STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPL	ETED	
		155196	B. WI	NG		07/21/	2015	
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIE	R			HANNA AVE			
ALTENH	EIM HEALTH & LI\	/ING COMMUNITY			APOLIS, IN 46237			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
F 0000								
Bldg. 00	This visit was fo	or a Departification and	F 00	000	This plan of correction is to se	erve		
	This visit was for a Recertification and		1 00	000	as Altenheim Health and Living			
	State Licensure	Survey.			Community's credible allegation			
					of compliance. Submission of			
	Survey dates: Ju	uly 8, 9, 10, 13, 14, 15,			this plan of correction does no			
	16, 17, 20, and 2	21, 2015.			constitute an admission by			
					Altenheim Health and Living	,		
	Facility number	: 000103			Community or its managemen	t		
	Provider numbe				company that the allegations contained in the survey report	oro		
	AIM number: 1				a true and accurate portrayal of			
	Anvi number. 1	.00290000			the provision of nursing care a			
					other services in this facility.			
	Census bed type	2.			does this submission constitut			
	SNF: 33				an agreement or admission of	the		
	SNF/NF: 48				survey allegations.			
	Residential: 71							
	Total: 152							
	Census Payor T	ype:						
	Medicare: 31							
	Medicaid: 35							
	Other: 15							
	Total: 81							
	10.001. 01							
	Those deficient	ion moffoot atota fin din an						
		ies reflect state findings						
		nce with 410 IAC						
	16.2-3.1.							
F 0224	483.13(c)							
SS=E	PROHIBIT							
Bldg. 00		//NEGLECT/MISAPPROP						
	RIATN							
	I				I			

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

TITLE

(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.

	VT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		ILDING	00	COMPLETED	
		155196	B. Wl	NG		07/21/2015	
NAME OF F	PROVIDER OR SUPPLIER			STREET.	ADDRESS, CITY, STATE, ZIP CODE		
					HANNA AVE		
ALTENH	EIM HEALTH & LIV	ING COMMUNITY		INDIAN	IAPOLIS, IN 46237		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	E	LETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)	D.A	ATE
	,	levelop and implement d procedures that prohibit					
	mistreatment, neg	•					
	_	appropriation of resident					
	property.						
	Based on intervi	ew and record review,	F 02	224	F224 483.13(c) PROHIBIT		4/2015
	the facility failed	l to ensure strategies			MISTREATMENT/NEGLECT/I	ЛIS	
	were implemente	ed to prevent staff to			APPROPRIATION What  Corrective action(s) will be		
	resident mistreat	ment for 9 of 9 residents			accomplished for those		
	reviewed for an	allegation of			residents found to have beer	ı	
		Resident #107, #29, #96,			affected by the deficient		
	#17, #62, #44, #8				practice? Residents #107, #		
	anonymous resid				#96, #17, #62, #44, #89, and #		
	unonymous resic				have been assessed by social services and monitored to ens		
	Findings include				no negative outcomes have	JIE	
	i mamgs merade	·•			occurred and to date, no nega	tive	
	1) A review on t	07/9/2015 at 10 A.M., of			outcomes have been discover		
	· /	rt dated 03/31/2015,			by the assessments conducted	i.	
	_	·			The anonymous resident that voiced concerns has had no		
		nt #107 reported 2 staff			negative outcomes either base	ed be	
		and treated her rudely.			on the additional actions the		
		ow up report dated			facility took by interviewing 10		
	· · · · · · · · · · · · · · · · · · ·	cated both employees			of the remaining residents usir	.g	
		l brought back to work			the QIS abuse questionnaire. The facility has a system in pla		
		of the investigation. A			to ensure strategies are	.ce	
		et (MDS) assessment			implemented to prevent staff to	,	
	dated 03/04/2013	5, assessed Resident			resident mistreatment. <b>How</b>		
	#107 as having a	Brief Interview for			other residents having the		
	Mental Status (B	BIMs) score of 15 out of			potential to be affected by th		
	15, indicating the	e resident was able to be			same deficient practice will be		
	interviewed.				identified and what corrective action(s) will be taken? A	,	
					thorough investigation was		
	2.) A review on	07/9/2015 at 10 A.M., of			conducted on every employee		
	· ·	rt dated 04/07/2015,			(CNA #6 and all others) acuse	d of	
		nt #29 reported a			mistreatment and the		
		g Assistant (CNA) raised			administrative staff at the facili	iy	
		5 1 10010tuilt (C1 1/1) Tuibea			in conjunction with corporate		

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLI	ETED
		155196	B. W	ING		07/21/2	2015
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			HANNA AVE		
ALTENH	EIM HEALTH & LIV	ING COMMUNITY			APOLIS, IN 46237		
(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	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	their voice at her	r. The follow up report			oversight have taken appropria	ate	
	dated 04/10/201	5, indicated the CNA			actions on each employee		
		work. A Minimal Data			including: further education,		
		ssment dated 03/12/2015,			progressive discipline, and terminiation. All residents,		
	` ′				family members and staff have	,	
		ssessed Resident #29 as having a Brief nterview for Mental Status (BIMs) score f 9 out of 15, indicating the resident was			the potential to be affected by		
					deficient practice. All staff		
	-	· ·			members will be in-serviced or		
	able to be interv	iewed.			types of abuse to include ever		
					type of allegation and complain	nt	
	3.a.) A review of	n 07/9/2015 at 10 A.M.,			issue dating back to 4 to 5 months ago to current. The		
	of an incident re	port dated 06/07/2015,			inservicing will begin immediat	elv	
	indicated a famil	ly member reported a			and all shifts will receive the	Ciy	
	Certified Nursin	g Assistant (CNA) was			training prior to working in the		
		o Resident #96. The			building until 100% compliance	e is	
	1	dated 06/17/2015,			achieved. Third party vendors		
		•			receive the same training. A p		
		ployee was terminated			test will be given with 10 speci	fic	
	on 06/1//2015, 1	for sub-standard work.			issues surrounding the exact issues trended for the reportate	olee	
					dating back 4 to 5 months to	103	
	b. A review on 0	07/9/2015 at 10 A.M., of			current and staff will be require	ed	
	an incident repor	rt dated 07/08/2015,			to achieve a 100% or higher		
	indicated Reside	ent #96 reported CNA #6			score to demonstrate		
	was mean. A M	inimal Data Set (MDS)			competency. An action plan w		
		d 05/06/2015, assessed			created for a specific reportable	e	
		having a Brief Interview			from June 20, 2015 by the director of nursing at the same		
		s (BIMs) score of 7 out			time June 20, 2015 to address		
		cognitive impairment.			the exact abuse reportable iss		
	or 13, moderate	cognitive impairment.			that were reported at that time		
	D	. 07/00/0017			Changes were introduced into	the	
	1	riew on 07/09/2015 at			community to include: (1)		
		Pirector of Nursing			weekend designated supervisor		
	(DON) indicated	the DON office			solely responsible to manage a prevent customer care concert		
	relocated during	the month of April 2015,			and report directly to the direct		
	to resident care a	areas to better monitor			of nursing. Staff patterns were		
	staff to resident	interactions.			changed, decrease in hours of		
					staff to prevent burnout and hi		
	I		ı				

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155196	B. W	ING		07/21/	2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R			HANNA AVE		
ΔΙ ΤΕΝΙΗ	EIM HEALTH & LIV	ING COMMUNITY			APOLIS, IN 46237		
	- LIWITILALITI & LIV	ING COMMONT I		INDIAN			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	4.) A review on	07/9/2015 at 10 A.M., of			fair to cover shifts to prevent s	taff	
	an incident repor	rt dated 06/20/2015,			burn out. The new nurse manager that is covering		
	indicated a fami	ly member reported a			weekends will begin using CQ	D	
		Certified Nursing Assistant (CNA) called			audit tools to conduct staff, far		
	Resident #17 a derogatory term and was				and resident interviews, 10 wil		
		lating to Resident #17.			done on random people (staff,		
	Tude and milling	ating to Resident #17.			residents and families) each		
	1	07/0/2017			Saturday and Sunday and the		
	, , , , , , , , , , , , , , , , , , ,	07/9/2015 at 10 A.M., of			results will be kept by the		
	_	rt dated 07/05/2015,			administrator and reviewed		
	indicated Reside	ent # 62 reported a			weekly for 8 weeks by the	4	
	Certified Nursin	g Assistant (CNA) hit			corporate nurse consultant and monthly after that for 3 month		
	her head on the	siderail when changing			and reevaluated by the director		
		52 stated she told the			operations. All residents and	. 0.	
		t the CNA continued.			family members have been		
	_				interviewed by social service(s	5)	
	_	eport dated 07/10/2015,			designee from outside source		
	indicated the all				utilizing the QIS family intervie		
		and the CNA returned to			questionnaire on July 10, 2015		
	work with no dis	sciplinary action. A			Any findings will be reported to the administrator immediately		
	Minimal Data So	et (MDS) assessment			then the ISDH with a thorough		
	dated 05/07/201	5, assessed Resident #62			investigation. The facility has	17 G	
	as having a Brie	f Interview for Mental			retained a third party social		
	_	core of 15 out of 15,			services consultant firm to visit	t	
	` ,	sident was able to be			once per month for 3 months t		
	_	sident was able to be			conduct randome resident, sta		
	interviewed.				and family abuse interviews us		
					the QIS questionnaire to ensur		
		ge 1 interview on			the facility has a system in pla- that prevents staff to resident	ce	
	07/08/2015, an a	nonymous resident			mistreatment. What measur	ros	
	reported an unkr	nown night shift staff			will be put into place or what		
	member told Re	sident #44, "I've already			systemic changes will be ma		
		eral times. You will			to ensure that the deficient	-	
		care." A Minimal Data			practice does not recur? Th	e	
					family and resident QIS intervi	ew	
	` ′	ssment dated 06/06/2015,			tool will be broken into 1/3rds		
	1	nous resident as having a			completed on all residents and	I	
	Brief Interview	for Mental Status (BIMs)			family members monthly over		

