STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	03/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLISONVILLE MEADOWS ASSISTED LIVING	10410 ALLISONVILLE ROAD, FISHERS, , 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00390467. Complaint IN00390467 - State deficiencies related to the allegations are cited at R349. Survey date: March 16, 2023 Facility number: 13039 Residential Census: 106 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on March 20, 2023	R 0000		
R 0349	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(a)(1-4) (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated	R 0349	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**	03/20/2023

	with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on interview and record review, the facility failed to ensure a clinical record for a resident was complete and readily accessible for 1 of 3 residents reviewed for transfers or discharge requirements from the facility. (Resident B) Findings include: The clinical record for Resident B was reviewed on 3/17/23 at 11:15 a.m. Resident B's diagnoses included, but not limited to, dementia with behavioral disturbance, delusional disorders, anxiety disorder, Parkinson's disease, and weakness. Resident B's closed clinical record did not contain a Notice of Transfer/Discharge. A physician's order dated 8/15/22 at 9:15 a.m. indicated, Resident B was discharged to another residential care facility. The facility transfer/discharge packet sent with Resident B to the new facility included: an AL (Assisted Living) Discharge to Other Facility form, Resident B's		1.) All residents discharged from the community have the potential to be affected. 2.) The receiving community was provided with requested documents from the clinical record via email prior to resident discharge on the following dates: 7/6/22 & 7/14/22. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** 1.) All discharges within the last thirty days were reviewed to ensure the clinical records were complete and readily accessible per transfer or discharge requirement of the facility. 2.) In-service completed by March 20th, 2023, for all nursing team members to ensure all necessary documents are in closed charts from transfer or discharge of the Resident, including but not limited to information regarding functional abilities and physical limitations,	

face sheet, current orders, a copy of their Medicare card, an out of hospital do not resuscitate declaration and order, copy of resident progress note dated 8/15/22 at 9:26 a.m., and a log of discontinued/destroyed medication. The transfer/discharge packet in the clinical record did not indicate the receiving facility received the following information regarding Resident B:

Nurses' notes relating to the resident's:

- functional abilities and physical limitations

- nursing care

- date of last chest x-ray and skin test for tuberculosis

A Checklist for Community Initiated Discharge (Senior Living) was provided by DON (Director of Nursing) on 3/16/23 at 10:31 a.m. The checklist indicated, "Notice of Transfer/Discharge completed fully including receiving location name/address."

An interview with DON conducted on 3/16/23 at 12 p.m. indicated, the facility did not have a Transfer to Another Facility policy/procedure.

A copy of an email sent from DON to Indiana Department of

nursing
care, and date of last chest x-ray and skin test for tuberculosis.

What measures will be put into place or systemic changes you will make to ensure that the deficient practice does not reoccur?

1.) In-service completed by March 20th, 2023,
for all nursing team members to ensure all necessary documents are in closed
charts from transfer or discharge of the Resident, including but not limited to information regarding functional abilities and physical limitations, nursing
care, and date of last chest x-ray and skin test for tuberculosis.

How the corrective action(s) will be monitored to ensure the deficient practice will not reoccur, i.e., what quality assurance program will be put into place?

	Health dated 3/16/23 at 2:01 p.m. indicated, "The documents they were searching for are in my email. When they questioned if the information had been provided to the receiving community the answer was "yes." I simply could not recall how I had provided the necessary information until they were already gone. I have time stamped emails to the accepting community providing face sheets, nurses notes, healthcare agreement/service plan, and therapy notes. All of which is listed under to regulation/tag in question. The email sent 7/6/2022 at 1:53pm [sic] to the admissions personnel at the receiving community included 3 attachments: OT [sic, Occupational Therapy] notes, PT [sic, Physical Therapy] notes, and 30 days of our nursing notes. The email sent 7/14/2022 at 2:02pm [sic] to the admissions personnel and director of clinical services included 1 attachment (8 pages): resident face sheet, healthcare agreement/service plan, and 2 weeks of our nursing notes. This resident discharged to this community on 8/15/2022." The evidence that the emails' information was provided to the receiving facility was not available in Resident B's clinical		A QA tool will be implemented to ensure all necessary documents are in the chart at time of discharge. Completion=2 times a month for 30 days, then 1 time a month for 60 days, then one time every 90 days until 3 consecutive months of compliance.	

record as of 3/16/23 thus, making Resident B's record not complete nor readily accessible.

This state tag relates to complaint IN00390467.

Based on interview and record review, the facility failed to ensure a clinical record for a resident was complete and readily accessible for 1 of 3 residents reviewed for transfers or discharge requirements from the facility. (Resident B)

Findings include:

The clinical record for Resident B was reviewed on 3/17/23 at 11:15 a.m. Resident B's diagnoses included, but not limited to, dementia with behavioral disturbance, delusional disorders, anxiety disorder, Parkinson's disease, and weakness. Resident B's closed clinical record did not contain a Notice of Transfer/Discharge.

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order, copy of resident progress note dated 8/15/22 at 9:26 a.m., and a log of discontinued/destroyed medication. The transfer/discharge packet in the clinical record did not indicate the receiving facility received the following information regarding Resident B:

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE