STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE LAKES HEALTH CAMPUS	9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	This visit was for a Recertification and State Licensure survey. This visit included the investigation of Complaints IN00138950 and IN00139130. Complaint IN00138950: Substantiated. Federal/State deficiency related to the allegations is cited at F 323. Complaint IN00139130: Substantiated. No deficiencies related to the allegations are cited. Survey dates: November 12, 13, 14, 15, 18, 19, 20, and 21, 2013 Facility number: 012305 Provider number: 155779 AIM number: 200987990 Survey team: Janet Stanton, R.N.--Team Coordinator Michelle Hosteter, R.N. Gloria Bond, R.N. Census bed type: SNF--50 SNF/NF--8 Residential--49 Total--107	F000000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Annual Recertification and State Licensure Survey and Complaint Survey (IN000138950 and IN000139130) on November 21, 2013. Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE LAKES HEALTH CAMPUS	9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060

(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
	Census payor type: Medicare--19 Medicaid--4 Other--84 Total--107 Residential sample: 8 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2. Quality Review was completed by Tammy Alley RN on December 2, 2013.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE LAKES HEALTH CAMPUS	9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060

(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
F000157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.			
	Based on interview and record review, the facility failed to ensure a physician was notified regarding elevated blood sugars, for 1 of 1 residents reviewed for blood sugars;	F000157	F 157 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #19 has been discharged. Resident #44 family	12/21/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/21/2013
NAME OF PROVIDER OR SUPPLIER PRAIRIE LAKES HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060	

(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
	and failed to notify the family of a change in continence status, for 1 of 1 residents reviewed for Notification of Change. (Residents #19 and #44) Findings include: 1. The record review for Resident #19 was completed on 11/15/13 at 2 P.M. Diagnoses included, but were not limited to, atrial fibrillation, diabetes, chronic kidney disease Stage IV. The October 2013 MAR (Medication Administration Record) listed an order, dated 8/26/13, which required the physician be called if a blood sugar was less than 70, or over 300. On 10/5/13, documentation on the MAR indicated the night time blood sugar was 303. The blood sugar on 10/8/13 for the lunch time was 301. There was no evidence/documentation the physician had been notified of the blood sugars over 300. A discharge note dated 10/8/13 indicated the resident had gone to the hospital after a fall, and had sustained a contusion of left hip and thoracic spine compression fracture. A Nurse's note, dated 10/8/13,		has been notified of change in continence status.Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: 1). DHS or designee will review all residents with Accu-check orders for past 7 days to ensure MD was notified of results per call parameters. 2). DHS or designee will review all resident's continence status for past 7 days and notify the responsible party of any changes. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Licensed Nurses on the following campus guidelines: 1. Physician Notification 2. Responsible Party Notification How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: 1). Review of all residents with accu-checks orders to ensure MD was notified of results per call parameters. The following audits will be conducted by the DHS or designee 5 times per week on-going to ensure compliance: 1). Review of caretracker report / widget for increased incontinence to ensure the responsible party	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/21/2013
NAME OF PROVIDER OR SUPPLIER PRAIRIE LAKES HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060	

(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
	indicated "... the resident returned from the E.R. [Emergency Room] with new orders for Norco [a pain medication].... She refused dinner, blood sugar 402...." There was no documentation that the physician had been notified regarding the elevated blood sugar. In an interview on 11/15/13 at 2:20 P.M., the interim DHS (Director of Health Services) indicated the nurse should have notified the physician of blood sugars over 300, if that was the physician's order. On 11/15/13 at 2:25 P.M., a request was made to the DHS for information regarding physician notification of blood sugars over 300. As of the exit conference on 11/21/13 at 12:00 P.M., no other information had been provided. 2. In an interview on 11/13/13 at 3:00 P.M., a family member indicated Resident #44 was continent when she came to facility. The family felt the staff were putting adult briefs on the resident, and not toileting her often enough. The family requested that the staff not put the resident in the adult briefs any more. She		has been notified of any change The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE LAKES HEALTH CAMPUS	9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060

(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
	indicated the resident was now incontinent. She indicated she was never really told this was a problem, but had discovered it when she came to visit. The admission assessment form dated 8/30/13, indicated the resident was always continent of bowel and bladder. An "Elimination Circumstance Investigation" form, dated 9/5/13, indicated there was a change in continence status, and the resident was immobile and currently was on toileting program. The form had a space to document the notification of the family, but the area was blank. 3.1-5(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/21/2013
NAME OF PROVIDER OR SUPPLIER PRAIRIE LAKES HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060	

(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
F000241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.			
	Based on observation and record review, the facility failed to ensure staff were treating a resident who is legally blind and hard of hearing with dignity and respect, for 1 of 1 resident reviewed for dignity. (Resident #44) Findings include: The record for Resident #44 was reviewed on 11/14/13 at 11 A.M. Diagnoses included, but were not limited to, anemia, high blood pressure, and legally blind. In an interview on 11/13/13 at 1 P.M., a family member indicated she had to assist the resident in getting her hearing aids fixed because the resident was not able to hear well and was having trouble hearing conversation. On 11/19/13 at 2:30 P.M., the resident was observed sitting in her wheelchair by the television. The resident was sitting at the intersection by the nurses station, the 300	F000241	F 241 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #44 was observed interacting with staff. Staff noted to converse appropriately with the resident, treating her with dignity and respect. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected by this deficient practice. Residents observed interacting with staff. Staff noted to converse appropriately with residents, treating them with dignity and respect. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will educate the staff on the following campus guideline: Resident Rights How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following observations will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance:	12/21/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/21/2013
NAME OF PROVIDER OR SUPPLIER PRAIRIE LAKES HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060	

(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
	hallway, and a busy service hallway where several visitors and residents were passing by. The people were observed talking to one another. Announcements were heard from the intercom on the telephone on the nurses desk. The resident responded at one point by asking for someone named Marie, saying "show me the way out of here". An unidentified CNA came up behind the resident and said her name to her. The CNA told the resident she was going to get her (the resident) a cup of coffee, and then walked off. The resident was still talking to the staff person after they walked away. The Social Services Director (SSD) also walked up and started talking to the resident, and he asked if she wanted to go to an activity, which she refused. When he also talked to her about Catholic communion, the resident indicated they would have it the first Sunday of every month. The SSD then changed the subject and asked if she wanted to watch the news. He asked if she could hear it and the resident commented she heard all the bad stuff. The SSD then walked away without telling the resident he was walking away. She continued to talk to him and was		Observe 5 residents / staff interaction per hallway to ensure residents are being treated with dignity and respect. The results of the observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/21/2013
NAME OF PROVIDER OR SUPPLIER PRAIRIE LAKES HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060	

(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
	talking about church services after he was gone. The SSD had stepped over to the nurses desk and was within hearing distance. As the resident continued to talk, he did not respond. At that time, the resident was sitting near the 300 hallway and the service hallway where staff came by with rolling carts, making a fair amount of noise. At one point a person with a garbage can made a loud noise and the resident commented, " What was that ?" LPN #1 and the SSD were at the desk and did not answer her. 3.1-32(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/21/2013
NAME OF PROVIDER OR SUPPLIER PRAIRIE LAKES HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060	

