STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155291		09/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE VALLEY MEADOWS	3017 VALLEY FARMS RD INDIANAPOLIS, IN 46214

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00182388. Complaint IN00182388 - Substantiated. Federal/State deficiency related to the allegations is cited at F 514. Survey dates: September 21, 22, 2015 Facility number: 000188 Provider number: 155291 AIM number: 100266310 Census bed type: SNF/NF: 111 Total: 111 Census payor type: Medicare: 16 Medicaid: 72 Other: 23 Total: 111 Sample: 3 This deficiency reflects State findings in accordance with 410 IAC 16.2-3.1. Quality review completed on 9/26/15 by 29479.	F 0000	Thecreation and submission of this Plan of Correction does not constitute anadmission by this provider of any conclusion set forth in the statement ofdeficiencies, or of any violation of regulation. Thisprovider respectfully requests that the 2567 Plan of Correction be consideredthe Letter of Credible Allegation and requests a Desk Review in lieu of a PostSurvey Revisit on or after October 9, 2015.	

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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F 0514 SS=D Bldg. 00	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview, the facility failed to ensure documentation of staff signatures and information regarding anticipated return from leave of absence (LOA) for 1 of 3 residents reviewed for LOA documentation (Resident B). Finding includes: The record for Resident B was reviewed on 9/21/15 at 10:00 a.m. Diagnoses included, but were not limited to, dementia. A physician's order, dated 8/6/15, indicated the resident was able to go LOA with a responsible party and medications.	F 0514	It isthe intent of this provider to maintain clinical records on each resident inaccordance with accepted professional standards and practices that arecomplete; accurately documented; readily accessible. **What corrective action(s) will beaccomplished for those residents found to have been affected by the allegeddeficient practice?** ResidentB has returned home to his independent living apartment. **How will you identify otherresidents having the potential to be affected by the same alleged deficient practiceand what corrective action will be taken** Thealleged deficient practice has the potential to affect all residents thatparticipate in a leave of absence from the facility. An auditof leave of absence logs for all residents will be completed by	10/09/2015

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	A Social Service note, dated 8/17/15 at 4:35 p.m., indicated Resident B desired to return to his independent living community when he discharged from the facility. A 30 day MDS (minimum Data Set) Assessment, dated 9/1/15, indicated Resident B had a BIMS (Brief Interview for Mental Status) score of 12 and was moderately cognitively impaired. The record indicated the resident signed himself into the facility. A nursing notes, dated 9/8/15 at 10:23 a.m., indicated the resident was alert and oriented and was able to voice his wants and needs. "Out on Pass" forms indicated Resident B had been on LOA 13 times between 8/12/15 and 9/11/15. The form included columns for signatures of the nurse releasing the resident on LOA and responsible party taking the resident out of the facility. The form included places to document the date and time of departure and return, along with a place for facility staff to sign when the resident returned to the facility. An LOA form, dated 8/12/15, indicated a nurse's signature at the time the resident left the facility. No other nurses' signatures were on the form. "Out on Pass" forms did not		October 9, 2015in order to identify any missing and/or inaccurate documentation. **What measures will be put intoplace or what systemic changes you will make to ensure that the allegeddeficient practice does not recur** Allstaff was reeducated regarding the facility Leave of Absence Policy andProcedure by the Director of Nursing on September 29, 2015. Proper documentation and communicationregarding Leaves of absence were reviewed. **How the corrective action(s) willbe monitored to ensure the deficient practice will not recur, i.e., whatquality assurance program will be put into place** The Directorof Nursing/designee will complete the Leave of Absence Continuous Quality Improvementtool weekly for four weeks, bi-monthly for two months, and quarterly thereafter. The results of these audits will be reviewedby the Continuous Quality Improvement Committee overseen by the ED during thecommittee's monthly meeting. If a threshold of 95% is not achieved, correctiveaction plans will be developed and implemented to ensure continuedcompliance.	

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	indicate dates and times the resident returned from LOA on 8/31/15, 8/15 (blank as to what day it was), 9/4/15, 9/9/15, 9/10/15, 9/11/15. A Progress Note, dated 9/2/15 at 11:05 a.m., indicated Resident B had gone LOA with his family for lunch. No documentation of his return was found. Progress Notes indicated Resident B went on LOA with his family on 9/9/15 at 11:44 a.m., and returned to the facility at 4:41 p.m. the same date. During an interview with the SSD (Social Services Director) on 9/22/15 at 9:05 a.m., she indicated nurses asked when the resident planned to return from LOA because they needed to know whether to send medications with them. During an interview with the DNS (Director of Nursing Services) on 9/22/15 at 9:35 a.m., she indicated staff were expected to sign when a resident returned from LOA. The DNS indicated some returns from LOA were documented in the Progress Notes. She indicated staff did not document anticipated return from LOA. A "Leave of Absence" policy, dated 7/2012 and revised 5/2013, was provided			

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	by the DNS on 9/21/15 at 1:15 p.m. and identified as current. The policy indicated, "...Policy: Continuity of care and safety during a resident leave of absence is maintained...Procedure...7. The resident/responsible person shall sign out when leaving and sign in when returning to the facility...11. Nursing staff will notify the dietary department of departure and expected return of resident if LOA expected during meal service to make plans for the missed meal...." This federal tag relates to Complaint IN00182388. 3.1-50(a)(1)			