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3)			(X3) DATE S	(3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLI	ETED	
		155196	B. W	ING		07/21/2	2015	
			_	STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIEF	8			HANNA AVE			
AI TENH	EIM HEALTH & LIV	ING COMMUNITY			APOLIS, IN 46237			
					, a dele, at 1620.			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	each quarter to discover any		DATE	
		of 15, indicating the			additional concerns ongoing w	rith		
	resident was able	e to be interviewed.			no stop date. Findings will be			
					addressed, reported and			
	During an interv	riew on 07/08/2015 at			investigated immediately with			
	4:30 P.M., the A	dministrator indicated			appropriate actions taken. A r	new		
	having no know	ledge of this incident.			CQR tool will be developed to			
		aving no knowledge of this incident.			review the results on the interviews to determine if any			
	7.) During a stag	ge 1 interview on			trends exists such as: shift, da	avs		
	'	nonymous resident			of the week, employee type or			
		aring an unknown			specific halls. Action plans wil			
	_	other resident, "I've been			created to address any trends			
					findings and reported through	the		
	1	what the h do you			QA committee and monitored			
		mal Data Set (MDS)			monthly by the corporate nurse and director of operations	=		
		d 06/06/2015, assessed			monthly for 3 months and			
	1	dent as having a Brief			re-evaluated after that. Staff			
		ental Status (BIMs) score			training tools will be introduced			
	of 15 out of 15,	indicating the resident			and inserviced monthly for the			
	was able to be in	nterviewed.			next 3 months related specificate to abuse and customer services			
					with competency testing	<sup>*</sup>		
	During an interv	riew on 07/08/2015 at			conducted and a threshold of			
	4:30 P.M., the A	dministrator indicated			90% will be mandatory on all			
	having no know	ledge of this incident.			posttests to ensure staff know			
					how to recognize abuse,			
	8.) During a stag	ge 1 interview on			recognize staff burn out in pee	ers,		
		ident #89 indicated an			and know how to effectively handle abuse allegations and			
	·	ff member jumped all			prevention. Results of intervie	ws		
		going to dialysis. A			and results of inservicing and			
					post testing will be reviewed by			
		et (MDS) assessment			the QA committee of the facilit	, I		
		5, assessed anonymous			and any trend will be brought the committee to discuss,	.O		
		ng a Brief Interview for			evaluate and add additional			
	`	BIMs) score of 15 out of			interventions, actions and			
	_	e resident was able to be			oversight to ensure compliance	e.		
	interviewed.				The corporate nurse consultar			
					will conduct weekly inspection:	s of		

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Event ID:

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Facility ID: 000103

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. B	UILDING	00	COMPLE	ГED
		155196	B. W	ING	<del></del>	07/21/2	015
			1	CTDEET /	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	8					
A 1 TENU 1		UNIO COMMALINITY			HANNA AVE		
ALIENH	EIM HEALTH & LIV	ING COMMUNITY		INDIAN	IAPOLIS, IN 46237		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	During an interv	iew on 07/09/2015 at			this action plan for compliance	,	
	12:55 P.M., the	Administrator indicated			using a CQR audit tool to ensu		
	1	ledge of this incident.			all pieces are performed exact	-	
	l liaving no know	leage of this inclacit.			to the letter of this plan. This	will	
	0.5				be done weekly for 8 weeks,		
		ge 1 interview on			monthly after that for 3 months		
	07/09/2015 at 4:	22 P.M., Resident #86			and the director of operations, director of clinical services and		
	indicated a night shift Certified Nursing				the nurse consultant will	1	
	Assistant (CNA)	talked with an attitude			re-evaluate the oversight after		
		esident was not the only			that. As the QA committee me		
		ded to be taken care of.			monthly abuse reportable eve	I .	
					will be reviewed to determine		
		Set (MDS) assessment			trends in shifts or days of the		
	dated 06/10/201	5, assessed anonymous			week or other types of trends.	lf	
	resident as havir	ng a Brief Interview for			a trend is identified the QA		
	Mental Status (E	BIMs) score of 13 out of			committee will put a plan in pla		
	15, indicating th	e resident was able to be			to address that specific cohort	of	
	interviewed.				staff/shift/day of the week to ensure mistreatment is		
	interviewed.				dissiminated. A third party so	oial	
					services consultant Lacy Beyl		
	_	iew on 07/09/2015 at			Associates will conduct 3 visits		
	5:00 P.M., the A	dministrator indicated			over the next 90 days to condi		
	having no know	ledge of this incident.			their own QIS staff, resident a		
					family interviews to provide		
	During an interv	iew on 07/9/2015 at 4:30			independent analysis of		
	_	ndicated some of the			compliance and the results wil	I be	
					reviewed by the director of		
	_	considered poor			operations, director of clinical		
		e rather than abuse. The			services and the corporate nu	rse	
	Administrator in	dicated some residents			consultant with the facility	vulto	
	misperceive staf	f member's			administration team. If the residemonstrate any trends or rev	I .	
	communication	at times.			their has not been a systemic	cai	
					change then Lacy Beyl service	es	
	During an intern	iew on 07/10/2015 of			will be continued until the culti		
	_	iew on 07/10/2015 at			of abuse prevention is integral	I .	
		arding a pro-active			into the community. How the		
		nonitor for and prevent			corrective action(s) will be		
	staff to resident	mistreatment, the			monitored to ensure the		
	Administrator in	dicated the pro-active			deficient practice will not rec	ur,	

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLI	ETED
		155196	B. W	NG		07/21/	2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	t			HANNA AVE		
ΔΙ ΤΕΝΙΗ	EIM HEALTH & LIV	ING COMMUNITY			APOLIS, IN 46237		
	T						
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	· ·		DATE
	-	lace was the Caring			i.e., what quality assurance		
	Hearts Program	(a resident			program will be put into place The family and resident QIS	er	
	communication	program that allows them			interview tool will be broken in	ıto	
	to voice grievan	ces). No other specific			1/3rds and completed on all		
	pro-active interv	rentions were indicated to			residents and family members	;	
	be in place prior				monthly over each quarter to		
	complete prior	2010.			discover any additional conce	rns	
	Di :	uring an interview on 07/10/2015 at			ongoing with no stop date.		
	_				Findings will be addressed,		
	_	rding how the night shift			reported and investigated		
		d, the Regional Director			immediately with appropriate actions taken. Staff training to	oole	
	of Operations in	dicated, "Night shift staff			will be introduced and inservice		
	issues were not l	prought to our attention			monthly for the next 3 months		
	prior to this surv	rey."			related specifically to abuse a		
		-			customer service with		
	On 07/14/2015 a	at 10:56 A.M., the			competency testing conducted		
		Consultant provided a			and a threshold of 90% will be	;	
		-			mandatory on all post tests to		
	facility policy, ti				ensure staff know how to recognize abuse, recognize st	off	
	· ·	ed 08/21/2013, and			burn out in peers, and know h		
	_	icy was the one currently			to effectively handle abuse		
	being used by th	e facility. The policy			allegations and prevention.		
	indicated, "Ou	r abuse			Results of interviews and resu	ılts	
	prevention/interv	vention program			of inservicing and post testing		
	-	not necessarily limited			be reviewed by the QA commi		
	·	g residents and family			of the facility and any trend wi	ll be	
		he resident's admission to			brought to the committee to discuss, evaluate and add		
	_				additional interventions, action	19	
	<u> </u>	and to whom complaints,			and oversight to ensure		
	_	incidents of abuse should			compliance. The corporate nu	urse	
	_	Monitoring staff on all			consultant will conduct weekly	,	
	shifts to identify	inappropriate behaviors			inspections of this action plan		
	toward residents	(e.g., using derogatory			compliance using a CQR audi		
	language, rough	handling of residents,			tool. This will be done weekly		
		ts while giving care,			8 weeks, monthly after that for months and the director of	13	
		its who need toileting			operations, director of clinical		
	_	nate or defecate in their			services or the nurse consulta	<sub>int</sub>	
	assistance to uni	iate of defecate III tileli	1				

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		155196	B. WING		07/21/2015	
			STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹		HANNA AVE		
		ING COMMUNITY		IAPOLIS, IN 46237		
ALTENT	EIN HEALTH & LIV	TING COMMONT F	INDIAN	NAPOLIS, IN 40237		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY 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	
	clothing/beds, et	tc.)"		will re-evaluate the oversight a	after	
		,		that. A third party social service	ces	
	2.1.20(-)			consultant Lacy Beyl and		
	3.1-28(a)			Associates will conduct 2 visits	3	
				over the next 90 days to condi		
				their own QIS staff, resident a	nd	
				family interviews to provide		
				independent analysis of		
				compliance and the results wil	I be	
				reviewed by the director of		
				operations, director of clinical	roo	
				services and the corporate null consultant with the facility	150	
				administration team. If the res	vulte	
				demonstrate any trends or rev		
				their has not been a systemic	Cai	
				change then Lacy Beyl service	25	
				will be continued until the culture		
				of abuse prevention is integral		
				into the community. The resi		
				of these reviews will be discus		
				at the monthly facility Quality		
				Assurance Committee meeting	g	
				monthly for 3 months and ther	1	
				quarterly thereafter once		
				compliance is at 100%.		
				Frequency and duration of		
				reviews will be increased as		
				needed, if compliance is below	V	
				100%. Compliance date:		
				8/14/2015. The Administrator	at	
				Altenheim Health and Living		
				Community is responsible in		
				ensuring compliance in this Pl	an	
				of Correction.		
F 0225	483.13(c)(1)(ii)-(iii	i) (c)(2) - (4)				
SS=E	INVESTIGATE/RI					
Bldg. 00	ALLEGATIONS/IN					
Blug. 00						
	The facility must not employ individuals who have been found guilty of abusing,					
		treating residents by a				
	5 5 5 5 6 7 7 1 1 1 1					

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155196	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 07/21/2015
	PROVIDER OR SUPPLIER		3525 E	ADDRESS, CITY, STATE, ZIP CODE HANNA AVE IAPOLIS, IN 46237	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL 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
	into the State nurs abuse, neglect, m misappropriation of any knowledge it I law against an em indicate unfitness or other facility state registry or licensing	ve had a finding entered se aide registry concerning istreatment of residents or of their property; and report has of actions by a court of aployee, which would for service as a nurse aide aff to the State nurse aide ag authorities.			
	violations involving abuse, including it and misappropriate are reported immediadministrator of the officials in accordations.	g mistreatment, neglect, or njuries of unknown source tion of resident property			
	alleged violations investigated, and	nave evidence that all are thoroughly must prevent further hile the investigation is in			
	reported to the ad designated repres officials in accorda (including to the S certification agency the incident, and it	entative and to other ance with State law			
	the facility failed action had been by facility policy	ew and record review, It to ensure a corrective implemented as indicated to prevent staff to ment for 9 of 9 residents allegation of	F 0225	F225 483.13(c)(1)(ii)-(iii), (c)(2)- (4)INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS  What Corrective action(s) will be accomplished for those residents	08/14/2015

