

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155196	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/10/2014
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NAME OF PROVIDER OR SUPPLIER ALTENHEIM HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3525 E HANNA AVE INDIANAPOLIS, IN 46237
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F000000	<p>This visit was for the Investigation of Complaint IN00148896.</p> <p>This visit was in conjunction with the Recertification and State Licensure Survey and State Residential Licensure Survey.</p> <p>Complaint IN00148896 - Substantiated. Federal/state deficiencies related to the allegation are cited at F280 and F323.</p> <p>Survey dates: June 1, 2, 3, 4, 5, 6, 9 & 10, 2014.</p> <p>Facility number: 000103 Provider number: 155196 AIM number: 100290000</p> <p>Survey team: Dottie Plummer, RN - TC Marcy Smith, RN Karen Homan, RN Patti Allen, SW (June 1, 2, 3, 4, 6, 9 & 10, 2014)</p> <p>Census bed type: SNF/NF: 67 Residential: 69 Total: 136</p> <p>Census payor type:</p>	F000000		

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.

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F000280 SS=D	<p>Medicare: 20 Medicaid: 33 Other: 83 Total: 136</p> <p>Sample: 3</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on June 17, 2014; by Kimberly Perigo, RN.</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p>			

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	<p>Based on observation, record review, and interview, the facility failed to ensure a care plan was accurate and updated for a resident who was injured during a surface to surface transfer. (Resident #A)</p> <p>Findings include:</p> <p>The clinical record of Resident #A was reviewed on 6/5/14 at 10:00 a.m. Diagnoses included, but were not limited to, muscle weakness, difficulty walking, and dementia.</p> <p>A quarterly Minimum Data Set assessment, dated 1/30/14, and an annual Minimum Data Set dated 5/7/14, both indicated Resident #A was severely cognitively impaired and needed extensive assistance of 2 people for transferring.</p> <p>A care plan for Resident #A, dated 4/28/12, and current through 8/21/14, indicated she was at risk for falls related to impaired mobility and dementia. The goal was she would remain free from injury. Approaches were, bed in low position (initiated 1/23/14), encourage resident to assume a standing position slowly (initiated 4/28/12), give resident verbal reminders not to ambulate/transfer without assistance (initiated 4/28/12), keep call light and personal items within</p>	F000280	<p>Date: 6/20/2014 Tag # F 280 SS=D Right to participate planning care Description of findings: The facility failed to ensure a care plan was accurate and updated for a resident who was injured during a surface to surface transfer. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1. Resident #A care plan and staff's assignment sheets checked to assure the proper level of assistance needed for transfers is accurate. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? 1. Residents who require the assistance of healthcare workers for transfers have the potential to be affected. The care plans and nurse aide assignment sheets have been audited for those residents who need assistance with transfers and the care plans and nurse aide assignment sheets reflect the correct assistance staff needs to provide to ensure safe transfers are happening. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? 1. Employees will be in-serviced and checked off on safe and effective transfer techniques. 2. Unit managers/or designee will audit 4 transfers,</p>	07/10/2014

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	<p>reach (initiated 4/28/12), and provide toileting assistance per resident's needs (initiated 4/28/12).</p> <p>A care plan for Resident #A, dated 5/9/12, and current through 8/21/14, indicated she required extensive assist with most activities of daily living related to weakness, impaired mobility, and cognitive deficits. Approaches included, side rails (on both sides of the bed) up to assist with bed mobility/positioning, transfers, transfer with assist of 1 (staff person) using gait belt for safety. All approaches were initiated 5/9/12.</p> <p>An Incident Report Form, dated 5/7/14, sent by the facility to the Indiana State Department of Health, indicated on 5/6/14 at 6:30 p.m., a Certified Nursing Assistant (CNA) was transferring Resident #A from her wheelchair to her bed. During the transfer, the resident received a 14 centimeter (cm) laceration (irregular tear of the skin) to her left lower leg. The laceration was cleaned and covered, and Resident #A was sent to an emergency room for evaluation and treatment. The report indicated the resident received 24 staples (a means of fastening tissue/skin to another) to the area of the laceration on her left lower leg. The report indicated the resident's transfer program, plan of care, and</p>		<p>randomly on all shifts 7 days per week, weekly for 60 days and upon completion will audit 4 transfers, randomly on all shifts 7 per week, every thirty days. 3. All new hires will receive transfer training with return demonstration check offs. 4. Director of nursing or designee will audit 3 different transfers randomly on all shifts 7days per week, weekly for 60 days. 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? 1. All audits will be brought to QA for a minimum of 120 days. 2. A minimum threshold of 95% accuracy will be expected on the transfer technique audit tools used or additional corrective actions will be put into place until the goal is met. 3. The administrator/or designee will ensure compliance.</p> <p>By What date the systemic changes will be completed? 7/10/2014</p>	

