STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155329	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT INDIANAPOLIS	1302 N LESLEY AVE INDIANAPOLIS, IN 46219

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F000000	This visit was for a Recertification and State Licensure Survey. This visit included Investigation of Complaint IN00129119. Complaint IN00129119 - Unsubstantiated due to lack of evidence. Survey Dates: 5/28/2013- 6/05/2013 Facility number: 000222 Provider number: 155329 AIM number: 100274950 Survey Team: Courtney Mujic, RN- TC Beth Walsh, RN Karina Gates, Generalist Census Bed Type: SNF: 10 SNF/NF: 139 Total: 149 Census Payor Type: Medicare: 41 Medicaid: 79 Other: 29 Total: 149 These deficiencies reflect state findings cited in accordance with 410	F000000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after June 26, 2013.	

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.

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	IAC 16.2. Quality review 6/12/13 by Suzanne Williams, RN			

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F000248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. Based on observation, interview, and record review, the facility failed to ensure a resident's preferred activities were consistently provided for 1 of 3 residents reviewed for activities, out of 13 who met the criteria for activities. (Resident #128) Findings include: The clinical record for Resident #128 was reviewed on 6/3/13 at 11:30 a.m. The diagnoses for Resident #128 included, but were not limited to: hypothyroidism, hypertension, anemia, and history of pulmonary embolism. During an interview with Family Member #4, on 5/30/13 at 11:30 a.m., Family Member #4 indicated staff does not encourage Resident #128 to attend activities. A review of an Activity Assessment with a Family Member (no name), dated 4/20/13, indicated listening to	F000248	**F248 Activities Meet interests/Needs of each resident** It is the practice of this provider to ensure that all alleged violations involving activities meet interests/needs of each resident are in accordance with State and Federal law. **What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** A new Activity assessment was completed on resident #128. The residents care plan was updated with her preferred activities. Activities will be provided according to the resident's preference. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by this alleged deficient practice. Activities staff will be educated on activity preferences and following the residents activity care plan by the Activities Director or designee on or before 6/26/2013. Activities will complete a house wide audit to ensure that	06/26/2013

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	music, specifically "Spanish music and oldies" was very important. The assessment also indicated keeping up with the news, specifically on the television, was very important. In a section, titled, "Activity Areas of Emphasis," it indicated television and music as Independent Activities. The Assessment also indicated, the "resident attend [sic] concert, theme party, church, use [sic] attend bingo everyday, but resident had a decline in health and her son want [sic] her to lay down after meals." A review of an Activity Assessment, with a staff member (no name), for a sig (significant) change, was dated 5/13/13. It indicated it was very important to "listen to music you like," with a specification of oldies and Spanish music. The Assessment also indicated it was somewhat important to keep up with the news, on television. In a section, titled, "Activity Areas of Emphasis," it indicated television and music as Independent Activities. The assessment also indicated, in the Summary Section, "Resident had a sig change in health, resident receive [sic] hospice care, have 1;1 [sic] visit weekly for social and cognitive stimulation. Will continue to observed [sic] resident condition and proceed		all residents have a current activity assessment and they are receiving activities based on the assessment/preference. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** Activities staff will be educated on activity preferences and following the residents activity care plan by the Activities Director or designee on or before 6/26/2013 A daily/activity preferences form will be completed quarterly, annually and with significant change by the activities director. The residents care plan will then be updated with the current resident activity preferences by the activities director or IDT team. The activities director will utilize an activity attendance record to ensure residents are participating in their activity preference. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** An activity CQI audit tool will be completed for six months with audits being completed once weekly for one month, bi-weekly for 2 months, and then monthly for 3 months by a nurse manager or designee The activity CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued	

