STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING <u>00</u>		00	COMPLETED		
155196		B. WI	B. WING			2017	
NAME OF PROVIDER OR SUPPLIER ALTENHEIM HEALTH & LIVING COMMUNITY		/ING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3525 E HANNA AVE INDIANAPOLIS, IN 46237			(VS)	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIADE DEFICIENCY)	TE	DATE
	REGULATORT OF	X ESC IDENTIF TING INFORMATION)		IAG			DATE
F 0000 Bldg. 00	This visit was for Complaints INO IN00245145. Complaint IN00 Federal/State deallegations are conference F514. Complaint IN00	or the Investigation of 10245044 and 10245044 and 10245044 and 10245044 - Substantiated. Efficiencies related to the exted at F282, F309 and 10245145 - Substantiated. The related to the allegations of 155196 100290000 ope: 41 35 83 159	F 00		This plan of correction is to serve as Altenheim Health an Living Community's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Altenheim Health and Living Community or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. We respectfully request a desk review for this deficiency.	te y d	
	Other:	31					

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

(X6) DATE

Any defiency statement 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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TITLE

000103

PRINTED: 11/29/2017 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC A. BUILDING	00	(X3) DATE SURVEY COMPLETED		
155196		B. WING		11/15/2017		
NAME OF PROVIDER OR SUPPLIER ALTENHEIM HEALTH & LIVING COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 3525 E HANNA AVE INDIANAPOLIS, IN 46237				
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.					
	Quality Review completed on November 17, 2017.					
F 0282 SS=D Bldg. 00	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-					
	(ii) Be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview,	F 0282	What corrective Actions w	ill 11/29/2017		
	the facility failed to follow physician's orders for wound care for 1 of 3 residents reviewed for wound care in a sample of 4 (Resident B).	- 0202	be accomplished for those residents found to have beer affected by the deficient practice?			

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Event ID:

45WZ11

Facility ID: 000103

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. B	A. BUILDING 00		COMPLETED		
		155196	B. W	ING	11/15/2017		
				GTDEET	ADDRESS SITU STATE ZID SODE	l .	
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
A		/INIC COMMANDATIV			HANNA AVE		
ALIENH	EIM HEALTH & LIV	VING COMMUNITY		INDIAN	IAPOLIS, IN 46237		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF COR		(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	Findings includ	e:			Resident B no longer resides	s in	
					the facility.		
	The record for I	Resident B was reviewed					
		9:45 a.m. Diagnoses for					
		C					
		uded but were not limited					
	-	knee replacement and			2. How will other residents		
	revision and Me	ethicillin-resistant			having the potential to be		
	Staphylococcus	aureus (MRSA).			affected by the same deficien	nt	
					practice be identified and wh		
	Recapitulation of	of the physician's orders			corrective action will be take		
	_	and October 2017					
	_	llowing: (original order					
		• • •					
	· · · · · · · · · · · · · · · · · · ·	cleanse the area to the left			All residents receiving woun	d	
		al saline and pat dry.			care residing in the Skilled Nursing Facility have the		
	Cover with bord	dered gauze every day and					
	as needed.				potential to be affected by th	е	
					alleged deficient practice.		
	Review of the n	nedication administration			Director of Nursing/designed		
	record (MAR) f	For September and			will completed an audit of all		
	` ′	documentation the			current residents receiving wound care for accuracy of		
		he left knee were			following physician orders.		
					Audit to be completed by		
	_	dered for the following			November 29, 2017.		
	dates:				,		
	9/23/17						
	9/24/17						
	9/25/17				3. What measures will be put		
	9/26/17				into place or what systematic	C	
	9/27/17				changes will be made to		
	9/29/17				ensure that the deficient		
					practice does not occur?		
	10/3/17						
	10/6/17						
					Director of Nursing/Designed		
	During an inter-	view with the Director of			will educated licensed nursing		
Nursing (DON) on 11/15/17 at 10:05				staff on following physician			