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	<p>assignment sheet were reviewed.</p> <p>During an observation on 6/2/14 at 1:00 p.m., Resident A's right leg had a dressing on it. During an interview with Unit Manager #1 and the Director of Nursing, on 6/6/14 at 11:30 a.m., Unit Manager #1 indicated it was Resident #A's right leg, not her left leg, which received the skin laceration.</p> <p>A nurse's note, dated 5/6/14 at 6:30 p.m., indicated, "...called to the room per CNA. CNA reported resident had a skin tear and was bleeding. Upon entering the resident's room, signee observed resident in bed and her right LE [lower extremity] was bleeding from a [large] laceration.assessed the area, reported to MD [medical doctor] on unit [MD observed], Laceration is 16 cm in length, 3 cm open with 6 cm skin flap, muscle visible...Resident continues to have...bleeding from laceration. Resident denies pain and is asking questions of what happened and what was wrong. Staff reassured resident."</p> <p>A nurse's note dated 5/6/14 at 6:36 p.m., indicated an ambulance was called as the physician wanted the resident to be evaluated in the emergency room. A nurse's note dated 5/6/14 at 7:00 p.m., indicated the resident was transported to</p>			

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	<p>the hospital.</p> <p>A nurse's note dated 5/6/14 at 10:33 p.m. indicated Resident #A returned from the hospital at 10:10 p.m. The note indicated, "She has 24 staples in place to RLE [right lower extremity], that need to be removed in 14 days...."</p> <p>Review of an Associate Warning Notice, provided by the Director of Nursing on 6/2/14 at 3:10 p.m., indicated, "Employee transferred resident as 1 person assist when assignment sheet states 2 person."</p> <p>During an interview with Unit Manager #1 on 6/5/14 at 3:00 p.m., she indicated CNA #2 should have used 2 people to transfer Resident #A on 5/6/14. She indicated the resident was inconsistent in her ability to assist with transfers and that was why they made Resident #A, "A 2 person transfer."</p> <p>Review of Resident #A's current care plans dated 4/28/12 and 5/9/12, the care plans did not indicate Resident #A was a 2 person transfer. Further information regarding why her need for a 2 person transfer was not careplanned was requested from the DON on 6/5/14 at 3:00 p.m. No further information was provided by survey exit on 6/9/14 at 11:15 a.m.</p>			

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F000323 SS=G	<p>This Federal tag relates to Complaint IN00148896.</p> <p>3.1-35(d)(2)(B)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure a resident was safely transferred from one surface to another, which resulted in the resident receiving a 14 centimeter skin tear to her leg, a trip to the emergency room, and 24 staples to close the wound, for 1 of 3 residents reviewed for accidents. (Resident #A)</p> <p>Findings include:</p> <p>The clinical record of Resident #A was reviewed on 6/5/14 at 10:00 a.m. Diagnoses included, but were not limited to, muscle weakness, difficulty walking, and dementia.</p>	F000323	<p>Date: 6/20/2014 Tag # F 323 SS=G Free of accident hazards/supervision/devices Description of findings: The facility failed to ensure a resident was safely transferred from one surface to another, which resulted in the resident receiving a 14 cm skin tear to her leg, a trip to the ER, and 24 staples to close the wound, for 1 of 3 residents reviewed. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1. Resident #A care plan and staff's assignment sheets checked to assure the proper level of assistance needed for transfers is accurate. How other residents having the potential to be affected by the same deficient practice will be</p>	07/10/2014