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155196	l ,	ILDING	ONSTRUCTION  00	(X3) DATE COMPL <b>07/21</b> /	ETED
	PROVIDER OR SUPPLIER			3525 E	ADDRESS, CITY, STATE, ZIP CODE HANNA AVE IAPOLIS, IN 46237		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	mistreatment. (I #17, #62, #44, #4 anonymous resid				found to have been affected by the d eficient practice?		
	Findings include	:			Residents #107, #29, #96, #17, #62, #44, #89, and #86 have been assessed by social services and monitored to ensure no negative		
	an incident repor	07/9/2015 at 10 A.M., of rt dated 03/31/2015, nt #107 reported 2 staff			outcomes have occurred and to date, no negative outcomes have been discovered by the assessment	:s	
	indicated Resident #107 reported 2 staff members yelled and treated her rudely.  The incident follow up report dated 04/06/2015, indicated both employees				conducted. The anonymous resident that voiced concerns has had no negative outcomes either		
	04/06/2015, indicated both employees were cleared and brought back to work upon completion of the investigation. A				based on the additional actions the facility took by interviewing 100% of the remaining residents using the QIS abuse questionnaire.		
	dated 03/04/201: #107 as having a Mental Status (E	et (MDS) assessment 5, assessed Resident 6 Brief Interview for 6 IMs) score of 15 out of 6 resident was able to be			The facility has a system in place to ensure strategies are implemented to prevent staff to resident mistreatment.		
	, , , , , , , , , , , , , , , , , , ,	07/9/2015 at 10 A.M., of t dated 04/07/2015,			Each report will be taken serious, the harmful situation will be removed immediately and then reported to the ISDH.		
	indicated Reside Certified Nursing their voice at her dated 04/10/2013	nt #29 reported a g Assistant (CNA) raised The follow up report , indicated the CNA			Abuse investigation will be conducted thoroughly to help facility determine corrective action for each case.	s	
	was reinstated to work. A Minimal Data Set (MDS) assessment dated 03/12/2015, assessed Resident #29 as having a Brief Interview for Mental Status (BIMs) score of 9 out of 15, indicating the resident was able to be interviewed.				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?		
					All residents, family members and		

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STATEMEN	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155196	B. W	ING		07/21/	2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				HANNA AVE		
AI TENILI	EIM HEALTH & LIV	ING COMMUNITY			APOLIS, IN 46237		
ALICINII	EINTIEALITI & LIV	ING COMMONT I		INDIAN	AFOLIS, IN 40231		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	3.a.) A review or	n 07/9/2015 at 10 A.M.,			staff have the potential to be		
	of an incident re	port dated 06/07/2015,			affected by the deficient practice.		
	indicated a famil	y member reported a					
	Certified Nursin	g Assistant (CNA) was			All staff members will be inserviced on all types of abuse to include		
	extremely rude t	o Resident #96. The			every type of allegation and		
	1	follow up report dated 06/17/2015, ndicated the employee was terminated			complaint issue dating back to 4 to 5	5	
					months ago to current. The	-	
					inservicing will begin immediately		
	011 00/1 //2013, 1	for sub-standard work.			and all shifts will receive the training	g	
		<b>-</b> /2/ <b>-</b> 24			prior to working in the building until	Ī	
		7/9/2015 at 10 A.M., of			100% compliance is achieved. Third	ı	
	an incident repor	rt dated 07/08/2015,			party vendors will receive the same		
	indicated Reside	nt #96 reported CNA #6			training.		
	was mean. A M	inimal Data Set (MDS)					
	assessment dated	d 05/06/2015, assessed			A post test will be given with 10		
		having a Brief Interview			specific issues surrounding the exac	t	
		s (BIMs) score of 7 out			issues trended for the reportables		
		cognitive impairment.			dating back 4 to 5 months to curren		
	or 13, moderate	eogintive impairment.			and staff will be required to achieve a 100% score to demonstrate		
	D	. 07/00/2015			competency.		
	_	iew on 07/09/2015 at			competency.		
		irector of Nursing			An action plan was created for a		
	(DON) indicated				specific reportable from June 20,		
	relocated during	the month of April 2015,			2015 by the director of nursing at		
	to resident care a	areas to better monitor			the same time June 20, 2015 to		
	staff to resident	interactions.			address the exact abuse reportable		
					issues that were reported at that		
	4) A review on	07/9/2015 at 10 A.M., of			time. Changes were introduced into	)	
	· ′	rt dated 06/20/2015,			the community to include: (1)		
		ly member reported a			weekend designated supervisor		
					solely responsible to manage and	.	
		g Assistant (CNA) called			prevent customer care concerns and	a	
		erogatory term and was			report directly to the director of		
	rude and intimid	ating to Resident #17.			nursing. Staff patterns were changed, decrease in hours of staff		
					to prevent burnout and hiring fair to	<u> </u>	
	5.) A review on	07/9/2015 at 10 A.M., of			cover shifts to prevent staff burn	_	
	an incident repor	rt dated 07/05/2015,			out. The new nurse manager that is		

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETED	
		155196	B. W	ING		07/21/2015	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		$\dashv$
NAME OF F	PROVIDER OR SUPPLIEF	8			HANNA AVE		
AI TENH	EIM HEALTH & LIV	ING COMMUNITY			APOLIS, IN 46237		
			_		, a G2.6, at 1626.		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	т
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA'  DEFICIENCY)		i
TAG		LSC IDENTIFYING INFORMATION)	+	TAG		DATE	
		ent # 62 reported a			covering weekends will begin using		
		g Assistant (CNA) hit			CQR audit tools to conduct staff, family, and resident interviews, 10		
	her head on the	siderail when changing			will be done on random people		
	her. Resident #6	52 stated she told the			(staff, residents and families) each		
	CNA to stop, bu	t the CNA continued.			Saturday and Sunday and the result:	5	
	The follow up re	eport dated 07/10/2015,			will be kept by the administrator		
	_	ndicated the allegation was			and reviewed weekly for 8 weeks by	,	
		and the CNA returned to			the corporate nurse consultant and		
		sciplinary action. A			monthly after that for 3 months and	t	
					reevaluated by the director of		
		et (MDS) assessment			operations.		
		5, assessed Resident #62					
		f Interview for Mental			All residents and family members		
	` ,	core of 15 out of 15,			will be interviewed by social		
	indicating the re	sident was able to be			service(s) designee from outside		
	interviewed.				source utilizing the QIS family		
					interview questionnaire on July 10, 2015. Any findings will be reported		
	6.) During a stag	ge 1 interview on			to the administrator immediately		
	1 ' '	nonymous resident			and then the ISDH with a thorough		
	· ·	nown night shift staff			f/u investigation.		
	-	sident #44, "I've already					
		•			The facility has retained a third part	у	
		eral times. You will			social services consultant firm to		
		care." A Minimal Data			visit once per month for 3 months to		
		ssment dated 06/06/2015,			conduct randome resident, staff and	i l	
	assessed anonyn	nous resident as having a			family abuse interviews using the		
	Brief Interview	for Mental Status (BIMs)			QIS questionnaire to ensure the		
	score of 15 out of	of 15, indicating the			facility has a system in place that		
	resident was able	e to be interviewed.			prevents staff to resident		
					mistreatment.		
	During an interv	riew on 07/08/2015 at					
	_	dministrator indicated					
	1				What measures will be put into		
	naving no know	ledge of this incident.			place or what systemic changes wil		
	<b>5</b> , 5 .				be made to ensure that the		
		ge 1 interview on			deficient practice does not recur?		
	07/08/2015, an a	nonymous resident					

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155196	B. W	ING		07/21/	2015
				STREET	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIE	R			HANNA AVE		
ΔΙ ΤΕΝΙΗ	EIM HEALTH & LIV	ING COMMUNITY			IAPOLIS, IN 46237		
	_						
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	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
	reported overhea	aring an unknown			A thorough investigation was		
	employee tell an	other resident, "I've been			conducted on every employee (CNA		
	in here 5 times.	what the h do you			#6 and all others) acused of		
	want?" A Minimal Data Set (MDS)				mistreatment and the administrativ	е	
	` '				staff at the facility in conjunction		
	assessment dated 06/06/2015, assessed				with corporate oversight have taker	1	
	anonymous resident as having a Brief				appropriate actions on each		
	Interview for Mental Status (BIMs) score				employee including: further		
	of 15 out of 15, indicating the resident				education, progressive discipline,		
	was able to be interviewed.				and terminiation.		
					T. 6 3		
	During an interv	riew on 07/08/2015 at			The family and resident QIS		
	1				interview tool will be broken into		
	4:30 P.M., the Administrator indicated				1/3rds and completed on all		
	having no know	ledge of this incident.			residents and family members		
					monthly over each quarter to		
	8.) During a stag	ge 1 interview on			discover any additional concerns		
	07/09/2015, Res	ident #89 indicated an			ongoing with no stop date. Findings	•	
	· ·	ff member jumped all			will be addressed, reported and investigated immediately with		
	_	going to dialysis. A			appropriate actions taken. A new		
					CQR tool will be developed to review		
		et (MDS) assessment			the results on the interviews to	vv	
		5, assessed anonymous			determine if any trends exists such		
	resident as havir	ng a Brief Interview for			as: shift, days of the week,		
	Mental Status (E	BIMs) score of 15 out of			employee type or specific halls.		
	15, indicating th	e resident was able to be			Action plans will be created to		
	interviewed.				address any trends or findings and		
	11101 / 10 // 0 4.				reported through the QA committee	2	
	Daning on intern	in an 07/00/2015 at			and monitored monthly by the		
	1	riew on 07/09/2015 at			corporate nurse and director of		
	1	Administrator indicated			operations monthly for 3 months		
	having no know	ledge of this incident.			and re-evaluated after that.		
	9.) During a stag	ge 1 interview on			Staff training tools will be		
	07/09/2015 at 4:22 P.M., Resident #86 indicated a night shift Certified Nursing Assistant (CNA) talked with an attitude				introduced and inserviced monthly		
					for the next 3 months related		
					specifically to abuse and customer		
	` ′				service with competency testing		
	and stated this re	esident was not the only			conducted and a threshold of 90%		

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETED
		155196	B. W	ING		07/21/2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIEF	8			HANNA AVE	
ALTENH	EIM HEALTH & LIV	ING COMMUNITY			APOLIS, IN 46237	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	resident that nee	ded to be taken care of.			will be mandatory on all posttests to	
	A Minimal Data	Set (MDS) assessment			ensure staff know how to recognize	
	dated 06/10/201	5, assessed anonymous			abuse, recognize staff burn out in	
	resident as having a Brief Interview for Mental Status (BIMs) score of 13 out of				peers, and know how to effectively	
					handle abuse allegations and	
	`	e resident was able to be			prevention.	
	interviewed.	e resident was able to be			Results of interviews and results of	
	interviewed.				inservicing and post testing will be	
	During on intern	riovy on 07/00/2015 at			reviewed by the QA committee of	
	_	riew on 07/09/2015 at			the facility and any trend will be	
	· ·	Administrator indicated			brought to the committee to	
	having no know	ledge of this incident.			discuss, evaluate and add additiona	ı
					interventions, actions and oversight	
	During an interv	riew on 07/9/2015 at 4:30			to ensure compliance.	
	P.M., the DON i	indicated some of the				
		e considered poor			The corporate nurse consultant will	
	_	e rather than abuse. The			conduct weekly inspections of this	
		idicated some residents			action plan for compliance using a	
	misperceive staf				CQR audit tool. This will be done weekly for 8 weeks, monthly after	
	-				that for 3 months and the director of	nf
	communication	at times.			operations, director of clinical	
					services or nurse consultant will	
	During an interv	riew on 07/10/2015 at			re-evaluate the oversight after that.	
	11:03 A.M., rega	arding a pro-active				
	intervention to n	nonitor for and prevent			A third party social services	
	staff to resident	mistreatment, the			consultant Lacy Beyl and Associates	l l
	Administrator in	idicated the pro-active			will conduct 2 visits over the next 90	)
		place was the Caring			days to conduct their own QIS staff,	
	Hearts Program	C			resident and family interviews to	
	1	`			provide independent analysis of	
		program that allows them			compliance and the results will be	
	_	ces). No other specific			reviewed by the director of	
	-	rentions were indicated to			operations, director of clinical	
	be in place prior	to June 2015.			services and the corporate nurse	
					consultant with the facility administration team. If the results	
	During an interv	riew on 07/10/2015 at			demonstrate any trends or reveal	
		rding how the night shift			their has not been a systemic	
	1	J	1		then has not been a systemic	ı

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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. BU	JILDING	00	COMPL	ETED
		155196	B. WI	ING		07/21/	2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				HANNA AVE		
ALTENILI	EIM HEALTH & LIV				APOLIS, IN 46237		
ALTENIII	EINTIEALTH & LIV	ING COMMONTT		INDIAN	AFOLIS, 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 APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	staff is monitore	d, the Regional Director			change then Lacy Beyl services will		
		dicated, "Night shift staff			be continued until the culture of		
	-	_			abuse prevention is integrated into		
	issues were not brought to our attention				the community.		
	prior to this surv	ey."			·		
					As the QA committee meets		
	On 07/14/2015 at 10:56 A.M., the				monthly abuse reportable events		
	Clinical Nurse C	onsultant provided a			will be reviewed to determine any		
	facility policy, ti	*			trends in shifts or days of the week		
					or other types of trends. If a trend is	s	
		ed 08/21/2013, and			identified the QA committee will pu	t	
	indicated the pol	icy was the one currently			a plan in place to address that		
	being used by th	e facility. The policy			specific cohort of staff/shift/day of		
	indicated, "Ou	r abuse			the week to ensure mistreatment is		
	prevention/interv				dissiminated.		
	•						
		ot necessarily limited			How the corrective action(s) will be		
	tod. Informin	g residents and family			monitored to ensure the deficient		
	members upon tl	ne resident's admission to			practice will not recur, i.e., what		
	the facility how	and to whom complaints,			quality assurance program will be		
	<del>-</del>	incidents of abuse should			put into place?		
	_				par mo pass.		
	•	Monitoring staff on all			The family and resident QIS		
	-	inappropriate behaviors			interview tool will be broken into		
	toward residents	(e.g., using derogatory			1/3rds and completed on all		
	language, rough	handling of residents,			residents and family members		
		ts while giving care,			monthly over each quarter to		
		ts who need toileting			discover any additional concerns		
		•			ongoing with no stop date. Findings		
		nate or defecate in their			will be addressed, reported and	'	
	clothing/beds, et	c.)"			investigated immediately with		
					-		
	3.1-28(a)				appropriate actions taken.		
	<b>-</b> (w)				Staff training tools will be		
					introduced and inserviced monthly		
					for the next 3 months related		
					specifically to abuse and customer		
					service with competency testing		
					conducted and a threshold of 90%		
					will be mandatory on all post tests		

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PRINTED: 08/11/2015 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER  ALTENHEIM HEALTH & LIVING COMMUNITY  (XV4) ID  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MINST BE REFECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG  DEFINITION  REGULATORY OR LSC IDENTIFYING INFORMATION)  TO the onsure staff know how to recognize abuse, recognize staff burn out in peers, and know how to effectively handle abuse allegations and prevention.  Results of interviews and results of inservicing and post testing will be reviewed by the QA committee of the facility and any trend will be brought to the committee of discuss, evaluate and add additional interventions, actions and oversight to ensure compliance.  The corporate nurse consultant will conduct weekly inspections of this action plan for compliance using a CQR audit Con. This will be done weekly for 8 weeks, months and the director of operations, director of clinical services or the nurse consultant will re-evaluate the oversight after that.  A third party social services consultant will re-evaluate the oversight after that.  A third party social services consultant tausy get and Associates consultant Lausy get and Associates will conduct 2 visits over the next 90 days to conduct their own QIS staff, resident and family interviews to provide independent analysis of compliance and the results will be reviewed by the director of operations, director of clinical services and the corporate nurse consultant with the facility administration team. If the results demonstrate any trends or reveal		OF CORRECTION	IDENTIFICATION NUMBER: 155196	A. BUILDING B. WING	00	COMPLETED 07/21/2015		
PREFIX TAG REQUILATORY OR ISC IDENTIFYING INFORMATION)  TAG CHOSENERS SEPRENCE DID TO LA PROPRIETADE CHOSENERS SEPRENCE DID TO LA PROPRIETA DID TO LA PROPRIETA SEPRENCE DID TO LA PROPRIETA SEPRENCE DID TO				3525 E HANNA AVE				
recognize abuse, recognize staff burn out in peers, and know how to effectively handle abuse allegations and prevention.  Results of interviews and results of inservicing and post testing will be reviewed by the QA committee of the facility and any trend will be brought to the committee of discuss, evaluate and add additional interventions, actions and oversight to ensure compilance.  The corporate nurse consultant will conduct weekly inspections of this action plan for compliance using a CQR audit tool. This will be done weekly for 8 weeks, monthly after that for 3 months and the director of operations, director of clinical services or the nurse consultant will re-evaluate the oversight after that.  A third party social services consultant will re-evaluate the oversight after that.  A third party social services consultant will re-evaluate the oversight after that.  A third party social services consultant will re-evaluate the rown QB staff, resident and family interviews to provide independent analysis of compilance and the results will be reviewed by the director of operations, director of clinical services and the corporate nurse consultant with the facility administration team. If the results	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION		
their has not been a systemic change then Lacy Beyl services will					recognize abuse, recognize staff burn out in peers, and know how to effectively handle abuse allegations and prevention.  Results of interviews and results of inservicing and post testing will be reviewed by the QA committee of the facility and any trend will be brought to the committee to discuss, evaluate and add additiona interventions, actions and oversight to ensure compliance.  The corporate nurse consultant will conduct weekly inspections of this action plan for compliance using a CQR audit tool. This will be done weekly for 8 weeks, monthly after that for 3 months and the director coperations, director of clinical services or the nurse consultant will re-evaluate the oversight after that.  A third party social services consultant Lacy Beyl and Associates will conduct 2 visits over the next 90 days to conduct their own QIS staff, resident and family interviews to provide independent analysis of compliance and the results will be reviewed by the director of operations, director of clinical services and the corporate nurse consultant with the facility administration team. If the results demonstrate any trends or reveal their has not been a systemic	of O		

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Event ID:

JVTX11

Facility ID: 000103

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	N OF CORRECTION IDENTIFICATION NUMBER: A. I		A. BUILDING  B. WING	<u> </u>		
	PROVIDER OR SUPPLIER		3525 E	ADDRESS, CITY, STATE, ZIP CODE HANNA AVE IAPOLIS, IN 46237		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL 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	
				be continued until the culture of abuse prevention is integrated into the community.  The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance below 100%.  Compliance date: 8/14/2015. The Administrator at Altenheim Health and Living Community is responsible in ensuring compliance in this Plan of Correction.		
F 0226 SS=E Bldg. 00	ETC POLICIES The facility must d written policies and mistreatment, neg residents and mist property. Based on intervice the facility failed	expropriation of resident  ew and record review,  to ensure of their written policy hat resident  9 of 9 residents	F 0226	F226 483.13(c)  DEVELOPMENT/IM[LEMENT  ABUSE/NEGLECT, ETC POLICIES  What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	08/14/2015	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155196	B. W	ING		07/21/	2015
				CTDEET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	3					
A1 TENII 1		VINIO CONANALINITY			HANNA AVE		
ALIENH	EIM HEALTH & LIV	ING COMMUNITY		INDIAN	APOLIS, IN 46237		
(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
	mistreatment. (R	Resident #107, #29, #96,			Residents #107, #29, #96, #17, #62,		
	#17, #62, #44, #	89, #86, and an			#44, #89, and #86 have been		
	anonymous resident)				assessed by social services and		
	unony mous resid	30111)			monitored to ensure no negative		
	F: 1: : 1 1				outcomes have occurred and to		
	Findings include	<b>:</b> :			date, no negative outcomes have		
					been discovered by the assessments	5	
	1.) A review on	07/9/2015 at 10 A.M., of			conducted. The anonymous		
	an incident repor	rt dated 03/31/2015,			resident that voiced concerns has		
	indicated Resident #107 reported 2 staff				had no negative outcomes either		
	members yelled and treated her rudely.				based on the additional actions the		
					facility took by interviewing 100% o	f	
	The incident follow up report dated				the remaining residents using the		
	04/06/2015, indicated both employees				QIS abuse questionnaire.		
	were cleared and	l brought back to work			The facility has a system in place to		
	upon completion	of the investigation. A			ensure strategies are implemented		
	Minimal Data So	et (MDS) assessment			to prevent staff to resident		
		5, assessed Resident			mistreatment.		
		a Brief Interview for			The facility has fully implemented		
					the company policy and procedure		
	,	BIMs) score of 15 out of			related to resident mistreatment,		
		e resident was able to be			abuse, abuse prevention, neglect		
	interviewed.				and misallocation.		
					Each report will be taken serious,		
	2.) A review on	07/9/2015 at 10 A.M., of			the harmful situation will be		
	1 1	rt dated 04/07/2015,			removed immediately and then		
	_	ent #29 reported a			reported to the ISDH.		
		•			Abuse investigation will be conducted thoroughly to help		
		g Assistant (CNA) raised			facility determine corrective actions		
		r. The follow up report			for each case.	'	
	dated 04/10/201	5, indicated the CNA			How other residents having the		
	was reinstated to	work. A Minimal Data			potential to be affected by the		
	Set (MDS) asses	ssment dated 03/12/2015,			same deficient practice will be		
	` ,	nt #29 as having a Brief			identified and what corrective		
		· ·			action(s) will be taken?		
	Interview for Mental Status (BIMs) score				All residents, family members and		
		ndicating the resident was			staff have the potential to be		
	able to be interv	iewed.			affected by the deficient practice.		
					All staff members will be inserviced		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155196	B. W	ING		07/21/	2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	2			HANNA AVE		
AI TENH	EIM HEALTH & LIV	ING COMMUNITY			APOLIS, IN 46237		
			1		711 0210, 114 10201		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL  LISC IDENTIFYING INFORMATION)		PREFIX	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		*		TAG	·		DATE
	· /	n 07/9/2015 at 10 A.M.,			on all types of abuse to include		
		port dated 06/07/2015,			every type of allegation and complaint issue dating back to 4 to 9	=	
	indicated a family member reported a				months ago to current. The	,	
	Certified Nursin	g Assistant (CNA) was			inservicing will begin immediately		
	extremely rude t	o Resident #96. The			and all shifts will receive the training	2	
	follow up report	dated 06/17/2015,			prior to working in the building unti		
	indicated the em	ployee was terminated			100% compliance is achieved. Third		
		for sub-standard work.			party vendors will receive the same		
	011 00/17/2015, 1	of suc standard work.			training.		
	h A rovious on (	07/9/2015 at 10 A.M., of			A post test will be given with 10		
					specific issues surrounding the exac	t	
	1	rt dated 07/08/2015,			issues trended for the reportables		
		ent #96 reported CNA #6			dating back 4 to 5 months to curren		
	was mean. A M	inimal Data Set (MDS)			and staff will be required to achieve		
	assessment dated	d 05/06/2015, assessed			a 100% score to demonstrate		
	Resident #96 as	having a Brief Interview			competency.		
	for Mental Statu	s (BIMs) score of 7 out			An action plan was created for a		
		cognitive impairment.			specific reportable from June 20, 2015 by the director of nursing at		
	,				the same time June 20, 2015 to		
	During an interv	riew on 07/09/2015 at			address the exact abuse reportable		
	-	Pirector of Nursing			issues that were reported at that		
	-	C			time. Changes were introduced into	)	
	, ,	I the DON office			the community to include: (1)		
	_	the month of April 2015,			weekend designated supervisor		
		areas to better monitor			solely responsible to manage and		
	staff to resident	interactions.			prevent customer care concerns and	ł	
					report directly to the director of		
	4.) A review on	07/9/2015 at 10 A.M., of			nursing. Staff patterns were		
	an incident repor	rt dated 06/20/2015,			changed, decrease in hours of staff		
	indicated a famil	ly member reported a			to prevent burnout and hiring fair to	)	
		g Assistant (CNA) called			cover shifts to prevent staff burn out. The new nurse manager that is		
		lerogatory term and was	1		covering weekends will begin using		
		ating to Resident #17.	1		CQR audit tools to conduct staff,		
		aung to Resident #1/.	1		family, and resident interviews, 10		
	5 \ A	07/0/2015 -4 10 4 3.5 - 6	1		will be done on random people		
	1	07/9/2015 at 10 A.M., of			(staff, residents and families) each		
	an incident repor	rt dated 07/05/2015,			Saturday and Sunday and the result	5	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 00 COMPLETED 155196 B. WING 07/21/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3525 E HANNA AVE ALTENHEIM HEALTH & LIVING COMMUNITY INDIANAPOLIS. IN 46237 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG  $\mathsf{TAG}$ indicated Resident # 62 reported a will be kept by the administrator and reviewed weekly for 8 weeks by Certified Nursing Assistant (CNA) hit the corporate nurse consultant and her head on the siderail when changing monthly after that for 3 months and her. Resident #62 stated she told the reevaluated by the director of CNA to stop, but the CNA continued. operations. The follow up report dated 07/10/2015, All residents and family members indicated the allegation was will be interviewed by social service(s) designee from outside unsubstantiated and the CNA returned to source utilizing the QIS family work with no disciplinary action. A interview questionnaire on July 10, Minimal Data Set (MDS) assessment 2015. Any findings will be reported dated 05/07/2015, assessed Resident #62 to the administrator immediately as having a Brief Interview for Mental and then the ISDH with a thorough Status (BIMs) score of 15 out of 15, f/u investigation. The facility has retained a third party indicating the resident was able to be social services consultant firm to interviewed. visit once per month for 3 months to conduct randome resident, staff and 6.) During a stage 1 interview on family abuse interviews using the 07/08/2015, an anonymous resident QIS questionnaire to ensure the reported an unknown night shift staff facility has a system in place that prevents staff to resident member told Resident #44, "I've already mistreatment. been in here several times. You will have to wait for care." A Minimal Data What measures will be put into Set (MDS) assessment dated 06/06/2015, place or what systemic changes will assessed anonymous resident as having a be made to ensure that the Brief Interview for Mental Status (BIMs) deficient practice does not recur? A thorough investigation was score of 15 out of 15, indicating the conducted on every employee (CNA resident was able to be interviewed. #6 and all others) acused of mistreatment and the administrative During an interview on 07/08/2015 at staff at the facility in conjunction 4:30 P.M., the Administrator indicated with corporate oversight have taken appropriate actions on each having no knowledge of this incident. employee including: further education, progressive discipline, 7.) During a stage 1 interview on and terminiation. 07/08/2015, an anonymous resident The family and resident QIS

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155196	B. W	ING		07/21/	2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	t			HANNA AVE		
AI TENILI	EIM HEALTH & LIV	ING COMMUNITY			APOLIS, IN 46237		
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(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	reported overhea	aring an unknown			interview tool will be broken into		
	employee tell an	other resident, "I've been			1/3rds and completed on all		
	in here 5 times, what the h do you				residents and family members		
	want?" A Minimal Data Set (MDS)				monthly over each quarter to		
	assessment dated 06/06/2015, assessed				discover any additional concerns		
	anonymous resident as having a Brief				ongoing with no stop date. Findings	•	
	<u> </u>	_			will be addressed, reported and investigated immediately with		
	Interview for Mental Status (BIMs) score				appropriate actions taken. A new		
	of 15 out of 15, indicating the resident				CQR tool will be developed to review	M	
	was able to be in	iterviewed.			the results on the interviews to	••	
					determine if any trends exists such		
	During an interv	iew on 07/08/2015 at			as: shift, days of the week,		
	4:30 P.M., the A	dministrator indicated			employee type or specific halls.		
	having no know	ledge of this incident.			Action plans will be created to		
	8 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2				address any trends or findings and		
	Q ) During a stag	ge 1 interview on			reported through the QA committee	e	
	'				and monitored monthly by the		
	•	ident #89 indicated an			corporate nurse and director of		
	_	ff member jumped all			operations monthly for 3 months		
	1	going to dialysis. A			and re-evaluated after that.		
	Minimal Data Se	et (MDS) assessment			Staff training tools will be		
	dated 06/07/201:	5, assessed anonymous			introduced and inserviced monthly		
	resident as havin	ng a Brief Interview for			for the next 3 months related		
		BIMs) score of 15 out of			specifically to abuse and customer		
	`	e resident was able to be			service with competency testing		
	interviewed.	o resident was dore to be			conducted and a threshold of 90% will be mandatory on all posttests to	•	
	interviewed.				ensure staff know how to recognize		
	<b>.</b>				abuse, recognize staff burn out in		
		riew on 07/09/2015 at			peers, and know how to effectively		
	•	Administrator indicated			handle abuse allegations and		
	having no know	ledge of this incident.			prevention.		
					Results of interviews and results of		
	9.) During a stag	ge 1 interview on			inservicing and post testing will be		
	07/09/2015 at 4:22 P.M., Resident #86				reviewed by the QA committee of		
		shift Certified Nursing			the facility and any trend will be		
	1	talked with an attitude			brought to the committee to		
	` ′				discuss, evaluate and add additional	I	
	and stated this re	esident was not the only	1		interventions actions and oversight		

