

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 01/09/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER ROSEWALK VILLAGE	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
F000000	<p>This visit was for the Investigation of Complaints IN00161155, IN00161395, and IN00161527.</p> <p>Complaint IN00161155- Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00161395- Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00161527- Substantiated. No deficiencies related to the allegations are cited.</p> <p>Unrelated deficiencies are cited.</p> <p>Survey date: January 7, 8, and 9, 2015</p> <p>Facility number 000222 Provider number 155329 AIM number 100274950</p> <p>Survey team: Chuck Stevenson RN TC</p> <p>Census bed type: SNF: 10 SNF/NF: 133 Total: 143</p>	F000000	<p>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.</p> <p>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 January 26th, 2015.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155329	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/09/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER ROSEWALK VILLAGE	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
F000279 SS=D	<p>Census payor type: Medicare: 47 Medicaid: 67 Other: 29 Total: 143</p> <p>Sample: 5</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2.3-1.</p> <p>Quality review completed on January 12, 2015 by Cheryl Fielden, RN.</p> <p>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.</p> <p>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.</p> <p>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</p>			

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 01/09/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER ROSEWALK VILLAGE	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
	<p>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).</p> <p>Based on record review and interview the facility failed to develop care plans for assistance with transferring for a resident who required maximum assistance of staff for all transfers (Resident D) and failed to develop a discharge care plan for a resident who left the facility against medical advice (Resident C.) 2 residents of 3 reviewed for care plans in a population of 5.</p> <p>Findings include:</p> <p>1. The record of Resident D was reviewed on 1/08/14 at 8:30 A.M. Diagnoses included, but were not limited to, vascular dementia, congestive heart failure, hypertension, chronic obstructive pulmonary disease, and obesity.</p> <p>An admission Minimum Data Set (MDS) assessment dated 11/23/14 indicated Resident D was severely cognitively impaired, did not ambulate, required extensive staff assistance for all activities of daily living, was frequently incontinent of bowel and bladder, and required extensive assistance of 2 staff members for mobility in bed and all transfers.</p>	F000279	<p>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 January 26th, 2015.</p> <p>F279 Right to participate planning care- revise cp</p> <p>It is the practice of this provider to ensure that all alleged violations involving right to participate in planning care are provided in accordance with State and Federal law through established procedures.</p> <p>What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?</p> <p>Residents B and D no longer reside in the facility.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>All residents who need assistance with transfers have the potential to be affected by the alleged deficient practice.</p>	01/26/2015

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 01/09/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER ROSEWALK VILLAGE	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
	<p>Progress notes for Resident D indicated on 11/12/14 11:49 A.M. "Is and extensive assist with transfers and ADL's (activities of daily living.)", on 11/17/14 12:26 P.M. "Extensive assist X2 (2 staff) with ADL's and transfers.", and on 11/21/14 10:33 P.M. "Res (resident) is extensive assist with adl's and transfers."</p> <p>A "Physical Therapy Plan of Care" dated 11/12/14 indicated "Reason for Referral: Referred to physical therapy due to decline in functional transfers and ambulation post heart failure and fall. Therapy Necessity: Skilled Therapy necessary for improving functional transfers and ambulation."</p> <p>A "PT (physical therapy) Treatment Note" dated 11/15/2014 indicated "...Patient's family present during treatment, CNA was planning to hoyer (use a mechanical lift) patient into w/c (wheelchair), but daughter told her to stop. Daughter does not want hoyer used. Therapist explained to daughter about safety and that patient was not able to safely pivot to w/c at this time."</p> <p>Resident D's record contained no health care plan for assistance with transfers, including but not limited to number of staff to assist, correct techniques for transfers, and appropriate use of a</p>		<p>All residents who transfer against medical advice from this facility have the potential to be affected by the alleged deficient practice.</p> <p>All Social Services staff and IDT members will be re-educated by CCC on discharge care planning for residents that leave against medical advice.</p> <p>All nursing staff will be inserviced on care planning for residents that need assistance with transfers.</p> <p>All residents who are a maximum assist for transfer care plans were reviewed by DNS/Designee to ensure care plans are address type of assistance that is required for transfers, and the use of mechanical lifts.</p> <p>All residents care plans were reviewed to ensure a care plan for discharge is present, and accurately reflects each resident transfer goal by Social Service Director.</p> <p>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</p> <p>IDT meets quarterly or with a significant change to ensure the care plan is updated to address each residents transfer needs.</p> <p>MDS Coordinator will ensure each</p>	

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 01/09/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER ROSEWALK VILLAGE	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
	<p>mechanical lift.</p> <p>During a meeting on 1/08/15 at 2:15 P.M. with the Executive Director, MDS Coordinator, Director of Social Services, and Director of Nursing Services present, the Director of Nursing Services indicated there was no care plan for assistance with transfers for Resident D.</p> <p>2. The record of Resident C was reviewed on 1/08/15 at 1:00 P.M. Diagnoses included, but were not limited to, dementia, adult failure to thrive, ischemic heart disease, atrial fibrillation, syncope and collapse, and hypertension.</p> <p>A Nurse Practitioner's note dated 6/06/14, Resident C's date of admission, indicated "She will most likely become either an AL (assisted living) or LTC (long term care) resident."</p> <p>A nurse's progress note dated 6/11/14 at 10:52 A.M., indicated "Res (resident) may have to remain in the facility for LTC due to her cognitive status...family reports they are not able to take care of res at home."</p> <p>A social services note dated 9/08/14 at 2:16 P.M., indicated "Res plans to discharge back to her home upon meeting nursing and rehab (rehabilitation) goals."</p>		<p>resident's transfer needs are addressed per plan of care.</p> <p>Social services staff will interview residents prior to discharge (when possible) to ensure they are fully informed and their wishes are known. Interview will be documented in medial record.</p> <p>IDT meets quarterly or with a significant change to ensure each resident's care plan addresses resident discharge plan, and to ensure the plan is accurate and up to date.</p> <p>MDS Coordinator will ensure the discharge plan for each resident is present and updated as needed.</p> <p>Care plan and profiles will be initiated with transfer status at the time of admission.</p> <p>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?</p> <p>A discharge CQI audit tool will be completed on all discharges for 1 month, then twice weekly x 4 weeks, weekly x 4 weeks, then monthly thereafter.</p> <p>The discharge CQI tool will be reviewed by the CQI Committee monthly for six months after which</p>	

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 01/09/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER ROSEWALK VILLAGE	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
	<p>A nurse practitioner note dated 11/06/14 at 11:13 A.M., indicated "...slowly progressing, will not be able to care for self at home."</p> <p>A nurse's note dated 11/18/14 at 4:15 A.M., indicated "...no concerns voiced in regards to pending discharge."</p> <p>A social services note dated 11/25/14 at 10:33 A.M. indicated "...res dghtrs (daughters) want to keep res at the facility for a few more days."</p> <p>A nurse's note dated 11/27/14 at 2:21 P.M., indicated "Res will be discharging in a couple of days."</p> <p>A nurse's note dated 11/27/14 at 5:01 P.M., indicated "Res went LOA (leave of absence) with family."</p> <p>A nurse's note dated 11/28/14 at 9:05 A.M., indicated "Resident left on a home visit on Thanksgiving and has not returned. Resident left AMA (against medical advice)."</p> <p>Resident C's record contained no discharge care plan, including, but not limited to, assessment of ongoing needs, assistance with home health care, necessary durable medical equipment,</p>		<p>the CQI team will re-evaluate the continued need for the audit. If a 100% threshold is not achieved an action plan will be developed.</p> <p>A care plan CQI audit tool will be reviewed weekly x 4 weeks, monthly for six months after which the CQI team will re-evaluate the continued need for the audit.</p> <p>Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee. Date of Compliance 1/26/15.</p>	

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 01/09/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER ROSEWALK VILLAGE	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
	<p>and medications.</p> <p>During a meeting on 1/08/15 at 2:15 P.M., with the Executive Director, MDS Coordinator, Director of Social Services, and Director of Nursing Services present, the Director of Nursing Services indicated there was no discharge care plan for Resident C.</p> <p>A facility policy titled "IDT Care Plan Review" originated 1/2010 and revised 4/2014 indicated:</p> <p>"Policy: It is the policy of this facility that each resident will have a comprehensive care plan...to promote the residents (sic) highest level of functioning including medical, nursing, mental and psychosocial needs."</p> <p>3.1-35(a)</p>			