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	<p>A quarterly Minimum Data Set assessment, dated 1/30/14, and an annual Minimum Data Set dated 5/7/14, both indicated Resident #A was severely cognitively impaired and needed extensive assistance of 2 people for transferring.</p> <p>An Incident Report Form, dated 5/7/14, sent by the facility to the Indiana State Department of Health, indicated on 5/6/14 at 6:30 p.m., a Certified Nursing Assistant (CNA) was transferring Resident #A from her wheelchair to her bed. During the transfer, the resident received a 14 centimeter (cm) laceration (irregular tear of the skin) to her left lower leg. The laceration was cleaned and covered, and Resident #A was sent to an emergency room for evaluation and treatment. The report indicated the resident received 24 staples (a means of fastening tissue/skin to one another) to the area of the laceration on her left lower leg. The report indicated the resident's transfer program, plan of care, and assignment sheet were being reviewed, the bed was padded, cognitively intact residents on the unit were being interviewed regarding their transfers, and the CNA was suspended pending investigation.</p> <p>During an observation on 6/2/14 at 1:00</p>		<p>identified and what corrective action(s) will be taken? 1. Residents who require the assistance of healthcare workers for transfers have the potential to be affected. The care plans and nurse aide assignment sheets have been audited for those residents who need assistance with transfers and the care plans and nurse aide assignment sheets reflect the correct assistance staff needs to provide to ensure safe transfers are happening. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? 1. Employees will be in-serviced and checked off on safe and effective transfer techniques. 2. Unit managers/or designee will audit 4 random transfers on all shifts 7 days per week for 60 days and upon completion will audit 4 random transfers, all shifts 7 days per week every thirty days. 3. All new hires will receive transfer training with return demonstration check offs. 4. Director of nursing or designee will audit 3 random transfers, including all shifts 7 days per week for 60 days . 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? 1. All audits will be brought to QA for a minimum of 120 days. 2. A minimum threshold of 95%</p>	

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	<p>p.m., Resident A's right leg had a dressing on it. During an interview with Unit Manager #1, and the Director of Nursing, on 6/6/14 at 11:30 a.m., Unit Manager #1 indicated it was Resident #A's right leg, not her left leg, which received the skin laceration.</p> <p>A nurse's note, dated 5/6/14 at 6:30 p.m., indicated, "...called to the room per CNA. CNA reported resident had a skin tear and was bleeding. Upon entering the resident's room, signee observed resident in bed and her right LE [lower extremity] was bleeding from a [large] laceration.assessed the area, reported to MD [medical doctor] on unit [MD observed], Laceration is 16 cm in length, 3 cm open with 6 cm skin flap, muscle visible...Resident continues to have...bleeding from laceration. Resident denies pain and is asking questions of what happened and what was wrong. Staff reassured resident."</p> <p>A nurse's note dated 5/6/14 at 6:36 p.m., indicated an ambulance was called as the physician wanted the resident to be evaluated in the emergency room. A nurse's note dated 5/6/14 at 7:00 p.m., indicated the resident was transported to the hospital.</p> <p>A nurse's note dated 5/6/14 at 10:33 p.m.</p>		accuracy will be expected on the transfer technique audit tools used or additional corrective actions will be put into place until the goal is met. 3. The administrator or designee will ensure compliance. By What date the systemic changes will be completed? 7/10/2014	

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	<p>indicated Resident #A returned from the hospital at 10:10 p.m. The note indicated, "She has 24 staples in place to RLE, [right lower extremity] that need to be removed in 14 days...."</p> <p>Review of an Associate Warning Notice, provided by the Director of Nursing on 6/2/14 at 3:10 p.m., indicated, "Employee transferred resident as 1 person assist when assignment sheet states 2 person."</p> <p>During an interview with CNA #2 on 6/4/14 at 3:30 p.m., she indicated Resident #A had been assigned to her on the evening shift, 5/6/14. CNA #2 indicated she wasn't really sure how Resident #A got her skin tear. She indicated her assignment sheet on 5/6/14, evening shift said Resident #A was a 2 person transfer, but she did not enlist the help of another staff person to transfer the resident.</p> <p>During an interview with the Director of Nursing on 6/2/14 at 3:00 p.m., she indicated she wasn't really sure what caused the laceration on Resident #A's leg, but CNA #2 should have used 2 people to transfer the resident.</p> <p>During an interview with Unit Manager #1 on 6/5/14 at 3:00 p.m., she indicated CNA #2 should have used 2 people to</p>			

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	<p>transfer Resident #A on 5/6/14. She indicated the resident was inconsistent in her ability to assist with transfers and that was why they made Resident #A, "A 2 person transfer."</p> <p>This Federal tag relates to Complaint IN00148896.</p> <p>3.1-45(a)(2)</p>				