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45WZ11 Facility ID: 000103

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155196		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 11/15/2017
	PROVIDER OR SUPPLIER EIM HEALTH & LIVING COMMUNITY	3525 E	ADDRESS, CITY, STATE, ZIP CODE E HANNA AVE NAPOLIS, IN 46237	
(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 APPROPRIA DEFICIENCY)	DATE
	a.m., she indicated, the missing dates for the dressing changes could not be found. This Federal tag relates to Complaint IN00245044. 3.1-35(g)(2)		orders for wound treatments Education will be completed November 29, 2017. Educati will be provided upon hire al annually regarding following physician orders for wound care.	l by ion nd
			4. How will the corrective actions be monitored to ens the deficient practice will no recur, and what quality assurance program?	
			The Wound Care Completed per Physician Order Audit was be completed 7 days a week on varied shifts, times 4 week 3 times per week x 12 weeks weekly x 8 weeks and then monthly x 6 months to total months until compliance is 100%. The results of these audits will be reviewed by the Quality Assurance Committed monthly. Frequency and duration of reviews will be increased as needed if compliance is below 100%	rill 5, eks, 6, 12
F 0309 SS=D Bldg. 00	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155196		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/15/2017				
	PROVIDER OR SUPPLIER		3525 E	STREET ADDRESS, CITY, STATE, ZIP CODE 3525 E HANNA AVE INDIANAPOLIS, IN 46237				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE				
	receive and the fa necessary care ar maintain the highe mental, and psych consistent with the	Each resident must cility must provide the ad services to attain or est practicable physical, associal well-being, e resident's seessment and plan of						
	that applies to all the provided to facility comprehensive as the facility must erreceive treatment with professional stromprehensive per the provided to the	a fundamental principle creatment and care residents. Based on the esessment of a resident, ensure that residents and care in accordance estandards of practice, the erson-centered care plan, choices, including but not						
	require such servi professional stand comprehensive pe							
	residents who req services, consiste							
	the facility failed treatments were	review and interview, I to ensure wound care completed as ordered for reviewed for wound care (Resident B).	F 0309	What corrective Actions we be accomplished for those residents found to have bee affected by the deficient practice?	11/25/2017			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BU	A. BUILDING <u>00</u>		COMPLETED		
		155196	B. W	B. WING 11/15/2011			
				STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				HANNA AVE		
AI TENILI	EIM HEALTH & LIV				IAPOLIS, IN 46237		
ALIENTI	CIIVI NEALTH & LIV	ING COMMONT F		INDIAN	IAPOLIS, IN 40237		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	Findings include	:					
					Resident B no longer resides	s in	
	The record for R	esident B was reviewed			the facility.		
		:45 a.m. Diagnoses for					
		ded but were not limited					
	-	knee replacement and					
		thicillin-resistant			2. How will other residents		
	Staphylococcus	aureus (MRSA).			having the potential to be		
					affected by the same deficien	nt	
	Recapitulation o	f the physician's orders			practice be identified and wh		
	for September as				corrective action will be take	n?	
	•	lowing: (original order					
		U \ U					
	· ·	leanse the area to the left					
		l saline and pat dry.			All residents receiving woun	d	
	Cover with bord	ered gauze every day and			care residing in the Skilled Nursing Facility have the		
	as needed.						
					potential to be affected by th	e	
	Review of the m	edication administration			alleged deficient practice. Director of Nursing/designee		
	record (MAR) fo	or September and			will complete an audit of all	,	
	` ′	locumentation the			current residents receiving		
	treatments for th				wound care for accuracy of		
					following physician orders.		
	•	lered for the following			Audit to be completed by		
	dates:				November 29, 2017.		
	9/23/17						
	9/24/17						
	9/25/17				0.14/1-24		
	9/26/17				3. What measures will be put		
	9/27/17				into place or what systematic changes will be made to	•	
	9/29/17				ensure that the deficient		
	10/3/17				practice does not occur?		
					p. Louise accomot coom.		
	10/6/17						
	During an interv	iew with the Director of			Director of Nursing/Designed)	
	Nursing (DON) and the Rehab Unit				will educated licensed nursing		