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	with care plan." A review of a care plan, dated 5/15/13, indicated the problem, Resident had low attendance to group activities and would benefit from one-on-one programming. An approach, dated 5/15/13, indicated to provide 1:1 visits 3 times a week. During the following observations, Resident #128 was observed lying in bed, awake, with no music/TV on: 5/29/13 at 1:50 p.m., 5/29/13 at 3:12 p.m., 6/3/13 at 1:20 p.m., 6/3/13 at 3:45 p.m., 6/4/13 at 2:00 p.m., and 6/4/13 at 2:45 p.m. A review of the 1:1 activity logs indicated the following: 5/16/13 (no time) for 10 minutes, offered exercise; resident had verbal and non-verbal response of listening. 5/17/13 (no time) for 10 minutes, offered music; resident had verbal and non-verbal response of smiling and listening. 5/20/13 (no time) for 10 minutes, offered short story; resident had verbal and non-verbal response of smiling and listening. 5/21/13 (no time) for 10 minutes, offered music; resident had verbal		need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee. Date of Compliance 6/26/2013.	

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	and non-verbal response of smiling and indicated enjoyment. 5/24/13 (no time) for 10 minutes, offered exercise; resident had verbal and non-verbal response of listening. 5/27/13 (no time) for 10 minutes, offered short story; resident had verbal and non-verbal response of smiling and listening. 5/29/13 (no time) for 10 minutes, offered exercise; resident had verbal and non-verbal response of listening. 5/30/13 (no time) for 10 minutes, offered music; resident had verbal and non-verbal response of listening and smiling. 6/3/13 (no time) for 10 minutes, offered music; resident had verbal and non-verbal response of smiling, listening, and indicated enjoyment. A review of Resident #128's Attendance on the May/June 2013 Activity Calendar indicated the following for musical events listed: 5/19/13 at 2:00 p.m.- Banjo and Tap-no participation, refusal, or reminder/encouragement to attend the activity. 5/20/13 at 9:00 a.m.- Music Stimulation-no participation, refusal, or reminder/encouragement to attend the activity. 5/30/13 at 3:10 p.m.-Music Stimulation-no participation, refusal,			

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	or reminder/encouragement to attend the activity. 6/3/13 at 3:10 p.m.-Music Stimulation-no participation, refusal, or reminder/encouragement to attend the activity. 6/4/13 at 10:40 a.m.-Golden Age-no participation, refusal, or reminder/encouragement to attend the activity. During an interview with Social Services Assistant (SSA) #7, on 6/4/13 at 1:45 p.m., she indicated Resident #128's primary language was Spanish. Resident #128 was able to make needs known and was able to understand simple sentences, but SSA #7 was unsure if Resident #128 was able to understand a short story. SSA#7 also indicated Resident #128 liked attending activities, but has had a change in condition and wasn't able to attend activities as she previously did. On 6/4/13, at 3:15 p.m., the Activity Director (AD) indicated Resident #128 liked attending activities, but now she receives 1:1 activities. She also indicated Resident #128 does really enjoy music, as indicated by the Activity Assessments. The AD also indicated she had not asked a family member if music playing in Resident			

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	#128's room while she was in there, would be beneficial, but the AD felt music playing while the Resident was in the room, was a good idea. The AD also indicated the facility does have a stereo/CD player and Spanish CDs that they could easily put in Resident #128's room to play, while she was in there. The AD also indicated she could easily turn Resident #128's television to a Spanish station for Resident #128, to listen to. At 3:45 p.m., on 6/4/13, the AD indicated 1:1 activities were only 10 minutes long. She also indicated she was going to put a CD player in Resident #128's room, at that time. The AD also indicated again, that she felt music playing in Resident #128's room was a good idea and would make her stay, at the facility, more enjoyable. During an interview, with Family Member #5, on 6/5/13 at 12:30 p.m., she indicated any type of stimulation for Resident #128 was a good idea and having music/TV playing, while Resident #128 was in her room, was a "wonderful" idea. 3.1-33(a)			

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F000278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. Based on record review, observation and interview, the facility failed to ensure the MDS assessment was accurate for a resident's oral/dental status, for 1 of 33 residents whose assessments were reviewed (Resident #308).	F000278	**F278 Assessment Accuracy/Coordination/certified** It is the practice of this provider to ensure that all alleged violations involving Assessment accuracy/coordination/certified	06/26/2013