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SU	JRVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLE	TED
		155196	B. W	ING		07/21/2	015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	<b>.</b>	
NAME OF I	PROVIDER OR SUPPLIEF	₹			HANNA AVE		
AI TENH	EIM HEALTH & LIV	ING COMMUNITY			IAPOLIS, IN 46237		
					1, 41 0207		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA'  DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	· · · · · · · · · · · · · · · · · · ·	-	DATE
		ded to be taken care of.			to ensure compliance.		
		Set (MDS) assessment			The corporate nurse consultant will		
	dated 06/10/201	5, assessed anonymous			conduct weekly inspections of this action plan for compliance using a		
	resident as having a Brief Interview for				CQR audit tool. This will be done		
	Mental Status (E	BIMs) score of 13 out of			weekly for 8 weeks, monthly after		
	15, indicating th	e resident was able to be			that for 3 months and the director of	of	
	interviewed.				operations, director of clinical		
	11101 (10 () 04.				services or the nurse consultant will		
	During on interes	riew on 07/09/2015 at			re-evaluate the oversight after that.		
					A third party social services		
	· ·	dministrator indicated			consultant Lacy Beyl and Associates		
	having no know.	ledge of this incident.			will conduct 2 visits over the next 90		
					days to conduct their own QIS staff,		
	During an interv	riew on 07/9/2015 at 4:30			resident and family interviews to		
	P.M., the DON i	indicated some of the			provide independent analysis of		
	reportables were	e considered poor			compliance and the results will be		
		e rather than abuse. The			reviewed by the director of		
		idicated some residents			operations, director of clinical		
	misperceive staf				services and the corporate nurse consultant with the facility		
	communication				administration team. If the results		
	Communication	at times.			demonstrate any trends or reveal		
		05/10/2015			their has not been a systemic		
		riew on 07/10/2015 at			change then Lacy Beyl services will		
	1	arding a pro-active			be continued until the culture of		
	intervention to n	nonitor for and prevent			abuse prevention is integrated into		
	staff to resident	mistreatment, the			the community.		
	Administrator in	dicated the pro-active			As the QA committee meets		
	intervention in p	blace was the Caring			monthly abuse reportable events		
	Hearts Program	(a resident			will be reviewed to determine any		
	_	program that allows them			trends in shifts or days of the week		
		ces). No other specific			or other types of trends. If a trend i		
	_	•			identified the QA committee will pu	ι	
	pro-active interventions were indicated to be in place prior to June 2015.				a plan in place to address that specific cohort of staff/shift/day of		
					the week to ensure mistreatment is		
					dissiminated.		
	_	riew on 07/10/2015 at			a.ss.iiiideed.		
	12:31 P.M. regar	rding how the night shift			How the corrective action(s) will be	,	

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		NSTRUCTION	(X3) DATE COMPL	
MIDILAN	OI CORRECTION	155196	B. WING		00	07/21/	
		155190				01/21/	2010
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
A1	EINALIENI TUO UU	INC COMMUNITY			HANNA AVE		
ALIENH	EIM HEALTH & LIV	ING COMMUNITY	"	NDIANA	APOLIS, IN 46237		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	II	)	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PRE	FIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	T	AG	DEFICIENCY)		DATE
	staff is monitore	d, the Regional Director			monitored to ensure the deficient		
	of Operations in	dicated, "Night shift staff			practice will not recur, i.e., what		
	issues were not b	prought to our attention			quality assurance program will be		
prior to this survey."				put into place?			
	prior to this surv	Cy.			The family and resident QIS		
	0.07/14/2015	110.56 A M. J.			interview tool will be broken into		
		t 10:56 A.M., the			1/3rds and completed on all		
		onsultant provided a			residents and family members		
	facility policy, ti	tled, "Abuse			monthly over each quarter to		
	Prevention," date	ed 08/21/2013, and			discover any additional concerns		
	· · · · · · · · · · · · · · · · · · ·	icy was the one currently			ongoing with no stop date. Finding	S	
	_	e facility. The policy			will be addressed, reported and		
					investigated immediately with		
	indicated, "Ou				appropriate actions taken.		
	prevention/interv	. •			Staff training tools will be		
	· ·	ot necessarily limited			introduced and inserviced monthly for the next 3 months related		
	tod. Informin	g residents and family			specifically to abuse and customer		
	members upon th	ne resident's admission to			service with competency testing		
		and to whom complaints,			conducted and a threshold of 90%		
		incidents of abuse should			will be mandatory on all post tests		
	_	Monitoring staff on all			to ensure staff know how to		
	-				recognize abuse, recognize staff		
	1	inappropriate behaviors			burn out in peers, and know how to	)	
		(e.g., using derogatory			effectively handle abuse allegations		
		handling of residents,			and prevention.		
	ignoring residen	ts while giving care,			Results of interviews and results of		
		ts who need toileting			inservicing and post testing will be		
		nate or defecate in their			reviewed by the QA committee of		
	clothing/beds, et				the facility and any trend will be		
	crouning/ocus, ct	o.j			brought to the committee to		
	2.1.20()				discuss, evaluate and add additiona	ıl	
	3.1-28(a)				interventions, actions and oversigh	t	
					to ensure compliance.		
					The corporate nurse consultant will		
					conduct weekly inspections of this		
					action plan for compliance using a		
					CQR audit tool to ensure all pieces		
					are performed exactly to the letter		
					of this plan. This will be done		

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	OF CORRECTION	IDENTIFICATION NUMBER:  155196	A. BUILDING B. WING	ONSTRUCTION 00	COMPLETED 07/21/2015		
	PROVIDER OR SUPPLIE	R /ING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE  3525 E HANNA AVE INDIANAPOLIS, IN 46237				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
				weekly for 8 weeks, monthly after that for 3 months and the director operations, director of clinical services and the nurse consultant will re-evaluate the oversight after that.  A third party social services consultant Lacy Beyl and Associate will conduct 2 visits over the next days to conduct their own QIS staff resident and family interviews to provide independent analysis of compliance and the results will be reviewed by the director of operations, director of clinical services and the corporate nurse consultant with the facility administration team. If the results demonstrate any trends or reveal their has not been a systemic change then Lacy Beyl services will be continued until the culture of abuse prevention is integrated into the community.  The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance below 100%.  Compliance date: 8/14/2015. The Administrator at Altenheim Health and Living Community is responsible in ensuring compliance in this Plan of Correction.	es 900 of f, so la		

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	of Correction identification number:  155196	A. BUILDING B. WING	00	COMPLETED 07/21/2015
	PROVIDER OR SUPPLIER EIM HEALTH & LIVING COMMUNITY	3525 E	ADDRESS, CITY, STATE, ZIP CODE 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)	(X5) COMPLETION DATE
F 0241 SS=D Bldg. 00	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.  Based on observation and interview, the facility failed to maintain a resident's dignity by not having covered their catheter drainage bag for 2 of 2 residents observed with an indwelling urinary catheter. (Resident #166 and Resident #106)  Findings include:  1. During a random observation on 7/10/15 at 3:30 p.m., Resident #166 was lying in bed and the catheter drainage bag was visible to anyone standing in the hallway. The catheter bag was observed to be hanging on the side of the bed with dark yellow fluid noted in the bag.	F 0241	F 241 483.15(a) DIGNITY AN RESPECT OF INDIVIDUALIT What corrective actions will accomplished for those residents found to have bee affected by the deficient practice? Resident #166 and #106 were given dignity bags cover catheter drainage bags have not experienced any negative outcome from this alleged deficient practice. He other residents having the potential to be affected by the same deficient practice will identified and what correctivaction will be taken? All residents with catheters have potential to be affected by the deficient practice. Audit completed of all residents with catheters for urinary drainage	be  n  d to and  ow  ne be /e the

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDEN		IDENTIFICATION NUMBER:	A. BUILDING <u>00</u> CO			COMPLETED	
		155196	B. WING 07/21/2015			07/21/2015	
				CTREET	ADDRESS OF STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE		
A1 TENU		(N.O. O.O. M. M. IN.U.T.) (			HANNA AVE		
ALTENH	EIM HEALTH & LIV	ING COMMUNITY		INDIAN	APOLIS, IN 46237		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	2. During a rand	dom observation of			performed and given dignity		
	Resident #106 or	n 7/14/15 at 9:50 a.m.,			bags. There were no adverse		
		nage bag was hanging on			outcomes related to the deficie		
		ne bed with a small			practice. What measures wil	l e	
					be put into place or what		
	amount of yellov	w fluid visible in the bag.			systemic changes will be ma	ae	
					to ensure that the deficient		
	On 7/15/15 at 10	0:08 a.m., the catheter			practice does not recur?  Nursing staff educated on		
	drainage bag of	Resident #106 was			Catheter Drainage Covering		
	visible from the	hallway and was hanging			Policy related to dignity and th	e l	
	over the end of t				expectation for a cathether		
					drainage bag to be covered wi	th a	
	Daning on intern	in and the Desident #106			dignity bag at all times. How t	:he	
	_	riew with Resident #106			corrective actions will be		
		45 a.m., the resident's			monitored to ensure the		
	catheter drainage	e bag was noted hanging			deficient practice will not rec	ur,	
	over the end of t	he bed with yellow fluid			what quality assurance		
	noted in the tubi	ng and bag.			program will be put into plac		
					Director of Nursing/Director of		
	On 7/17/15 at 11	:40 a.m., the catheter			Education/Unit	nr	
		#106 was hanging over			Managers/Weekend Supervisor will audit by visual observation		
	_	• •			placement of dignity bags over		
		ed and was uncovered.			urinary catheter drainage syste		
		s noted in the tubing and			3xs a day 3 days a week x 4		
	in the bag.				weeks, 2xs a day 3 days a we	ek	
					x 4 weeks, 1x a day 3 days a		
	During an interv	riew with Unit Manager			week for 4 weeks, then month	ly	
	_	7/15 at 11:45 a.m., UM			thereafter to ensure bags are	.,	
	` ′	privacy bag (a bag used			covered at all times. The resu		
		rainage) for Resident			of these reviews will be discus at the monthly facility Quality	SEU	
		_ ,			Assurance Committee meeting	,	
	_	ng on their electric chair			monthly for 3 months and then		
		obtaining second privacy			quarterly thereafter once		
	bag for the resid	ent to use while in bed.			compliance is at 100%.		
					Frequency and duration of		
	During an interv	riew with the Director of			reviews will be increased as		
	_	on 7/14/15 at 10:42 a.m.,			needed, if compliance is below	/	
	• • •	ted the expectation was			100%. Compliance date:	-4	
		ea me expectation was	1		8/14/2015. The Administrator	ar I	