(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
F000242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.			
	Based on interview and record review, the facility failed to ensure previous life schedule, preferences and choices were honored for 1 of 3 residents reviewed for choices. (Resident #44) Findings include: In an interview on 11/13/2013 at 2:55 P.M., a family member indicated Resident #44 goes to bed earlier here than she did at home. The family indicated when the resident had been at home, she was up at 7:00 A.M., and went to bed at 9 to 9:30 P.M. They indicated at times when they have visited, she has been in bed at 7:00 P.M. An undated form titled, "My Usual Routine," indicated Resident #44 usually got up at 7:00 A.M., and went to bed between 9-9:30 P.M. In an interview on 11/15/13 at 4 P.M.,	F000242	F 242 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #44 observed to ensure her personal preference for wake and bed time are being honored.Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents observed to ensure their personal preference for wake and bed time are being honored. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the nursing staff on the campus standard of understanding the needs, preferences and interests of the residents and practicing their usual and customary routines through the use of each resident's My Usual Routine form and the residents profile / care plan. It is the expectation that the preferences listed or voiced by the resident will be honored.	12/21/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE LAKES HEALTH CAMPUS	9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060

(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
	CNA #5 was not aware of the resident's routine. CNA #3 indicated the resident usually gets restless and is in bed around 8 P.M. CNA #5 indicated they find out this information via report, but it was not documented. 3.1-3(u)(1)		Nursing staff will also be re-educate on Resident Rights.How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following observations will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Observe 5 residents per hallway to ensure their personal preference for wake and / or bed time is being honored The results of the audit / observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter, for further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/21/2013
NAME OF PROVIDER OR SUPPLIER PRAIRIE LAKES HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060	

(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
F000279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).			
	Based on interview and record review the facility failed to develop a comprehensive care plan for dental care and behavior disturbances, for one resident reviewed for comprehensive care plans in a sample of 40 residents. (Resident # 41) Findings include : 1. Resident #41's record was reviewed on 11/15/2013 at 9 A.M. Diagnoses included but were not limited to, Alzheimer's disease,	F000279	F 279 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #41 - care plan was developed related to dental care and behavioral disturbances. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: DHS or designee will review all residents with dental concerns and behavior disturbances to ensure a care plan is in place. Measures put in place and systemic changes made to	12/21/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/21/2013
NAME OF PROVIDER OR SUPPLIER PRAIRIE LAKES HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060	

(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
	osteoarthritis, hypertension, and osteoporosis. During an interview on 11/15/2013 at 3 P.M., the resident's family member indicated the resident had trouble chewing but was doing better now after seeing the dentist and getting treatment for a tooth infection. He was continuing to watch her chewing because she still had broken teeth below the gum line on both sides of her lower jaw but was not feeling the discomfort she was. The MDS (Minimum Data Set) for this resident had no mention of oral problems. During an interview on 11/20/2013 at 10:46 A.M., the MDS coordinator indicated that it was because during her evaluation times no problem was reported and so no entry had been made. Resident # 41's medical record lacked any information indicating a comprehensive assessment and or care plan of her oral care. During an interview on 11/19/2013 at 2 P.M., the Assistant Director of Health Services, indicated that since Resident # 41's family member brushed this resident's teeth, they missed care planning her needs in this area.		ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Interdisciplinary Team on the following campus guidelines: Care Plans. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: review 5 residents per hallway with dental concerns and behavior disturbances to ensure a comprehensive plan of care has been developed. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/21/2013
NAME OF PROVIDER OR SUPPLIER PRAIRIE LAKES HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060	

(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
	During an interview on 11/20/2013 at 10:46 A.M., the MDS coordinator indicated the resident's oral needs should be care planned. 3.1-35(b)(1)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE LAKES HEALTH CAMPUS	9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060

(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
F000323 SS=D	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 fall prevention interventions were implemented for 3 of 9 residents reviewed for Accidents. (Residents #D, #E, and #N) Findings include: 1. On 11/14/2013 at 10:13 A.M., Resident #N was observed sitting in a wheelchair in the main dining room of the Legacy building. An alarming self-release belt was observed laying on the resident's lap/lower thigh area. The buckle was connected, but the belt extended out from the resident's body for about 1 foot. There was also a telephone-type cord for a seat pad alarm, however the connector end was not plugged into an alarm unit. The cord was dangling down behind the wheelchair seat back. There was no alarm unit on the wheelchair. There were 2 licensed nurses and 2 CNAs in the area, walking near and behind the resident, and sitting at the desk near the dining room. The	F000323	F 323 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #D, #E, #N are confidential as part of the complaint survey.Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: Review of all residents with fall prevention interventions to ensure they are implemented. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Nursing staff on the following campus guidelines: Fall Management Program How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Review of 5 residents per hallway with fall presentation interventions to ensure they are implemented. The results of the	12/21/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/21/2013
NAME OF PROVIDER OR SUPPLIER PRAIRIE LAKES HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060	

(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
	dining room was an "open concept" area, without walls or partitions between the desk, hallway, kitchenette, study area, and living room/lounge areas. On 11/14/2013 10:16 A.M., the resident continued to be in the dining room, sitting at a table with other residents having a snack. The self-release belt continued to be very loose, and the alarm cord was not connected to any alarm unit. In an interview on 11/13/2013 at 2:39 P.M., LPN #6 indicated the resident had a fall about 1 to 1 1/2 weeks ago, sometime in the mid-afternoon. He had tried to get up by himself out of the wheelchair, and fell. He had not sustained any injuries. On 11/15/13 at 10:11 A.M., the resident was observed sitting at a counter just outside the kitchenette, eating breakfast. The self-release belt was not buckled. The wheelchair seat pad alarm was not plugged into the alarm unit, which was hanging on one of the handles at the back of the wheelchair. The cord was dangling behind the wheelchair seat back, down back side of the wheelchair. In an interview at that time, CNA #9		audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/21/2013
NAME OF PROVIDER OR SUPPLIER PRAIRIE LAKES HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060	

(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
	indicated the resident was capable of unlatching the self-release belt on command, and that it shouldn't be "that loose." She buckled the seat belt and indicated she would tighten it until she could put "one fist" between the resident's body and the belt. She plugged in the alarm cord to unit. On 11/15/13 at 1:43 P.M., the resident was observed propelling himself from hall where he had his room, down to the end of another near-by hallway. He indicated he wasn't sure what he needed or exactly where he was. The self-release belt was undone. The seat pad alarm was still connected and turned on. In an interview on 11/19/13 at 1:50 P.M., LPN #4 indicated the concerns about alarm cords not being connected to the alarm unit had been brought to her attention. She indicated she had just completed visual scan and audit of all of the alarms on the unit, and had completed an inservice with the staff,. She indicated staff were now going to use tape to assure clip end was secure in the alarm unit. On 11/19/13 at 1:55 P.M., Resident #N was observed in his wheelchair,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/21/2013
NAME OF PROVIDER OR SUPPLIER PRAIRIE LAKES HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060	

(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
	propelling himself in the hall next to the dining room area. There was no alarm unit on the wheelchair, and the clip end of alarm cord was hanging down behind, and to side of, the back of the wheelchair. LPN #4 indicated she thought the resident may have just been weighed. The record for Resident #N was reviewed on 11/15/13 at 1:46 P.M. Diagnoses included, but were not limited to, dementia with delusions and behavioral issues, hypertension, diabetes Type II, chronic kidney disease, renal insufficiency, history of benign prostatic hypertrophy with urinary obstruction, and left leg weakness. The November, 2013 physician order recap (recapitulation) included the following orders: 8/30/13--Bed alarm while in bed. 8/30/13--Perimeter mattress due to poor safety awareness. 8/30/13--Chair alarm at all times while up in chair. 8/30/13--Bedside alarming mat next to bed. 10/22/13--Self-Release seat belt alarm on wheelchair due to frequent falls and decreased safety awareness--check function of alarm every shift.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/21/2013
NAME OF PROVIDER OR SUPPLIER PRAIRIE LAKES HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060	