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	Findings include: The clinical record for Resident #308 was reviewed on 6/4/13 at 1:30 p.m. The diagnoses for Resident #308 included, but were not limited to: anxiety. On 5/30/13 at 2:59 p.m., Resident #309 was observed with missing teeth as well as broken teeth on the top, front portion of his oral cavity. At this time, the resident indicated he was missing teeth and would like to go to the dentist. Review of Resident #308's 5/15/13 admission MDS (minimum data set) assessment, the oral/dental status section did not indicate he had broken natural teeth. An observation of Resident #308's oral cavity was made with MDS Assistant #7 on 6/5/13 at 11:18 a.m. During this observation, Resident #308 indicated, "Sometimes, when I bite down, it hurts." Immediately after the observation, MDS Assistant #7 indicated, "On the top, I saw broken teeth. The MDS should have indicated that." 3.1-31(i)		are in accordance with State and Federal law. **What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** A new dental assessment was completed on resident #309 indicating resident does have broken teeth present. Resident #309 has been offered an evaluation by a dentist. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by this alleged deficient practice. SDC or designee to educate facility nurses on accurate dental assessments and documentation on before 6/26/2013. A house audit will be completed on all residents to ensure an accurate dental	

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			assessment. Upon admission a dental assessment is completed by the nurse and documented on the admission assessment. On the first business day after a resident admits to the facility a nurse managers reviews the accuracy of the oral assessment completed. Thereafter on a weekly basis a nurse performs a weekly oral assessment and documents the findings in the weekly summary. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** SDC or designee to educate facility nurses on accurate dental assessments and documentation on before 6/26/2013. Upon admission a dental assessment is completed by the nurse and documented on the admission assessment. On the first business day after a resident admits to the facility a nurse manager will review the accuracy of the oral	

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			assessment completed Thereafter on a weekly basis a nurse will perform a weekly oral assessment and documents the findings in the weekly summary. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** An assessments CQI audit tool will be completed for six months with audits being completed once weekly for one month, bi-weekly for 2 months, and then monthly for 3 months by a nurse manager or designee The assessments CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee. Date of Compliance 6/26/2013.	

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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, observation and record review, the facility failed to develop a care plan for a resident's preference for dressing in a hospital gown and develop specific interventions for a fall risk care plan, for 2 of 33 residents reviewed for care plans. (Resident #138 and #170) Findings include: 1. The clinical record for Resident #138 was reviewed on 6/3/13 at 11:30 a.m. The diagnoses for Resident #138 included, but were not	F000279	**F279 Develop Comprehensive Care Plans** It is the practice of this provider to ensure that all alleged violations involving development of comprehensive care plans are in accordance with State and Federal law. **What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** Resident #138's care plan was updated with her preference of wearing a hospital gown during the day. Resident #170 no longer resides in the facility. **How will you identify other residents having the potential to be affected by**	06/26/2013