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	TOF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155196	(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/15/2017			
NAME OF PROVIDER OR SUPPLIER ALTENHEIM HEALTH & LIVING COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 3525 E HANNA AVE INDIANAPOLIS, IN 46237				
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	Manager on 11/15/17 at 12:45 p.m., they indicated there were no measurements due to the area was a pin hole which initially had a drain but was discontinued prior to admission. The area drained continuously because of an infected spacer and was changed often.		staff on following physician orders for wound treatments Education will be completed November 29, 2017. Educati will be provided upon hire as annually regarding following physician orders for wound care.	by on nd		
	This Federal tag relates to Complaint IN00245044. 3.1-37(a)		4. How will the corrective actions be monitored to ensithe deficient practice will no recur, and what quality assurance program?			
			The Wound Care Completed per Physician Order Audit we be completed 7 days a week on varied shifts, times 4 week 3 times per week x 12 weeks weekly x 8 weeks and then monthly x 6 months to total months until compliance is 100%. The results of these audits will be reviewed by the Quality Assurance Committed monthly. Frequency and duration of reviews will be increased as needed if compliance is below 100%	ill , , ks, , 12		
F 0514 SS=D Bldg. 00	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE (i) Medical records.					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X1) PROVIDER/SUPPLIER/S		(X2) MULTIPLE CC A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 11/15/2017			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3525 E HANNA AVE INDIANAPOLIS, IN 46237				
(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 A CTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			
		lards and practices, the ain medical records on are-					
	(iii) Readily access (iv) Systematically						
	(5) The medical re	cord must contain-					
	(i) Sufficient information to identify the resident;						
	(ii) A record of the	resident's assessments;					
	(iii) The comprehe services provided;	nsive plan of care and					
	•	any preadmission ident review evaluations s conducted by the State;					
	(v) Physician's, nu professional's pro	rse's, and other licensed gress notes; and					
	(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.						
	Based on record the facility failed orders were accu the clinical recor	review and interview, It to ensure the physician's trately transcribed into red for 1 of 3 residents hical record accuracy in a sident B).	F 0514	What corrective Actions we be accomplished for those residents found to have been affected by the deficient practice?	11/2)/2017		
				Resident B no longer resides	s in		

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STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETED	
155196		155196	B. WING 11		11/15/	11/15/2017	
NAME OF PROVIDER OR SUPPLIER			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
					HANNA AVE		
ALTENH	EIM HEALTH & LIV	ING COMMUNITY		INDIAN	IAPOLIS, IN 46237		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION PRIFTY (EACH CORRECTIVE ACTION SHOULD BE			(X5)
PREFIX	•	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	the facility.		DATE
	Findings include:				the facility.		
	on 11/14/17 at 9 Resident B inclu to, aftercare left revision and Me Staphylococcus Recapitulation o for September ar indicated the foll dated 9/22/17) c knee with norma Cover with bord and "as needed." The record lacked daily wound care During an interv Nursing on 11/14 indicated the ord needed treatmen been coded as a	lowing: (original order leanse the area to the left al saline and pat dry. ered gauze "every day"			2. How will other residents having the potential to be affected by the same deficie practice be identified and will corrective action will be taked. All residents receiving wour care residing in the Skilled Nursing Facility have the potential to be affected by the alleged deficient practice. Director of Nursing/designed will completed an audit of all current residents receiving wound care for accuracy of transcribed physician orders involving wound care. Audit be completed by November 2017. 3. What measures will be pure into place or what systematic changes will be made to ensure that the deficient practice does not occur?	hat en? nd ne e I s t to 29,	
					Director of Nursing/Designe will educate licensed nursin staff on accurately transcrib	g	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUIL	A. BUILDING 00		COMPLETED		
155196		B. WING	B. WING		11/15/	2017	
		.55.55					
NAME OF P	PROVIDER OR SUPPLIE	ER			ADDRESS, CITY, STATE, ZIP CODE		
		VIII.O O O O M M III III TO /			HANNA AVE		
ALTENHI	EIM HEALTH & LI	VING COMMUNITY		INDIAN	APOLIS, IN 46237		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PI	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					physician orders regarding		
					wound care. Education will	be	
					completed by November 29,		
					2017. Education will be		
					provided upon hire and		
					annually regarding following	1	
					physician orders for wound		
					care.		
					4. How will the corrective		
					actions be monitored to ensi	ure	
					the deficient practice will not	t	
					recur, and what quality		
					assurance program?		
					The Accurate transcription	o.f	
					physician ordered wound ca		
					audit, will be completed 7	.	
					daysa week, on varied shifts		
					times 4 weeks, 3 times per	,	
					week x 12 weeks, weekly x 8		
					-		
					weeks and then monthly x 6	ntil	
					months to total 12 months u	11111	
					compliance is 100%. The results of these audits will be	,	
						-	
					reviewed by the Quality		
					Assurance Committee		
					monthly. Frequency and		
					duration of reviews will be		
					increased as needed if		
I	Ī				compliance is below 100%		

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