(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
	11/11/13--D/C (discontinue) bed alarm "Fall Circumstance, Assessment and Intervention" forms included, but were not limited to, the following information about falls the resident had experienced: 8/9/13 at 1:15 A.M.--unwitnessed fall in room. Found kneeling beside bed. 8/22/13 at 10:00 A.M.--witnessed fall in front of Nurse's desk. Fell forward out of wheelchair. 9/12/13 at 7:20 A.M.--unwitnessed fall in room. Found on floor. 9/23/13 at 1:15 P.M.--unwitnessed fall in another resident's bathroom. Attempting to toilet self. "Alarm sounded." 10/7/13 at 4:40 P.M.--witnessed fall in hallway near wing of resident rooms. Attempted to stand from wheelchair unassisted and fell forward. 10/10/13 at 7:30 P.M.--witnessed fall in dining room. Slid from wheelchair. 10/15/13 at 2:30 P.M.--unwitnessed fall in another resident's room. "Alarm sounding." 10/30/13 at 9:50 A.M.--unwitnessed fall at doorway to his room. "Self release belt alarm clip broken." 11/1/13 at 1:28 P.M.--unwitnessed fall in his room. "During time of incident alarm wasn't heard, vacuum being ran."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/21/2013
NAME OF PROVIDER OR SUPPLIER PRAIRIE LAKES HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060	

(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
	11/4/13 at 10:15 A.M.--unwitnessed fall onto floor next to bed. Attempting self-transfer. "Wants to go to bed." The IDT (Interdisciplinary Team) review on 11/5/13 indicated "Request M.D. to review medications related to restlessness." On 9/20/13, the facility's Consulting Psychiatrist had increased the dosage of the resident's Risperdal, an antipsychotic medication, from 0.5 mg. (milligrams) twice a day to 0.5 mg. in the morning and 0.75 mg. at 5:00 P.M. The 2010 Nursing Spectrum Drug Handbook indicated side effects from Risperdal included, but were not limited to, aggressive behavior, dizziness, agitation, anxiety, hyperkinesia, drowsiness, nervousness and orthostatic hypotension. A Care Plan entry, dated 8/6/13, addressed a problem of "At risk for fall/injury" due to history of falls, potential for falls, disease process--dementia, functional problems--immobility, medication usage--antipsychotic, antidepressant. Interventions were listed as: Report falls; monitor side effects of any drugs that can cause gait disturbance, orthostatic hypotension, weakness,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/21/2013
NAME OF PROVIDER OR SUPPLIER PRAIRIE LAKES HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060	

(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
	sedation, vertigo (dizziness), change in mental status; low bed; quarter side rails; call light in reach; area free of clutter; defined parameter mattress; bedside sensor mat; bed/chair alarms; brace; wheelchair; lock brakes on bed, chair before transferring; sit on side of bed for a few minutes when rising from a lying positron before transferring/standing; appropriate footwear; 7/20/13--perimeter mattress/bed alarm; 7/22/13--bedside mat; 7/23/13--chair alarm, body pillow. An "Individual Plan Report" from the computer CareTracker system included the following interventions: "ADLS, ALL STAFF: I have a history of falling. 7/22/13--I now have a bed alarm, chair, and bed side mat to help keep me safe. 7/30/13--I now have a body pillow on my bed to remind me where the side of the bed is so I do not fall. 8/28/13--Change out mattress to a parameter mattress to keep from falling out of bed. 10/11/13--I now have Dycem in my wheelchair so that I do not slide out of my chair. 10/16/13--(NURSING STAFF) I now have an alarming seat belt. Please make sure that you check to see that			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/21/2013
NAME OF PROVIDER OR SUPPLIER PRAIRIE LAKES HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060	

(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
	the belt is in place and that it is functioning so that the belt helps to reduce the potiental (sic) for me to fall and injure myself. 11/4/13--Nursing staff please transfer me to the couch after lunch so that I do not try to get to the couch on my own and fall. 11/8/13--I no longer have a bed alarm, but I still need my alarming floor mat to alert staff that I am trying to get out of bed and potentially fall. FALLS: Place a PSA (personal safety alarm) on by bed/chair to remind me to ask for assist with transfers if necessary and to alert you if I don't." 2. The record for Resident #E was reviewed on 11/19/13 at 9 A.M. Diagnoses included, but were not limited to, dementia, history of breast cancer, degenerative joint disease, osteoporosis, and anxiety. The resident was originally admitted on 8/7/13, and was discharged to a geriatric psychiatric unit on 9/9/13 due to aggressive behavior, when she rammed her walker into other residents and staff. She returned to the facility on 9/25/13. The "Safety" portion of the admission			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/21/2013
NAME OF PROVIDER OR SUPPLIER PRAIRIE LAKES HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060	

(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
	assessment done on 9/25/13 indicated, "... uses walker/wheelchair, has cognitive impairment, does not have a history of falls, requires assistance to transfer and ambulate, forgets to wear glasses, requires assistive device and forgets to use, takes meds that may affect balance, cognition or gait, has disease that predisposes to falls, is unable to use call lights. Safety plan of care: provide and assure assistive device is accessible, ensure glasses are clean and in place, implement enabler to assist with fall prevention (1/4 side rails), observe medications for side effects that may effect balance, cognition or gait...." The resident had falls on the following dates per "Fall Investigation" documentation: 9/26/13--Found on the floor at 6:15 A.M. The resident had rolled out of bed onto the floor. The resident had received Risperdal 0.5 milligrams at 8 P.M., the night before, and was readmitted to a different room than prior to admission. The resident was a 2 person transfer and required assistance to stand or walk and refused to comply with safety measures such as call light use, alarms, appliances. The prevention			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/21/2013
NAME OF PROVIDER OR SUPPLIER PRAIRIE LAKES HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060	

(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
	update added a defined parameter mattress as a fall intervention. The IDT (Interdisciplinary Team) review indicated the root cause of the fall was the resident rolled out of bed. 9/28/13-- Found on floor at 4:45 P.M., in the resident's room. She was trying to get out of bed and was transferring herself. The investigation indicated staff offered to take the resident to the dining room, since dinner was scheduled for 5 P.M., and the resident was hungry. An intervention of low bed was already in place. 10/3/13--Found on the floor at 2:30 P.M., in the television room. The root cause was listed as "she slides in wheelchair when trying to move in wheelchair. Put nonskid cushion in wheelchair (dycem on top of cushion). Resident refused all vital signs." 10/6/13 --Found on floor at 9:40 A.M., in her room. The room was clean and clutter free, the resident was clean and in proper attire, and the staff placed personal alarms at this time. The other prevention was to offer to get the resident up at 7 A.M. The IDT review indicated the root cause of the fall was restlessness and poor safety awareness. 10/12/13--Found on floor at 11:15 P.M., in her room, attempting to self transfer. "Last medications that could			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/21/2013
NAME OF PROVIDER OR SUPPLIER PRAIRIE LAKES HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060	