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	limited to: chronic kidney disease, dementia, and atrial fibrillation. During an interview with Resident #138, on 5/29/13 at 10:58 a.m., Resident #138 was observed in a hospital gown. Resident #138 indicated this was their preference for dress while residing in the facility. During the following observations, Resident #138 was observed dressed in a hospital gown: 5/30/13 at 10:12 a.m., 5/30/13 at 2:15 p.m., 5/31/13 at 2:45 p.m., and 6/3/13 at 3:40 p.m. The care plans reviewed for Resident #138 included, but were not limited to: Resident refuses showers at times, dated 4/2/13, Resident has grooming program to maintain current level of ADL (Activities of Daily Living) status, dated 1/11/13, Resident requires staff assist to complete daily bathing, grooming, personal hygiene, and toileting due to weakness and decreased safety awareness, dated 4/21/11. One of the interventions listed for the staff assist care plan, dated 4/21/11, indicated to encourage resident to choose what to wear daily, compliment appearance. If resident has difficulty choosing, limit choices		**the same deficient practice and what corrective action will be taken?** All residents who prefer to wear a gown during the day and all residents at risk for falls have the potential to be affected by this alleged deficient practice. SDC or designee to educate facility nurses and IDT team on resident specific comprehensive care plans on or before 6/26/2013. All care plans of those residents who prefer to wear a gown will be reviewed and updated with their preference by the DNS or designee All care plans of those residents at risk for falls will be reviewed by the DNS or designee to ensure that all interventions are specific and understandable **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** SDC or designee to educate facility nurses and IDT team on detailed comprehensive care plans on or before 6/26/2013. IDT will review and updates all resident care plans for accuracy related to fall and clothing preference upon admission, with significant change, quarterly, and annually per MDS schedule. IDT will ensure all care plans are specific and interventions are accurately written. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155329	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/05/2013
NAME OF PROVIDER OR SUPPLIER ROSEWALK VILLAGE AT INDIANAPOLIS		STREET ADDRESS, CITY, STATE, ZIP CODE 1302 N LESLEY AVE INDIANAPOLIS, IN 46219	

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	to 2-3 items. A care plan for resident's clothing preference for a hospital gown was not located in the clinical record. At 12:00 p.m., on 6/4/13, the DoN (Director of Nursing) indicated the purpose of care plans was to direct the resident's plan of care and care plans were for staff to utilize. He also indicated care plans were supposed to be individualized to each resident and if a resident had a specific preference/need, then that preference/need should be care planned. The DoN also indicated residents were typically dressed in street clothes, but if the resident had a preference for a hospital gown to worn daily, then that was something that should be care planned. 2. The clinical record for Resident #170 was reviewed on 6/3/13 at 11:00 a.m. The diagnoses for Resident #170 included, but were not limited to: dementia and gait abnormality. A review of a Fall Event, dated 5/19/13, indicated Resident #170 had an unwitnessed fall on the same date. A review of the Risk for Fall care plan,		**assurance program will be put into place?** A care plan CQI audit tool will be completed for six months with audits being completed once weekly for one month, bi-weekly for 2 months, and then monthly for 3 months by a nurse manager or designee The Care plan CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee. Date of Compliance 6/26/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155329	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/05/2013
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	dated 3/14/13, indicated an intervention of "environmental changes:" [sic]. During an interview, on 6/3/13 at 1:20 p.m., with Unit Manager/LPN #1, on the Unit where Resident #170 resides, indicated the above intervention needs to be clarified because the intervention was unclear on what the intervention meant. She also indicated she was going to change the intervention at that time. On 6/4/13, at 12:00 p.m., the DoN (Director of Nursing) indicated the purpose of care plans was to direct the resident's plan of care and care plans were for staff to utilize. He also indicated he was unsure if all staff members would be able to understand what the above intervention meant and the intervention needed to be clarified. 3.1-35(a)			

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F000282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.			
	Based on interview and record review, the facility failed to administer insulin per physician's orders for 1 of 10 residents reviewed for unnecessary medications. (Resident #309) Findings include: The clinical record for Resident #309 was reviewed on 6/5/13 at 12:00 p.m. The diagnoses for Resident #309 included, but were not limited to: diabetes mellitus. The June, 2013 Physician's Orders for Resident #309 indicated Accuchecks before meals and at bedtime, as well as Humalog (insulin) to be injected per sliding scale as follows: 150-200=2 Units 201-250=4 Units 251-300=6 Units 301-350=8 Units 351-400=10 Units	F000282	**F282 Services by qualified persons/per care plan** It is the practice of this provider to ensure that all alleged violations involving services by qualified persons/per care plan are in accordance with State and Federal law. **What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** The MD evaluated resident #309s recent blood sugars and insulin coverage All nurses have been re-educated on sliding scale insulin coverage and documentation by the SDC or designee on or before 6/26/2013. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents who receive sliding scale insulin have the potential to be affected by this alleged deficient practice. The SDC or designee will educate all facility nurses on sliding scale insulin coverage and documentation on or before 6/26/2013. A member of the nurse management team will review the mar and tar twice weekly to ensure that sliding scale insulin is	06/26/2013