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i '		Î ,	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING B. WING	00	COMPLETED	
		155196	_		07/21/2015	
NAME OF P	ROVIDER OR SUPPLIER			T ADDRESS, CITY, STATE, ZIP CODE		
AI TENIHI	EIM HEALTH & LIV	ING COMMUNITY		E HANNA AVE NAPOLIS, IN 46237		
(X4) ID PREFIX		FATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL	ID PROVIDER'S PLAN OF CORRECTION SHOULD PROFIX (EACH CORRECTIVE ACTION SHOULD PROFIXE AC		(X5) COMPLETION	
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE	
	for a catheter dra with a dignity ba case if no dignity The DON indica have a policy spe catheter drainage	inage bag to be covered g at all times, or a pillow bags were available. ted the facility did not ecific to covering the and had privacy/dignity or use with the catheter		Altenheim Health and Living Community is responsible in ensuring compliance in this Pla of Correction.		
F 0248 SS=D Bldg. 00	EACH RES The facility must p program of activitie accordance with the assessment, the ir mental, and psyche resident. Based on observe record review, the a dependent reside activities consists for 1 of 3 resider provided to cogn residents. (Residents) Findings include	nterests and the physical, osocial well-being of each ation, interview, and he facility failed to ensure dent was provided with ent with their interests has reviewed for activities itively impaired dent #95)	F 0248	F 248 483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RESIDENT  What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?  Resident #95 was not able to be interviewed for activity preference	08/14/2015	
		rd review, completed		related to diagnosis. Resident's husband interviewed and actives of		
	1/13/13 at 12.3/	p.m., indicated Resident		inaspana interviewed and actives of		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 00 COMPLETED 155196 B. WING 07/21/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3525 E HANNA AVE ALTENHEIM HEALTH & LIVING COMMUNITY INDIANAPOLIS. IN 46237 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG  $\mathsf{TAG}$ #95 had diagnoses including, but not choice implemented and updated to care plan. limited to, dementia. How other residents having the An Admission Minimum Data Set potential to be affected by the (MDS) assessment dated 5/22/15, same deficient practice will be assessed Resident #95 as having a BIMS identified and what corrective (Brief Interview for Mental Status) of 1 action will be taken? out of 15, indicating severe cognitive All residents with cognitive impairment. An Activity Assessment impairment, BIMs (Brief Interview completed 5/22/15, assessed the for Mental Status) 1-13, have the resident's hobbies as collecting beanie potential to be affected by the babies, watching TV, naps, and family deficient practice. All residents with cognitive impairment audited and time, and preferred independent activities Activities Director/Activities versus group activities. Assistant completed updated assessment of activity preferences. A care plan dated 5/21/15, and edited on 7/10/15, indicated the resident chose not What measures will be put into to participate in group activities and place or what systemic changes will be made to ensure that the preferred to rest in bed between meals. deficient practice does not recur? Interventions included encourage the resident to pursue independent activities Activity assistants #12, #13 and CNA of watching TV (television), listening to #11 have received education related music, naps, and spending time with to residents rights and needs to receive activities according to their husband. Offer CD (compact disc) individual preferences. player/CDs for independent use as desired, and provide a calendar of Activities Director/Activities monthly activity programs. Assistant and staff members were educated on providing activities to Observation on 7/8/15 at 3:14 p.m., the residents with cognitive impairment, and how to assess/provide activities resident was in bed with their eyes for resident with cognitive closed. Their spouse was at the bedside impairment. looking at newspaper. The TV was on in the room. When the resident had their Activities Director/Activities eyes open, the resident did not attempt to Assistant will attend morning clinical

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	<u> </u>			COMPLETED	
		155196	B. W	B. WING 07/21/2015			
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		_
NAME OF I	PROVIDER OR SUPPLIEF	8			HANNA AVE		
ALTENH	EIM HEALTH & LIV	ING COMMUNITY			APOLIS, IN 46237		
(X4) ID				ID	,	(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	J
TAG	`	LISC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	•
0	look at the TV.		+	1110	meeting Monday through Friday to	51112	
	look at the 1 v.				be informed of any resident with		
	01	7/0/15 -4 0.45 41.			worsening cognitive status/new		
		7/9/15 at 9:45 a.m., the			admissions thus needing new		
		ped with their eyes			activities assessment and plan.		
		vities consistent with the					
	resident's prefere	ences were present.			How the corrective actions will be		
					monitored to ensure the deficient		
	Observation on '	7/13/15 at 6:22 a.m., the			practice will not recur, what quality	′	
	resident was awa	ake and attempting to get			assurance program will be put into		
	legs out of bed.	Certified Nursing			place?		
	Assistant (CNA) #11 assisted the resident back into bed. No activities consistent with the resident's preferences were				Activities Director/Director of		
					Nursing/Activity Assistants will		
					review documentation and observe		
	present.	is preferences were			activity participation in cognitively		
	present.				impaired residents weekly		
	01	7/14/15 -4 11:40			indefinitely.		
		7/14/15 at 11:48 a.m.,					
		resting with their eyes			The results of these reviews will be		
	-	ouse was sitting at the			discussed at the monthly facility  Quality Assurance Committee		
		cated the resident had			meeting monthly for 3 months and		
		ugh out the visit. No			then quarterly thereafter once		
	activities consist	tent with the resident's			compliance is at 100%. Frequency		
	preferences were	e present.			and duration of reviews will be		
					increased as needed, if compliance i	s	
	During an interv	riew with the Activity			below 100%.		
	Director (AD) or	n 7/14/15 at 4:45 p.m.,					
	the AD indicated	d Resident #95 was not			Compliance date: 8/14/2015. The		
	currently on a sc	cheduled one on one			Administrator at Altenheim Health		
	visitation schedu				and Living Community is responsible in ensuring compliance in this Plan		
		aily Record of Resident			of Correction.		
		July 2015, with the AD.			5. 55//CCCIOIII		
	•	•					
		was completed on the					
	_	11/15, and indicated the					
		ended occupational and					
	physical therapy	8 days of the month, had					

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	ND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155196  A. BUILDING  B. WING			COMPL 07/21/	ETED	
	PROVIDER OR SUPPLIER		3525 E	ADDRESS, CITY, STATE, ZIP CODE HANNA AVE APOLIS, IN 46237		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	and had visited with days. The AI assistant had beer residents in that with to check to see with resident had been. During an interval Assistant #12 and on 715/15 at 3:5 Assistant #13 incomo been invited to an especially in the resident had reful Activity Assistant Activity Assi	iew with Activity d Activity Assistant #13 4 p.m., Activity dicated the resident had ttend group activities mornings, but the sed and had cursed at the at so the Activity t the resident alone. at #12 indicated the nent completed on cated the resident with spouse instead of activities. The activity ed the resident had been ehabilitation unit, had to the long term care been reassessed for ces when admitted to the nit. The assistants did wing what the resident's				

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	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155196	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING 00 COMPLETED  B. WING 07/21/2015				
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		
F 0280 SS=D Bldg. 00	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.  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.  Based on observation, interview, and record review, the facility failed to ensure the care plans were updated for a resident admitted to hospice services and had behaviors disrupting daily care for 1 of 25 residents' care plans reviewed.  (Resident #95)  Findings include:	F 0280	F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?  Resident #95 care plan was updated to reflect hospice service admission	d .		
	a. The clinical record review of Resident		Resident # 95 care plan was update	d		

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETED	
		155196	B. W	B. WING 07/21/2015			
				STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹			HANNA AVE		
AI TENHI	FIM HEALTH & LIV	ING COMMUNITY			IAPOLIS, IN 46237		
					1		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL  LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)	TE COMPLETION DATE	
IAG		<u> </u>	+	IAG	to include behaviors that disrupted	DATE	
		on 7/13/15 at 12:37 p.m.,			daily care such as; refusal of care,		
		ident had diagnoses			combativeness and/or refusal of		
	including, but no	ot limited to, dementia.			food and fluids. Resident #95 has		
					not experienced any negative		
	A current care p	lan dated 5/18/15, and			outcome from this alleged deficient	:	
	edited on 7/10/1	5, indicated the resident			practice.		
	had an establish	ed a goal through					
		irning home with their			How other residents having the		
		abilitation was completed.			potential to be affected by the		
	The state of the s	cluded, but were not			same deficient practice will be		
		resident to maintain			identified and what corrective		
	,				action will be taken?		
		ssist with making choices			All residents whom have admitted t		
		d have services or			hospice care resulting in change of	.0	
		ged prior to/upon			discharge plans have the potential		
	discharge.				to be affected by the same alleged		
					deficient practice. Audit of all		
	An IDT (Inter D	isciplinary Team)			residents on hospice performed and	b	
	Clinically At Ris	sk Review dated 6/18/15			care plans updated as needed		
	at 1:15 p.m., ind	icated the resident was					
	_	pice services with a			All resident who have behaviors tha		
	_	nentia. The notation on			disrupt daily care such as; refusal of		
	_	ed the care plan was			care, combativeness, and/or refusa		
		dated and the resident			of food and fluids have the potentia to be affected by the same alleged	ai e	
	_				deficient practice. Audit of all		
	would be discha	igeu nom id i.			residents with behaviors that		
					interfere with daily care performed		
		riew with the Social			and care plans updated as needed.		
		or (SSD) on 7/14/15 at					
	4:31 p.m., the SS	SD indicated the			What measures will be put into		
	discharge plan w	vas initiated when the			place or what systemic changes wil	II	
	resident was firs	t admitted to the facility			be made to ensure that the		
	and should have	been updated when the			deficient practice does not recur?		
		nitted to hospice services.					
		ted the family had			Social Services educated on care		
		resident to remain in the			plan updates when a resident has		