(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
	contribute to fall: Depakote 8 p.m., Risperdal and Trazadone." The "Prevention" update indicated adding an alarming bedside mat. The IDT review indicated the root cause was possible medication adjustment. 10/18/13--Found on floor at 10 P.M., in her room on her knees at her bedside. The resident complained the night light in her room was too bright. Prevention update: removed night light. On 11/19/13 at 9:38 A.M., the resident was observed sitting in the television room by the nurses station. The personal alarm was on her wheelchair. The alarm cord was hanging down from the wheelchair and not plugged into the alarm unit. LPN #4 indicated at that time it should have been plugged in. 3. The record review for Resident D was completed on 11/18/13 at 11:30 A.M. Diagnoses included, but were not limited to, history of a femur fracture, low calcium, depression, Alzheimer's disease, benign prostatic hypertrophy (trouble urinating), epilepsy (seizures), and vertigo (dizziness). The sections for "Mobility" and "ADLs (Activity of Daily Living) on an			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/21/2013
NAME OF PROVIDER OR SUPPLIER PRAIRIE LAKES HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060	

(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
	undated "Admission Assessment" indicated the resident's ambulation was limited, required the assistance of one staff person with transfers, and used a walker. The Minimum Data Set assessment, dated 10/7/13, indicated the resident was to be supervised, and required the physical assistance of one staff when walking in her room. The "Monthly Nursing Assessment and Data Collection" form, dated 11/4/13, indicated the resident used a walker daily as an enabler and did not require assistance to transfer or ambulate. The Physical Therapy Department Discharge Summary dated 11/6/13 indicated, "...Standing Balance...The patient demonstrates standing balance...[able to maintain static balance with upper extremity support]...gait score of 19/28, which relates to the high risk fall risk category...." The "Fall Investigation" forms documentation indicated the resident had falls as follows: 9/30/13--The resident fell in his bathroom at 9 A.M.,The resident complained of left shoulder pain. The			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/21/2013
NAME OF PROVIDER OR SUPPLIER PRAIRIE LAKES HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060	

(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
	safety equipment was in place but was not functioning properly. The Interdisciplinary (IDT) notes indicated the resident had toileted himself and the door chime did not sound. The chime was repositioned. An X-ray of his left shoulder indicated degenerative disease, no fracture. 10/16/13--At 6 A.M., the resident was found on floor in his room. Vital signs were taken. The IDT review indicated instability and no foot wear on. A new prevention intervention added was an alarming floor mat 10/24/13--In the resident's room at 4 A.M., According to the IDT meeting notes, He fell when he got up to go to the bathroom. There was no injury. 11/5/13--At 3:30 P.M., the resident fell in his room as he was picking candy up off of the floor. The "Prevention" intervention added was to check for orthostatic hypotension for 3 days, and educate the resident on not picking things up off of the floor without assistance. IDT review indicated the resident had balance issues. . On 11/15/13 at 8:15 A.M., the resident was observed lying in bed with his eyes closed and snoring. The door to the bathroom was observed open. LPN #4 indicated at that time the alarm on the bathroom			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/21/2013
NAME OF PROVIDER OR SUPPLIER PRAIRIE LAKES HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060	

(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
	door was supposed to sound when the resident shuts the bathroom door. She also indicated he was supposed to have an alarm on the bed. LPN # 4 shut the door to show how it worked, but then opened the door back up and left it open. On 11/18/13 at 10:05 A.M., the resident was observed to be standing by the closet. The resident's walker was across the room. There were 2 nursing students in the bathroom assisting the spouse. They indicated he was picking out some clothes. They had the door shut most of the way and could not see the resident. In an interview on 11/18/13 at 10:10 A.M., LPN # 4 indicated the resident had two pressure alarms that would go off at the nurses station when the resident got out of bed. LPN #4 pushed on the alarms underneath of the bed sheets on the residents bed, and went out to the nurses station. The pressure alarm for the bed was not sounding when LPN #4 checked it at the desk. She found the unit was unplugged from the wall. She indicated the alarm unit should have been plugged in at all times. In an interview on 11/18/13 at 2:45 P.M., the interim Director of Health			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/21/2013
NAME OF PROVIDER OR SUPPLIER PRAIRIE LAKES HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060	

(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
	Services (DHS) indicated the door alarm for Resident #84 was for motion of the door when the door was opened and shut. The DHS indicated the resident and his spouse preferred to have the door to their room kept closed. She also indicated the bathroom door should remain shut at all times for the alarm to work properly. This Federal tag relates to Complaint IN00138950. 3.1-45(a)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE LAKES HEALTH CAMPUS	9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000329 SS=E	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. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			
	Based on interview and record review, the facility failed to identify specific behaviors to support the use or increased dosage of psychoactive medications. The facility failed to ensure behavior monitoring was complete and accurate. The facility failed to identify and attempt GDRs (Gradual Dose Reduction) of psychotropic medications or provide information why a GDR might be clinically contraindicated. The facility failed to monitor for side effects of	F000329	F 329 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #N is confidential as part of the complaint survey. Resident #18, #29 and #34 - 1). specific behaviors will be identified on the resident's care plan to support the use of or increased dosage of a psychoactive. 2). Behavior monitoring tool is in place, complete and accurate. 3). Will request the resident's MD to review their psychoactive	12/21/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/21/2013
NAME OF PROVIDER OR SUPPLIER PRAIRIE LAKES HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060	

(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
	medications. This deficiency impacted 4 of 5 residents reviewed for Unnecessary Medication Use. (Residents #18, #29, #34, and #N) Findings include: 1. The record for Resident #29 was reviewed on 11/15/13 at 10:24 A.M. Diagnoses included, but were not limited to, dementia with behavioral disturbances, hypertension, depressive disorder, urinary incontinence, sleep apnea, and glaucoma. A readmission History and Physical report, dated 3/24/12, indicated the resident had been admitted to a geriatric psychiatric unit for neuropsychiatric issues. The report indicated the resident was having increased difficulty with paranoia and delusional thinking. The psychiatrist had made multiple changes in her medications, and she was now on Remeron (an antidepressant medication) and Risperdal (an antipsychotic medication). The physician indicated "Still having some difficulty with some paranoid thinking.... Unfortunately, there is some issue with the family does not want to see Dr. (name of the psychiatrist) again. I am concerned		medication for possible Gradual Dose Reduction (GDR) or to provide information why a GDR might be clinically contraindicated. 4). Will add side effect monitoring for psychoactive medications to the residents care plan Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: DHS or designee will review residents with behaviors and / or psychoactive medications and ensure the following: 1). specific behaviors will be identified on the resident's care plan to support the use of or increased dosage of a psychoactive. 2). Behavior monitoring tool is in place, complete and accurate. 3). Request MD to review scheduled GDR for psychotropic medications or provide information why a GDR might be clinically contraindicated. 4). Will add side effect monitoring for psychoactive medications to the residents care plan Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate on the following: 1). Behavior documentation in care tracker - Nurses, CNAs, Social Service. 2). Clinically At Risk Program - Interdisciplinary Team. 3). Guideline for accessing behavior detail reports in care tracker - interdisciplinary	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/21/2013
NAME OF PROVIDER OR SUPPLIER PRAIRIE LAKES HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060	

(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
	with her mental status that we may require further ongoing psychiatric help." A physician's progress note, dated 9/26/13, did not address or identify any behavioral issues. A physician's progress note, dated 10/10/13, indicated in part "Very pleasant. She has history of profound dementia. She is very confused. She is verbal. She answers questions appropriately today.... She does have a history of coexisting depression and anxiety. She is on Remeron. She does have PRN (as needed) Ativan (an antianxiety medication) available.... Review of Systems: Psychiatric/Behavioral--Positive for confusion and dysphoric mood. Negative for behavioral problems and agitation. The patient is not nervous/anxious...." The November 2013 physician order recap (recapitulation) sheet included the following current psychotropic medication orders, with the date of the original order: 6/12/12--Mirtazapine (Remeron--an antidepressant medication) 30 mg. (milligram) Soltab--dissolve 1 tablet by mouth at bedtime for depression. 5/27/12--Risperidone (Risperdal--an		Team. 4). Guideline for Psychotropic Medication Usage and Gradual Dose Reduction - Interdisciplinary Team. 5). Mental Health Wellness Program - Nurses, CNAs, Social Service. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Review of 5 residents per hallway with behaviors and / or psychoactive medication use for the following: 1). specific behaviors are identified on the resident's care plan to support the use of or increased dosage of a psychoactive. 2). Behavior monitoring tool is in place, complete and accurate. 3). GDR for psychotropic medications or documented information why a GDR might be clinically contraindicated is in the medical record based on the GDR schedule. 4) Side effect monitoring for psychoactive medications is documented on the residents care plan The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/21/2013
NAME OF PROVIDER OR SUPPLIER PRAIRIE LAKES HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060	

(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
	antipsychotic medication) 0.5 mg. 1 by mouth twice a day for psychosis. 9/26/13--Sertraline (Zoloft--an antidepressant medication) 25 mg. 1 po daily for depression. In an Interview on 11/15/13 at 3:15 P.M., the Legacy Skilled and Assisted Living unit Facilitator indicated behaviors for residents on skilled wing were entered into the CareTracker computer kiosk by nurses and CNAs. He indicated he gets a print-out of the entries each morning, which he gives to appropriate nursing staff. He hesitated when asked if he does any kind of quantitative summary of behaviors occurring over a specified time period (i.e. weekly, monthly, quarterly). He indicated he himself did not do any kind of summary. When asked if there was a Behavior Tracking/Monitoring policy/procedure, he indicated he was not sure. On 11/18/13 at 11:37 A.M., the interim Director of Health Services was requested to provide a print-out of the observed behaviors entered in the CareTracker system for Resident #29. She was also requested to provide documentation of any recommendations or attempts for a Gradual Dose Reduction (GDR) for the Risperdal and Remeron in the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/21/2013
NAME OF PROVIDER OR SUPPLIER PRAIRIE LAKES HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060	

(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
	past year, or documentation from the physician discussing why a GDR would be clinically contraindicated. On 11/19/13 a "Behavior Detail Report" was provided for review. The report indicated 167 "observations" (entries) had been made for behaviors between 9/18/13 at 4:28 A.M. and 11/17/18 at 7:25 A.M. One entry on 9/25/13 at 4:07 A.M. indicated the resident had woken up at 2:30 A.M. and "wasn't tired and couldn't sleep. Assisted to bathroom and redirected back to room several times. Eventually, got her to lay down on couch in T.V. room and go to sleep." An entry dated 10/6/13 at 3:12 P.M. indicated the resident was "wandering." All other entries indicated "None of these behaviors apply." On 11/19/13, the interim Director of Health Services was requested to provide a key or other documentation identifying the specific behavior choices available in the CareTracker system. She indicated she could provide a "snap shot" of the screen that would identify the selection available. At the final exit on 11/21/13 at 12:00			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/21/2013
NAME OF PROVIDER OR SUPPLIER PRAIRIE LAKES HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060	

(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.M., no additional information/documentation was provided for review related to specific behavior tracking for the use of the antipsychotic and antidepressant medications, or GDR attempts or explanation about why an attempt was contraindicated. At the exit, the interim Director of Health Services indicated they had provided whatever documentation they were able to locate. 2. The record for Resident #N was reviewed on 11/15/13 at 1:46 P.M. Diagnoses included, but were not limited to, dementia with delusions and behavioral issues, coronary atherosclerosis, hypertension, diabetes Type II, renal insufficiency, and weight loss. A physician's History and Physical report, dated 7/8/13, indicated the resident had "Chronic dementia with progressive decline. Has required full-time caregiver and has been living at home. Status has continued to decline. Caregivers noted he has lost about 25 pounds in the past 3 months; has had decreased interest in eating and drinking. Started to have increased problems with behaviors--became physically aggressive."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/21/2013
NAME OF PROVIDER OR SUPPLIER PRAIRIE LAKES HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060	

(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
	The November 2013 physician order recap (recapitulation) sheet included the following current psychotropic medication orders, with the date of the original order: 8/21/13--Start Risperidone (Risperdal--an antipsychotic medication) 0.5 mg. (milligrams) 1 by mouth twice a day. 9/21/13--Increase Risperdal to 0.5 mg. 1 by mouth every morning for dementia with behavior problems; and 0.5 mg.--give 1 tablet with 0.25 mg.=0.75 mg. every day at 1700 (5:00 P.M.). The facility Consultant psychiatrist "Psychiatric and Behavioral Health Assessment and Initial Treatment Plan" report, dated 9/20/13, indicated "He had one inpatient psych (psychiatric) admission..., followed by Dr. (name of psychiatrist) while still at home. He has had an admission to (another geriatric psychiatric unit) 8/13 to 8/23/13 second to increased physical aggression, i.e. throwing chair, attempting to hit staff, etc. Asked to evaluate per family/physician request. Staff report his behavior has improved, however does have episodes of increased agitation/anxiety, especially in the evening. He becomes restless and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/21/2013
NAME OF PROVIDER OR SUPPLIER PRAIRIE LAKES HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060	

(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
	paces/exit seeks...." In an Interview on 11/15/13 at 3:15 P.M., the Legacy Skilled and Assisted Living unit Facilitator indicated behaviors for residents on skilled wing were entered into the CareTracker computer kiosk by nurses and CNAs. He indicated he gets a print-out of the entries each morning, which he gives to appropriate nursing staff. He hesitated when asked if he does any kind of quantitative summary of behaviors occurring over a specified time period (i.e. weekly, monthly, quarterly). He indicated he himself did not do any kind of summary. When asked if there was a Behavior Tracking/Monitoring policy/procedure, he indicated he was not sure. On 11/18/13 at 11:37 A.M., the interim Director of Health Services was requested to provide a print-out of the observed behaviors entered in the CareTracker system for Resident #N, in order to demonstrate behaviors specific for the use of an antipsychotic medication, and which warranted an increase in his Risperdal on 9/20/13. On 11/19/13, a "Behavior Detail Report" was provided for review. The report indicated 172 "observations"			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/21/2013
NAME OF PROVIDER OR SUPPLIER PRAIRIE LAKES HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060	

(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
	(entries) had been made for behaviors between 9/18/13 at 2:43 A.M. and 11/17/13 at 12:53 A.M. Entries on 9/19/13 at 4:15 P.M., 9/29/13 at 4:37 P.M., 10/5/13 at 3:36 P.M., and 10/19/13 at 7:22 P.M. indicated a behavior of "wandering." All other entries indicated "None of these behaviors apply." On 11/19/13, the interim Director of Health Services was requested to provide a key or other documentation identifying the specific behavior choices available in the CareTracker system. She indicated she could provide a "snap shot" of the screen that would identify the selection available. At the final exit on 11/21/13 at 12:00 P.M., no additional information/documentation was provided for review related to specific behaviors that were tracked to support the use of an antipsychotic medication, and which warranted the increase in this medication. 3. The record review for Resident #34 was completed on 11/18/13 at 1:30 P.M. Diagnoses included, but			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/21/2013
NAME OF PROVIDER OR SUPPLIER PRAIRIE LAKES HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060	