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NAME OF PROVIDER OR SUPPLIER ROSEWALK VILLAGE AT INDIANAPOLIS		STREET ADDRESS, CITY, STATE, ZIP CODE 1302 N LESLEY AVE INDIANAPOLIS, IN 46219	

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	The Capillary Blood Glucose Monitoring Tool for Resident #309 indicated no units of insulin were given after the following Accucheck readings: 6/1/13, 9:00 p.m. = 172 6/2/13, 9:00 p.m. = 189 6/3/13, 9:00 p.m. = 169 During an interview with the DON (Director of Nursing) on 6/5/13 at 12:50 p.m., the above mentioned Capillary Blood Glucose Monitoring Tool for Resident #309 was reviewed by the DON who indicated, "Yeah, it looks like it wasn't given." The 5/21/13 diabetes mellitus care plan for Resident #309 indicated he was "at risk for adverse effects of hyperglycemia or hypoglycemia". Two approaches on the care plan were to "monitor blood sugars as ordered" and "medications as ordered." 3.1-35(g)(2)		being administered correctly as ordered. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** The SDC or designee will educate all facility nurses on sliding scale insulin coverage and documentation on or before 6/26/2013. Nurses will complete accu-checks as ordered per the physician's orders. The nurse will compare the accu-check result to the sliding scale insulin orders and administer the appropriate ordered amount of insulin. The nurse will then document the amount of insulin given on the diabetic flow-sheet. A member of the nurse management team will review the mar and tar three times a week to ensure that sliding scale insulin is being administered correctly as ordered. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** A MAR/TAR CQI audit tool will be completed for six months with audits being completed once weekly for one month, bi-weekly for 2 months, and then monthly for 3 months by a nurse manager or designee. A MAR/TAR CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT INDIANAPOLIS	1302 N LESLEY AVE INDIANAPOLIS, IN 46219

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			for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee. Date of Compliance 6/26/2013	

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NAME OF PROVIDER OR SUPPLIER ROSEWALK VILLAGE AT INDIANAPOLIS		STREET ADDRESS, CITY, STATE, ZIP CODE 1302 N LESLEY AVE INDIANAPOLIS, IN 46219	

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F000309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.			
	Based on interview and record review, the facility failed to ensure a hospice resident did not receive lab draws as ordered by the physician for 1 of 1 resident reviewed for hospice. Resident #161. Findings include: Resident #161's clinical record was reviewed on 6/3/2013 at 9:54 am. Diagnoses included, but were not limited to; kidney disease, peripheral vascular disease, osteoarthritis, hypertension, congestive heart failure, Alzheimer's. A care plan, dated 5/13/2013, indicated, "Problem: Resident is a (name of hospice company) hospice patient. Goal: Will maintain comfort with no s/s of psychological distress through next review. Approaches; Coordinate care with hospice. Keep family up to date on resident condition. Pain meds as ordered."	F000309	**F309 PROVIDE CARE/SERVICES FOR HISGHEST WELL BEING** It is the practice of this provider to ensure that all alleged violations involving providing care/services for highest well being are in accordance with State and Federal law. **What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** The lab was notified and all scheduled lab draws for resident # 161 were cancelled **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents who are palliative care or hospice have the potential to be affected by the alleged deficient practice The SDC or designee will educate all facility nurses and the lab nurse on properly discontinuing scheduled labs for hospice and palliative care residents who have orders for no labs on or before 6/26/2013. All charts of those	06/26/2013

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NAME OF PROVIDER OR SUPPLIER ROSEWALK VILLAGE AT INDIANAPOLIS		STREET ADDRESS, CITY, STATE, ZIP CODE 1302 N LESLEY AVE INDIANAPOLIS, IN 46219	

