial sanitation tour of the kitchen with prep Cook #25 on 2/15/2015 at 3:50 p.m., only one oven was observed working.</p> <p>During an interview at this time, Cook #</p> | F 456 | <p>1. What correction actions will be accomplished for those residents found to have been affected by the deficient practice? No residents were identified for the alleged deficient practice, therefore no corrective action can be taken for aspecific resident Oven was repaired on 3/3/15 The grill was cleaned</p> <p>2. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken? Residents who reside in the facility have the potential to be affected by the alleged deficient practice. Dietary staff was in-serviced by the Certified</p> | 03/25/2015 |

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 02/23/2015 |
|--|---|---|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260 |
|--|--|

| (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>25 indicated only one oven has been working. She indicated the other oven has not been working but she does not know for how long. She indicated she has had to put food on the steam table and take time to reheat it in the one working oven when it is available.</p> <p>During an interview with the CDM (Certified Dietary Manager) on 2/19/2015 at 12:15 p.m., he indicated he was not made aware that the one oven was not working until 2/18/2015.</p> <p>3.1-19(bb)</p> | | <p>Dietary Manager on kitchen cleaning schedules and process for maintenance requests for non functioning equipment 3. What measures will be put into place or what systemic changes will be made to ensure that deficient practice does not recur? Dietary staff will be in-serviced by the Certified Dietary Manager on kitchen cleaning schedules and process for maintenance requests for non functioning equipment by 3/25/15. The Registered Dietician will review kitchen sanitation during each facility visit. 4. How will the corrective actions be monitored to ensure thedeficient practice will not recur? The Kitchen Equipment Log will be reviewed by Registered Dietician monthly for 6 months, results will be submitted to the QA Committee for review and follow up, non compliance with facility procedure may results in re-education and/or progressive disciplinary action</p> | |