(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
	were not limited to Alzheimer's disease, diabetes, depression, high blood pressure, and history of a hip fracture. A Nurses note, dated 10/9/13 at 1:30 P.M., indicated the resident was seen by the Nurse Practitioner (NP), who ordered an in-and-out catheter to check for a urinary tract infection because the resident was experiencing increased confusion. The physician's progress note, dated 10/9/13 at 3:10 P.M., indicated the NP saw the resident and ordered labs. She indicated reason for the visit was a diagnosis of dementia with increased confusion. She ordered a psychology evaluation to be done by Social Services, and referred the resident to a consultant psychiatrist due to a diagnosis of depression. She ordered Remeron (an antidepressant) 15 milligrams every night. The physician's orders on 10/14/13 added a diagnosis of depression/anxiety. The resident's medications on a document titled " Routine Orders "(MD recapitulation) listed the following medications:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/21/2013
NAME OF PROVIDER OR SUPPLIER PRAIRIE LAKES HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060	

(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
	Citalopram (an antidepressant medication) 10 milligrams 1 by mouth daily for depression (4/11/13) Remeron (an antidepressant) 15 milligrams 1 tab by mouth daily every bedtime for anxiety depressed mood. (10/9/13) The PRN (as needed) medication tracking form for October 2013 indicated the resident had received the following medications: 10/16/13--Hydrocodone (a pain medication) 10/16/13-Ativan (an anti-anxiety medication) 0.5 milligrams at 4 P.M., for anxiety 10/20/13-Ativan 0.5 milligrams at 7:40 P.M., for anxiety 10/26/13-Ativan 0.5 milligrams at 22:50 P.M. (10:50 P.M.), for anxiety The facility's consultant Pharmacist "Medication Regimen Review" form indicated there were no irregularities or other review required for 1/8/13, 2/14/13, 4/15/13, 5/14/13, 6/9/13, 7/05/13, 8/16/13, 9/14/13, and 10/24/13. A request was made to the Director of Health Services (DHS) on 11/18/13, regarding any information regarding behaviors related to depression and anxiety, and any monitoring for side			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/21/2013
NAME OF PROVIDER OR SUPPLIER PRAIRIE LAKES HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060	

(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
	effects of the antidepressant medication. In an interview on 11/18/13 at 11:00 A.M., the interim Director of Health Services indicated Resident #34 had no behaviors tracked for anxiety or depression. She also indicated the mood and behavior tracking since August for this resident did not indicate any concerns as the documentation reflected no behaviors. The exit conference was held on 11/21/13 at noon. There was no documentation provided for side effects of anti-depressant medications provided at this time. 4. Resident # 18's record was reviewed on 11/15/2013 at 12:51 P.M. Diagnoses included but were not limited to, dementia without behavioral disturbance, muscle weakness, essential hypertension, and congestive heart failure. The November 2013 physician order recap (recapulation) listed medications which included, but were not limited to, Zyprexa (an anti-psychotic medication) 5 mg(milligrams) to be given by mouth			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/21/2013
NAME OF PROVIDER OR SUPPLIER PRAIRIE LAKES HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060	

(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
	twice daily for delirium, ordered on 10/3/13. The resident's record indicated the resident was admitted 10/2/2013. There was no re-evaluation of need for the antipsychotic medication for this resident found. There was no gradual dose reduction plan available. During an interview on 11/15/2013 at 1:22 P.M., the Social Service Director indicated he had just been at the facility 2 weeks. He was not aware of any dose reduction plan information available at this time. 3.1-48(a)(3) 3.1-48(a)(4) 3.1-48(b)(1) 3.1-48(b)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/21/2013
NAME OF PROVIDER OR SUPPLIER PRAIRIE LAKES HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060	

(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
F000431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview and record review, the facility failed to have medications labeled with the open date for 2 of 4 medication	F000431	F 431 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: The medications with no opened date	12/21/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/21/2013
NAME OF PROVIDER OR SUPPLIER PRAIRIE LAKES HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060	

(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
	rooms observed for medication storage. Findings include: The Medication Storage Review was completed on 11/20/13 at 10 A.M., on the 300 hallway, with LPN #7 in attendance. There were 2 meter dose inhalers (1 Albuterol and 1 Proventil) found for a resident that had no open date on them. LPN #7 indicated that inhalers should have an open date written on the label of medication. There were 2 bottles of nasal spray observed with no open date. There were 2 bottles of Natural Tears eye drops with no open date. LPN #7 indicated he was unaware of the policy for eye drops or nasal sprays. The tour for the 100 and 200 hallways were completed at 10:11 A.M., on 11/20/13. There was one bottle of open Fluvirin (flu vaccination) with no open date on it in the medication refrigerator. In an interview, LPN #8 indicated the nasal sprays and eye drops should have open dates on them. The medication refrigerator on the the Legacy Assisted Living and the Skilled unit medication room had 2		were destroyed and new medications ordered.Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: An audit will conducted of all opened medications on all medication carts and medication room refrigerators. Any medication that is noted to not be labeled, not have an open date or has a expired date will be destroyed and new medications will be ordered. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the licensed nursing staff on the following: The campus guideline for Specific Medication Administration Procedures How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: DHS or designee will complete an audit of all opened medications on all med carts and med room refrigerators to ensure that labels open date is in place. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/21/2013
NAME OF PROVIDER OR SUPPLIER PRAIRIE LAKES HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060	

(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
	undated and open bottles of Fluvirin. There were 3 out of 4 bottles of Fluvirin found that did not have an open date on them. In an interview with LPN #4 on 11/21/13 at 10:50 A.M., she indicated they should have an open date on them. On 11/20/13, a request was made for the facility policy for the dating of medications at the time they were opened. As of the exit conference on 11/21/13 at noon, no policy was provided. 3.1-25(j)		recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE LAKES HEALTH CAMPUS	9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview and record review, the facility failed to	F000441	F 441 Corrective actions accomplished for those residents	12/21/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/21/2013
NAME OF PROVIDER OR SUPPLIER PRAIRIE LAKES HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060	