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	A physician order, dated 5/16/2013 at 3:05 pm, indicated, "no lab draws." A (name of lab company) document indicated, "Test Name Basic Metabolic PNL (panel)Specimen Collected 5/23/2013 at 4:35 (am) Reported 5/23/2013 at 14:26 (2:26 pm)." A (name of lab company) document indicated, "Test Name Basic Metabolic PNL (panel)Specimen Collected 5/30/2013 at 4:30 (am) Reported 5/30/2013 at 13:42 (3:42 pm)." An interview with Unit Manager #4, on 6/3/2013 at 11:05 am, indicated the medical records department is in charge of following up on lab orders. She isn't sure why this happened, the lab company not the stopping lab draws, because everything they do is in the computer. She went in and put an order to stop the lab draws in the computer today, so they (the lab company) should stop sending someone from now on. An interview with Medical Records LPN #5, interviewed on 6/4/2013 at 10:35 am, indicated, the next day after the nurse puts in the new lab order in the computer, she (the		residents who are palliative care or hospice with orders for no labs have been audited and lab has been notified to ensure scheduled lab draws were cancelled. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** The SDC or designee will educate all facility nurses and the lab nurse on properly discontinuing scheduled labs for hospice and palliative care residents who have orders for no labs on or before 6/26/2013. Nurses will review new orders daily. When a resident receives an order for no labs the nurse will contact the lab and notify them to cancel any pending labs. Once daily Monday thru Friday excluding holidays the IDT reviews all labs orders in am meeting. On the weekends the nurse supervisor will review lab order on hospice residents. The lab nurse will then review each lab order and ensure that any discontinued labs draws have been cancelled. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** A Lab CQI audit tool will be completed for six months with audits being completed once weekly for one month, bi-weekly for 2 months, and then monthly for 3 months by a nurse manager	

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NAME OF PROVIDER OR SUPPLIER ROSEWALK VILLAGE AT INDIANAPOLIS		STREET ADDRESS, CITY, STATE, ZIP CODE 1302 N LESLEY AVE INDIANAPOLIS, IN 46219	

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	Medical Records LPN #5) goes over the pink sheets, which are the paper copy of the written order. The supervisors give her the pink slips every morning from the orders written the day before. It is possible she could miss one when she is checking them over. In an interview, on 6/4/2013 at 10:52 am, the D.O.N. indicated "Yes, the order to stop the lab draws were not put into the computer until you brought it to our attention." Medical Records LPN #5 indicated, "It was totally my fault, I am the last check to ensure the lab orders are correct. I must have overlook this one, I will be more careful from now on." 3.1-37(a)		or designee The Labs CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee. Date of Compliance 6/26/2013	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT INDIANAPOLIS	1302 N LESLEY AVE INDIANAPOLIS, IN 46219

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F000323 SS=E	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 potentially hazardous chemicals were stored in a secured area. This had the potential to affect 4 of 16 residents who resided on B Hall. Resident #4, #77, #212, and #7. Findings include: During a random observation, on 5/28/13 at 11:55 a.m., the door to the laundry room was unlocked and slightly ajar. A container of Ready-To-Use Laundry Pre-Spotter was observed on a container, next to a laundry sink. The label indicated the product was "danger-corrosive." A bottle of Scrubbing Bubbles was also observed on the laundry sink. There was no one observed in the laundry room or in the hallway that contained the door to the laundry room. During an interview with CNA #8, on 5/28/13 at 12:05 p.m., she indicated the door to the laundry room was	F000323	**F323 FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES** It is the practice of this provider to ensure that all alleged violations involving free of accident hazards/supervision/devices are in accordance with State and Federal law. **What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** No residents were found to be affected by the alleged deficient practice. The laundry room door was evaluated by the maintenance supervisor and was repaired so that it shuts, latches, and locks appropriately. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** 4 cognitively impaired residents on b hall had the potential to be	06/26/2013

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NAME OF PROVIDER OR SUPPLIER ROSEWALK VILLAGE AT INDIANAPOLIS		STREET ADDRESS, CITY, STATE, ZIP CODE 1302 N LESLEY AVE INDIANAPOLIS, IN 46219	

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	supposed to be closed and locked for residents' safety. On 5/28/13, at 12:10 p.m., the Maintenance Director, indicated the door to the laundry room should be shut and locked. He also indicated he checked the laundry room door frequently, to ensure the door was locked. The Maintenance Director also indicated the A/C unit,in the laundry room, had not been working for about a week, so someone was fixing the unit that day and probably did not latch the door properly. He also indicated, since the A/C was down, the wood on the doorframe might have warped and the laundry room door might not close like it should. A review of the Material Safety Data Sheets (MSDS) for "Ready-To-Use Laundry Pre-Spotter," dated 7/7/12, indicated the product was corrosive for inhalation, ingestion, eyes, and skin. The product can also cause eye and skin burns. A review of the MSDS for "Scrubbing Bubbles All Purpose Cleaner, Heavy Duty," dated 4/5/11, indicated potential health effects include: moderate eye irritation, skin irritation, and irritation to mouth, throat, and		affected by the alleged deficient practice The laundry room door was evaluated by the maintenance supervisor and was repaired so that it shuts, latches, and locks appropriately. The housekeeping supervisor or designee has educated the laundry staff on ensuring the laundry room door is locked before leaving the laundry area unattended and were educated on the proper storage of chemicals on or before 6/26/2013. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** The housekeeping supervisor or designee has educated the laundry staff on ensuring the laundry room door is locked before leaving the laundry area unattended and on proper storage of chemicals on or before 6/26/2013. The housekeeping/laundry supervisor or designee will check the laundry room door daily to ensure it latches and locks appropriately. If correction action is needed maintenance will be contacted	

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NAME OF PROVIDER OR SUPPLIER ROSEWALK VILLAGE AT INDIANAPOLIS		STREET ADDRESS, CITY, STATE, ZIP CODE 1302 N LESLEY AVE INDIANAPOLIS, IN 46219	

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	stomach, if ingested. A review of a list provided by the Administrator In Training, on 5/28/13 at 1:50 p.m., indicated Resident #4, #77, #212, and #7 were able to self-propel themselves in a wheelchair. The list also indicated Resident #4 had a BIMS (Brief Interview of Mental Status) score of 3, Resident #77 had a BIMS score of 7, Resident #212 had a BIMS score of 4, and Resident #7 had a BIMS score of 2. All the scores listed were indicative of severe cognitive impairment. 3.1-45(a)(1)		**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** The housekeeping/laundry supervisor or designee will check the laundry room door daily to ensure it latches and locks appropriately for 6 months. Findings will be presented in the monthly QA meeting for recommendations Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee. Date of Compliance 6/26/2013	

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F000465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, record review and interview, the facility failed to provide comfortable and home-like bathrooms/shower room for residents during random observations for 6 residents (Residents #61, 106, 89, 2, 66, 128). This had the potential to affect 30 residents who resided on C/D Hall who used these bathrooms and shower room. Findings include: 1. During a random observation of Resident #61 and #106's bathroom, on 5/29/13 at 11:11 a.m., an arm's length white scrape was observed on the wall near the door/sink. During a random observation of Resident #89 and #2's bathroom, on 5/29/13 at 11:24 a.m., an arm's length white scrape was observed on the wall, near the door/sink. Several black marks were observed under the white scrape, near the door/sink. On 6/5/13, at 11:10 a.m., during an environmental tour of the facility, the above white scrapes and black marks	F000465	**F465 SAFE/FUNCTIONAL/SANITARY/ COMFORTABLE ENVIRONMENT** It is the practice of this provider to ensure that all alleged violations involving safe/functional/sanitary/comfortable environment are in accordance with State and Federal law. **What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** The white scrape on the wall near the door/sink in 106 was repaired The white scrape on the wall near the door/sink and several black marks under the scrap were repaired in Resident # 89 and #2s bathroom The shower/tub was cleaned, the drain cover was replaced, and a shower curtain was hung in Resident # 89 and #2s bathroom The shower/tub was cleaned, the drain cover was replaced, and a shower curtain was hung in Resident # 66 and #128's bathroom The cracked shower tiles in the front of the shower in the c-hall shower room were repaired **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be**	06/26/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155329	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/05/2013
NAME OF PROVIDER OR SUPPLIER ROSEWALK VILLAGE AT INDIANAPOLIS		STREET ADDRESS, CITY, STATE, ZIP CODE 1302 N LESLEY AVE INDIANAPOLIS, IN 46219	

(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 observed with the Housekeeping and Maintenance Directors. The Housekeeping Director indicated the walls in the bathroom were not supposed to have white scrapes or black marks on the walls. He also indicated this can be fixed quickly with paint. The Housekeeping Director also agreed the white scrapes were about arm's length long. 2. During a random observation of Resident #89 and #2's room, on 5/29/13 at 11:24 a.m., the shower was observed to have green streaks on the fixtures and the floor of the bathtub/shower. There was no shower curtain, being utilized over the bathtub. There was also a missing drain cover, with a fist-size hole showing, where the drain cover should be. A random observation of Resident #66 and #128's bathroom, on 5/29/13 at 1:53 p.m., revealed green stains on the bathtub fixtures and shower floor. There was also a missing drain cover, with a fist-sized hole showing, where the drain cover should be. There was no shower curtain being utilized, over the bathtub. During an environmental tour, on		**taken?** All residents have the potential to be affected by the alleged deficient practice. The housekeeping supervisor will educate facility housekeepers on appropriate cleaning of showers and ensuring shower curtains are in place on or before 6/26/2013. The SDC or designee will educate all staff on reporting any non homelike environmental observations to the facility supervisor for repair on or before 6/26/2013. The facility department heads will complete daily rounds Monday thru Friday excluding holidays and report any environmental findings in the afternoon CQI meeting. A house audit will be completed by the housekeeping supervisor or designee of facility showers to ensure they are clean, in good repair, and have shower curtains in place. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** The facility department heads will complete daily rounds Monday thru Friday excluding holidays and report any environmental findings in the afternoon CQI meeting. Any follow up needed will be reported to the housekeeping supervisor or maintenance director for cleaning or repair. The housekeeping supervisor will educate facility housekeepers on appropriate cleaning of showers and ensuring	

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	6/5/13 at 11:15 a.m., the Housekeeping Director indicated he would not want to look at the above showers, with the green stains and missing drain covers, if he was in the bathroom. The Housekeeping Director also indicated he would not want his family members to have to look at that, while they were utilizing the bathroom. He indicated he was unsure why there was no shower curtain being utilized in the above rooms, except that the showers were not used for bathing and the last time the tubs were fixed, the workers probably forgot to put the shower curtains back up. He indicated he would have the shower cleaned and would get shower curtains for the above bathtubs, like the other rooms had. The Maintenance Director indicated he could have the missing drain covers fixed quickly. 3. During an environmental tour, on 6/5/13 at 11:20 a.m., several tiles, near the front of the shower by the fixtures, were noted to be cracked in the C Hall Shower Room. On 6/5/13, at 11:21 a.m., the Maintenance Director indicated the cracked shower tiles were not supposed to look like that and the cracked tiles do not provide a		shower curtains are in place on or before 6/26/2013. The SDC or designee will educate all staff on reporting any non homelike environmental observations to the facility supervisor for repair on or before 6/26/2013. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** Findings of department head rounds will be reviewed daily Monday thru Friday excluding holidays in the afternoon CQI meeting for 6 months. Areas of concern will be addressed. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee. Date of Compliance 6/26/2013	

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	home-like environment while bathing. A review of a list provided by the Administrator, on 6/5/13 at 1:50 p.m., indicated 28 residents utilize the C Hall Shower Room for bathing. 3.1-19(f)			