(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
	ensure the staff were sanitizing, washing hands, and changing gloves following proper procedures for sanitization of hands for 3 of 3 observations for infection control. (LPNs #1 and #10) Findings include: 1. On 11/15/13 at 11:37 A.M., LPN #1 was observed while checking Resident #38's blood sugars. LPN #1 took all of the monitoring tools and laid them on the resident's dresser. He then put gloves on and took the resident's finger and pricked it with lancet and squeezed the blood out of the finger. After checking the blood glucose level, he picked up the bottle of insulin off of the dresser with the same gloves on, and opened the cap of the needle, and withdrew the insulin from the multi dose vial. LPN #1 then took off his gloves. The nurse did not wash or sanitize his hands after removing the gloves. LPN #1 then went to the medication cart to gather items for the the next resident to check his blood sugar. LPN #1 prepared his blood sugar testing materials, the monitor, strips, alcohol pad and then put on a new pair of gloves without sanitizing or washing hands. LPN #1 then went to		found to be affected by the alleged deficient practice: LPN #1 and #10 were coached / educated regarding this alleged deficient practice regarding proper procedure for hand sanitation and changing of gloves per the Standard Precautions and Hand Washing Guidelines. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected by the same alleged deficient practice. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Licensed Nurses on the following campus guideline: Standard Precautions and Hand WashingHow the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: 1 nurse / 5 residents per hallway will be observed during treatment care and medication administration to ensure hand washing/sanitizing and glove use protocols are followed per the Standard Precautions and Hand washing guideline. The results of the audit	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/21/2013
NAME OF PROVIDER OR SUPPLIER PRAIRIE LAKES HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Resident #116 to perform his blood glucose check at 11:46 A.M. LPN #1 took the resident's finger and pricked it with lancet and with his gloves on, and squeezed the blood out of the finger. Then LPN #1 with his gloves still on, checked the blood sugar and then touched the doorknob to the bathroom, the doorknob to the hallway door, and the resident's handles on his wheelchair. The nurse then pushed the resident in the wheelchair down the hall to the medication cart with his gloves still on. In an interview on 11/15/13 at 3:30 P.M., the Director of Health Services indicated the nurse should wash hands after removing gloves after doing a blood glucose check. 2. During a suprapubic urinary catheter insertion site care dressing change observation, on 11/18/2013 at 10:15 A.M., LPN #10 was observed cleaning the site, changing gloves without sanitizing her hands between glove changes, applying ointment to the site, changing gloves without sanitizing her hands and applying a fresh dressing. 3. The facility's policy and procedure		observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/21/2013
NAME OF PROVIDER OR SUPPLIER PRAIRIE LAKES HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060	

(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
	used for hand washing and glove use was requested on 11/18/2013. A Standard Precautions purpose and procedure document dated Dec. 2010, was provided by the Director of Nursing at 11:35 A.M. The document indicated the following: " Gloves and Hand washing... Gloves should be changed after having contact with infective material... remove and discard gloves within the room and wash hands immediately...." 3.1-18(l)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/21/2013
NAME OF PROVIDER OR SUPPLIER PRAIRIE LAKES HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060	

(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
F009999	STATE FINDINGS 3.1-14 PERSONNEL (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. This State rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure new employee physical examinations were completed by appropriately credentialed medical professionals (i.e. Medical Doctor, Nurse Practitioner, Physician's Assistant, or Clinical Nurse Specialist--R.N.) within one month prior to employment , for 8 of 10 new employees hired between 6/25/13 and 10/29/13. (LPN #12, LPN #13, CNA #14, CNA #15, CNA #3, CSS #16, Dietary Chef #17, and Housekeeper #18) Findings include: Following the entrance conference on 11/12/13, the Executive Director provided completed Employee Records forms, listing all employees	F009999	F 9999 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: All new hires will have a physical exam completed by a credentialed medical professional within one month prior to hire. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All new hires will have a physical exam completed by a credentialed medical professional within one month prior to hire. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the campus leaders involved in the hiring process on the following state regulation: Personnel - a physical examination shall be required for each employee of the facility within one month prior to employment. Examination to be completed by appropriately credentialed medical professional. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Audit of all new hire	12/21/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/21/2013
NAME OF PROVIDER OR SUPPLIER PRAIRIE LAKES HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060	

(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
	in the facility with their position and date of hire. A random selection of 10 new employees were chosen for file review. Eight of the employees lacked a physical exam completed by one of the credentialed medical professionals within one month prior to hire, as follows: A. LPN #12, date of hire 10/29/13--The physical examination form indicated the exam was performed by a facility R.N./Staff Development Coordinator. The form was then signed by a Nurse Practitioner on 11/14/13. There was no documentation that indicated the facility RN who performed the exam had the required medical credentials to do so. B. LPN #13, date of hire 7/23/13--The physical examination form indicted the exam was performed on 7/19/13 by the facility's previous Director of Health Services/RN. The form was signed by a Nurse Practitioner on 10/28/13. There was no documentation that indicated the Director of Health Services who performed the exam had the required medical credentials to do so. C. CNA #14, date of hire 10/22/13--The physical examination form		employee files to ensure a physical examination was completed by a credentialed medical professional within one month prior to hire. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/21/2013
NAME OF PROVIDER OR SUPPLIER PRAIRIE LAKES HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060	

(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
	indicated the exam was performed by the Assistant Director of Health Services/RN on 10/25/13. The form was signed by the Nurse Practitioner on 11/14/13. There was no documentation that indicated the Assistant Director of Health Services who performed the exam had the required medical credentials to do so. D. CNA #15, date of hire 6/25/13--No physical examination form was located in the file. In an interview on 11/21/13 at 10:00 A.M., the interim Director of Health Services indicated the physical examination form had been sent to the physician's office for signature, but had since been lost. E. CNA #3, date of hire 8/20/13--The physical examination form indicated the exam was performed by the previous Director of Health Services on 8/14/13. The form was signed by the Nurse Practitioner on 10/28/13. F. CSS #16, date of hire 9/3/13--The physical examination form indicated the exam was performed by the previous Director of Health Services on 8/20/13. The form was signed by a Nurse Practitioner on 10/28/13. G. Dietary Chef #17, date of hire 9/24/13--The physical examination			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/21/2013
NAME OF PROVIDER OR SUPPLIER PRAIRIE LAKES HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060	

(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
	form indicated the exam was performed by a facility LPN on 9/2/13. There was no signature by an M.D. or Nurse Practitioner. H. Housekeeper #18, date of hire 9/4/13--The physical examination form indicated the exam was performed by a facility LPN on 9/26/13. There was no signature by an M.D. or Nurse Practitioner. In an interview on 10/21/13 at 10:00 A.M., the interim Director of Health Services indicated she had not been aware that facility nursing staff were performing the physical examinations for new hires. 3.1-14(t)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE LAKES HEALTH CAMPUS	9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060

(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
R000000	The following Residential deficiencies were cited in accordance with 410 IAC 16.2-5.	R000000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Annual Recertification and State Licensure Survey and Complaint Survey (IN000138950 and IN000139130) on November 21, 2013. Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE LAKES HEALTH CAMPUS	9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060

(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
R000184	410 IAC 16.2-5-1.6(h) Physical Plant Standards - Noncompliance (h) The facility shall have natural lighting augmented by artificial illumination, when necessary, to provide light intensity and to avoid glare and reflective surfaces that produce discomfort and as indicated in the following table: Minimum Average Area — Foot Candles Corridors and interior ramp — 15 Stairways and landing — 20 Recreation area — 40 Dining area — 20 Resident care room — 20 Nurses' station — 40 Nurses' desk for charts and records — 60 Medicine cabinet — 75 Utility room — 15 Janitor's closet — 15 Reading and bed lamps — 20 Toilet and bathing facilities — 20 Food preparation surfaces and utensil washing facilities — 70 Based on observation and interview, the facility failed to provide adequate lighting of at least a minimum of 20 foot candles in a residents rooms, for 3 of 3 rooms checked for lighting illumination. (Rooms 519, 520 and 521) Findings include: During an interview on 11/21/13 at 10:00 A.M., Resident #160 indicated her room (Room 519) was "kind of dark," and she wished it was brighter.	R000184	R 184 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #519, #520, #521 - Floor lamps placed in these resident's room to provide adequate lighting. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: A lighting tester has been ordered. Upon arrival of the testing device, the Director of Plant Operations (DPO) or designee will inspect each residential room, using the	12/21/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/21/2013
NAME OF PROVIDER OR SUPPLIER PRAIRIE LAKES HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060	

(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
	On 11/21/13 at 10:15 A.M., with the Director of Plant Operations (DPO) in attendance, the lighting in Room 519 was checked with a light meter. The light in the room was measured at 16 foot candles. The same reading of 16 foot candles was obtained in Room 521. In room 519, there was a reading of 14 foot candles, however one of the light bulbs in the lighting unit was out. On the day of the readings, all available lights in the rooms were turned on, the window blinds were open, and the sky outside was cloudy. In an interview at that time, the DPO indicated the amount of lighting in each room was standard at all of the Trilogy facilities, and that the corporate office makes this decision. He follows their guidelines.		device, to ensure adequate lighting. If adequate light is not provided, a floor lamp will be placed in the resident's room. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: 1). The company's Engineer plans to inspect the lighting for the residential rooms in effort to identify a solution to ensure adequate lighting is being provided. 2). The Executive Director will educate the DPO on the state regulation for providing adequate lighting of at least a minimum of 20 foot candles in a resident's room. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for 3 residential per hallway will be conducted by the DPO or designee 1 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Inspect the residential room, using the light testing device, to ensure adequate lighting. If adequate light is not provided, a floor lamp will be placed in the resident's room. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE LAKES HEALTH CAMPUS	9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060

(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
R000214	410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on interview and record review, the facility failed to obtain an evaluation of the individual needs of a resident prior to admission, for 3 of 3 residents admitted within the past year, in a sample of 6 residents reviewed. (Residents #150, #152, and #155) Findings include: 1. The record for Resident #152 was reviewed on 11/20/13 at 1:55 P.M. The admission information sheet indicated the resident was admitted on 3/22/13 to the Legacy Assisted Living dementia/Alzheimer's building. Diagnoses included, but were not limited to, senile dementia--Alzheimer's type, depression, chronic right shoulder pain, history of constipation, and gastroesophageal reflux disease. An evaluation of the resident's needs prior to admission was not found.	R000214	R 214 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #150, #152, #155 remain residents in the campus.Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents admitted to the residential campus have the potential to be affected by this same alleged deficient practice. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Admission Team on the following campus guidelines: Preadmission Evaluation. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: review	12/21/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/21/2013
NAME OF PROVIDER OR SUPPLIER PRAIRIE LAKES HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060	

(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
	In an interview on 11/20/13 at 3:30 P.M., the interim Director of Health Services indicated the facility uses the same "Evaluation and Service Plan" form for pre-admission evaluations, that is used for the other periodic evaluations and service plan updates. She indicated the form would be completed on the day a resident arrives at the facility to determine the "score" for services required. The "Evaluation and Service Plan" form for Resident #152 had no date in the #1 column even though there were evaluation scores in the boxes. Column #2 had a date of 7/26/13, and column #3 had a date of 9/27/13. There was no other date on the form to indicate when a pre-admission evaluation might have been completed. In an interview on 11/21/13 at 10:00 A.M., the interim Director of Health Services indicated the resident did not actually come into the facility until 3/27/13. She indicated she could not find an evaluation of the resident's needs prior her actual arrival in the facility, or before the previously scheduled date of admission of 3/22/13.		pre-admission evaluations for all residential new admission to ensure they were complete prior to the admission date. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/21/2013
NAME OF PROVIDER OR SUPPLIER PRAIRIE LAKES HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060	

(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
	2. The record for Resident #150 was reviewed on 11/21/13 at 1:45 P.M. Diagnoses included, but were not limited to, prostate cancer, dementia, depression, and high blood pressure The resident was admitted on 6/28/13. There was no preadmission evaluation found in the resident's chart. 3. Resident # 155's residential clinical record was reviewed on 11/20/2013 at 2:30 P.M. Diagnoses included but were not limited to memory loss, spinal fusion and anxiety. The resident was admitted on 7/20/2012. The resident's record lacked the required pre-admission evaluation. During an interview on 11/21/2013 at 10:00 A.M., with the Director of Health Services, indicated there was no pre-admission evaluation found for this resident.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE LAKES HEALTH CAMPUS	9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060

(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
R000217	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on interview and record review, the facility failed to identify and address the services to be provided to 1 of 1 residents who was experiencing frequent and recurrent UTIs (urinary tract infections); in a sample of 6 residents reviewed. (Resident #152)	R000217	R 217 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #152 service plan was updated to identify the services provided for frequent and recurrent UTIs. Identification of other residents having the potential to be affected by the	12/21/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/21/2013
NAME OF PROVIDER OR SUPPLIER PRAIRIE LAKES HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060	

(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
	Findings include: In an interview on 11/14/13 at 3:15 P.M., a family member indicated Resident #152 had received 6 antibiotics for 4 UTIs since the end of March or first of April, 2013. The family member indicated the resident would not initiate drinking fluids on her own due to her dementia, and was concerned the nursing staff were not assisting or cueing her enough. The record for Resident #152 was reviewed on 11/20/13 at 1:55 P.M. Diagnoses included, but were not limited to, senile dementia--Alzheimer's type, depression, fatigue, gastroesophageal reflux disease, chronic shoulder pain, and history of constipation. Physician orders for antibiotic medications from 4/23/13 were listed as follows: 5/12/13--Keflex 500 mg. (milligrams) twice a day for 10 days, for cough and elevated temperature. 6/9/13--Augmentin 500 mg. twice a day for 10 days, UTI. 7/26/13--Keflex 500 mg. twice a day for 10 days, right chest boil. 8/18/13--Cipro 250 mg. twice a day for 10 days, UTI.		same alleged deficient practice and corrective actions taken: DHS or designee will review / update the service plans for current residents to identify the services that are being provided. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Licensed Nurses on the following campus guidelines: Evaluation and Service Plan.How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: review of 5 resident service plans per residential hallway to ensure they identify the services being provided. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/21/2013
NAME OF PROVIDER OR SUPPLIER PRAIRIE LAKES HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060	

(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
	9/12/13--Pyridium (a urinary tract analgesic) 200 mg. three times a day for 48 hours. 9/13/13--Augmentin 500 mg. twice a day for 10 days, UTI. 10/14/13--Vibramycin 200 mg. twice a day for 10 days, UTI. 10/14/13--Macrobid 100 mg. daily; start after completion of Vibramycin. A physician's progress note dated 8/22/13 indicated "Plan: UTI--continue present antibiotic treatment. Recommend peri-care twice a day with fragrance-free anti-bacterial soap; Increase fluids. On 10/14/13, the resident was seen by a urologist, who ordered the Vibramycin trial and prophylactic Macrobid treatment. Follow-up appointments were to be scheduled with a Nurse Practitioner, and then with the urologist for possible further testing by CT scan and/or cystoscopy. The "Evaluation and Service Plan" form was last dated 9/27/13. The Service Plan had no documentation related to the resident's frequent UTIs, or for services to offer more assistance and/or cueing to the resident to increase fluid intake, as recommended by the physician on 8/22/13.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/21/2013
NAME OF PROVIDER OR SUPPLIER PRAIRIE LAKES HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060	

(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
	In an interview on 11/21/13 at 10:00 A.M., the interim Director of Health Services reviewed the Service Plan form and indicated the section titled "Eating/Nutrition" should have had information about staff encouraging and assisting the resident to increase fluid intake.			