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLE	ETED
		155196	B. W	B. WING 07/21/2015			2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	t			HANNA AVE		
AI TENILI	EIM HEALTH & LIV	ING COMMUNITY			APOLIS, IN 46237		
ALICINIII	EINTIEALITI & LIV			INDIAN	AFOLIS, IN 40237		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	facility for long	term care and not return			changing discharge plans.		
	home.						
					Nursing staff educated on Behavior		
	b. The clinical r	ecord review of Resident			Management Program policy.		
	#95_completed (	on 7/13/15 at 12:37 p.m.,			Nursing staff educated on reporting		
		ident had diagnoses			and documenting behaviors that		
					interfere with daily care.		
	including, but no	ot limited to, dementia.			How the corrective actions will be		
					monitored to ensure the deficient		
		Iinimum Data Set			practice will not recur, what quality	,	
	(MDS) assessme	ent dated 5/22/15,			assurance program will be put into	· I	
	assessed Resider	nt #95 as having a BIMS			place?		
	(Brief Interview	for Mental Status) of 1					
	`	ting severe cognitive			IDT to meet within 72 hours after a		
	impairment.	ing severe cognitive		resident change to hospice status.			
	impairment.				All care plans will be updated to		
		1 . 1 . (1 (1 5			reflect changes and reviewed for		
	0.0	ess note dated 6/1/15 at			accuracy. Residents with change of		
	-	ated the resident was not			condition resulting in change of		
	consuming food	and had refused			discharge plans will be reviewed a		
	medications. Th	e note also indicated the			second time in weekly IDT meeting		
	resident became	combative when the			to ensure accuracy.		
	staff attempted a	dressing change.			Discotor of Nussian / Init		
	1	2 2			Director of Nursing/Unit Manager/Social Services/Weekend		
	A nursing progra	ess note dated 6/6/15 at			Manger will review nursing progress		
	0.0				notes to ensure Behavior Events are		
	-	ated the resident had			opened. IDT will review Behavior		
	refused fluids thi	roughout the night.			Events daily Monday through Friday	,	
					and update care plans in clinical		
	A nursing progre	ess note dated 6/12/15 at			morning meeting as needed. All nev	v	
	9:33 p.m., indica	nted the resident had			or worsening behaviors will be		
	refused all medic	cations and food.			reviewed a second time in weekly		
					IDT meeting to ensure accuracy.		
	A hospice Sump	nary Report dated 7/1/15,					
	•	dent as taking only bites			The results of these reviews will be		
		- ·			discussed at the monthly facility		
	and sips and figh	nting with all care.			Quality Assurance Committee		
					meeting monthly for 3 months and		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ í	IULTIPLE CC UILDING	DNSTRUCTION	(X3) DATE COMPL		
AND PLAN	OF CORRECTION		B. W		00		
		155196	B. W			07/21/	2015
NAME OF F	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE		
		(N. C. C. C. M. M. N. U.T.)			HANNA AVE		
ALTENH	EIM HEALTH & LIV	ING COMMUNITY		INDIAN	APOLIS, IN 46237		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	The care plans for	or Resident #95 did not			then quarterly thereafter once		
	address refusal o	of care, combativeness, or			compliance is at 100%. Frequency		
	refusal of food a	nd fluids.			and duration of reviews will be		
					increased as needed, if compliance	IS	
	During an interv	iew with the Social			below 100%.		
	_	or (SSD) on 7/14/15 at			Compliance date: 8/14/2015. The		
		SD indicated the resident			Administrator at Altenheim Health		
		ehavior care plan as no			and Living Community is responsible	9	
	behavior observa	•			in ensuring compliance in this Plan		
					of Correction.		
	-	e resident. The SSD					
		rsing staff initiated an					
	-	oort any time a resident					
	_	ew or worsening behavior					
	and then a repor	t was generated for					
	discussion in the	morning meeting. The					
	SSD indicated a	lack of awareness of any					
	behavior issues	with Resident #95.					
	During an interv	iew with a family					
	member on 7/8/1	15 at 3:14 p.m., the					
		indicated Resident #95					
	· ·	staff providing care such					
		itioning, brushing teeth,					
		of bed. The family					
		ed the resident frequently					
		f and "tries to beat them					
	up," while provi	uing care.					
	_	iew with Licensed					
		(LPN) #9 on 7/13/15 at					
	7:30 a.m., LPN 7	#9 indicated the resident					
	had been comba	tive with care especially					
	with a hospice a	ide and LPN #9 had					
	spoken with the	hospice agency to have a					
					l .		

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155196	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE COMPL <b>07/21</b> /	ETED
	PROVIDER OR SUPPLIER		3525 E	ADDRESS, CITY, STATE, ZIP COD E HANNA AVE NAPOLIS, IN 46237	E	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	the resident. LP change in care githe level of agita during care.  During an interv Nursing Assistar	ver sent to the facility for N #9 indicated the iver seemed to help with tion for the resident iew with Certified at (CNA) #10 on 7/16/15				
	Nursing (DON): Management Pro 2013, and indica one currently use policy indicated, demonstrate any characteristics sh behavior program demonstrating no behaviorsand s behaviors toward or visitorIt is (t to ensure that the behavior is thoro documented and underlying causa	nould be involved in the m: Any resident				
	3.1-35(d)(2)(B)					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:						COMPLETED	
		155196	B. WI	B. WING		07/21/	2015
	ROVIDER OR SUPPLIER			3525 E	ADDRESS, CITY, STATE, ZIP CODE HANNA AVE APOLIS, IN 46237		
(X4) ID	SUMMARY S	SUMMARY STATEMENT 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 APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F 0282 SS=E Bldg. 00	CARE PLAN The services provifacility must be propersons in accordation written plan of care. Based on observatinterview, the facts services were proof care for a reside (immediate) medicate) medicate (immediate) (immedi	ance with each resident's e.  ation, record review, and cility failed to ensure ovided according to plans dent who needed a stat lication for abdominal 79), a resident with an ry catheter (Resident dent receiving esident #118).  cord of Resident #79 7/10/15 at 10:17 a.m. e resident included, but to, intestinal obstruction. admitted to the facility  d 4/14/15, and current indicated Resident #79 onstipation related to Approaches included and medications per	F 02	282	F 282 483.20(K)(3)(III) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?  Resident #79 was sent to the hospital on sent to the 5/10/15 and returned to facility on 5/13/15 and has had no further problems with abdominal pain nor needed additional medical intervention.  Resident #166 catheter was removed from the floor and cathete care provided and resident #166 has not had a negative outcome from this deficient practice.  Resident #118 fistula was assessed for thrill and bruit and observed with no signs or symptoms of infection and/or bleeding and resident #118 has not had a negative outcome from this deficient practice.	r	08/14/2015

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/C		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPL	ETED
		155196	B. WI	NG		07/21/	2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			HANNA AVE		
ALTENH	EIM HEALTH & LIV	ING COMMUNITY			IAPOLIS, IN 46237		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		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
					Desident #110 per /pert districts		
	Nurses' notes inc	dicated:			Resident #118 pre/post dialysis assess completed on 7/17/15 and		
					resident #118 receives pre/post		
	5/9/15 at 2:30 a.	m., Resident #79's			dialysis assessments by the licensed	ı	
	abdomen was di	stended and she was			nurse per the MD order and has had		
	complaining of abdominal pain. The				no negative outcome from this		
	physician was notified and ordered an				deficient practice.		
	1 * *	s done at 4:31 a.m. The					
	1	ray indicated, "Colonic			How other residents having the		
		ng term irritation with			potential to be affected by the		
		ty] type patternmay			same deficient practice will be identified and what corrective		
	represent clinica				action will be taken?		
	Tepresent chinea	i constipation.			action will be taken:		
	5/0/15 =4 (-20 =	Danidant #70!a			All residents with constipation care		
		m., Resident #79's			plans requiring a STAT medication		
		otified of the X-ray			have the potential to be affected by	,	
		rder was received for the			the deficient practice. Audit of all		
		only clear liquids for 24			resident with care plan for		
	hours and to be	given a bisacodyl rectal			constipation with STAT (immediate)	)	
	suppository to st	imulate a bowel			interventions reviewed.		
	movement.				All residents with catheter care		
					plans have the potential to be		
	A Medication A	dministration Record for			affected by the alleged deficient		
	May 9, 2015, inc	dicated the resident			practice. Audit of all residents with		
	received the sup	pository at 9:22 a.m.			catheter care plan for urinary		
	1				drainage audited.		
	Further nurses' n	notes indicated					
					All resident dialysis care plans have		
	5/9/15 at 1:33 n	m., the bisacodyl			the potential to be affected by the		
	_	ineffective and the			alleged deficient practice. Audit of resident dialysis care plans		
					performed.		
		otified. The physician			P		
	1 -	for other laxatives and			What measures will be put into		
	another supposit	ory.			place or what systemic changes wil	II	
					be made to ensure that the		
	5/9/15 at 9:25 p.	m., the resident had still			deficient practice does not recur?		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	UILDING	00	COMPLI	ETED
		155196	B. W	ING		07/21/	2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			HANNA AVE		
AI TENH	EIM HEALTH & LIV	ING COMMUNITY			IAPOLIS, IN 46237		
					1		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		movement and the			Licensed surveine staff advented on		
	physician was co	ontacted. "Writer			Licensed nursing staff educated on STAT medication administration		
	received stat [im	nmediately] order for (2)			Policy.		
	[brand name] enemaswriter has faxed order to pharmacy as a stat order and is currently waiting arrival for				Folicy.		
					Director of Nursing will be notified		
					by Licensed Nursing staff of all		
	administration."	5 4111 41 101			physicians' orders that are ordered		
	administration.				STAT (immediate).		
	The section was to						
		note, dated 5/10/15 at			Director of Nursing to be notified		
	6:14 a.m., indicated, "Pharmacy delivered				when STAT medication arrives and i	s	
	enemawriter attempted give enema resident screaming in pain unable to give				administered.		
	enema. resident	stated send me home or			Licensed Nurse to document time o	f	
	to hospital and l	et me die" The nurse			administration in Progress Note.		
	_	d placed a call to the			Nonetee staff advantad on infantion		
		e to notify them of			Nursing staff educated on infection		
		-			control related to catheter care		
	l resident being u	nable to tolerate enema.			including CNA #2.		
					Licensed nursing staff educated on		
		30 p.m., the DON			pre and post dialysis assessments		
	provided a deliv	ery slip from the facility			Policy and fistula assessment.		
	pharmacy which	indicated the enemas					
	had been deliver	red to the facility on			Stat orders, foley catheter		
	5/10/15 at 1:05 a	a.m. The DON indicated			procedures and pre/post dialysis		
	she did not knov	www.y waited			assessments will be reviewed daily		
		to attempt to administer			by the clinical team to ensure the		
	· ·	it had been ordered stat			corrective system is in place and		
					working. A weekend supervisor will		
	and delivered by	pharmacy at 1:05 a.m.			oversee these processes to ensure 7	7	
					day per week compliance.		
	A nurse's note d	ated 5/10/15 at 6:49 a.m.,					
	indicated the ph	ysician wanted Resident			How the corrective actions will be monitored to ensure the deficient		
	#79 to be sent to	the hospital emergency			practice will not recur, what quality	,	
	room.				assurance program will be put into	1	
					place?		
	A nurse's note d	ated 5/10 15 at 7:14 a.m.,			F		
	A nuise s note u	aicu 3/10 13 ai /.14 a.III.,	1		1		

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETED
		155196	B. W	ING		07/21/2015
				CTDEET /	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER	-				
A. TENU.		INIO OOMALINITY			HANNA AVE	
ALTENHI	EIM HEALTH & LIV	ING COMMUNITY		INDIAN	APOLIS, IN 46237	
(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	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	indicated Reside	nt #79 was taken in an			Physicians Orders and Progress	
	ambulance to the hospital.				noted will be reviewed Monday	
	amountee to the hospital.				through Friday in clinical meeting to	
	0 = 4 = 4 = . 0	1 1			ensure STAT orders that arrive are	
	On 7/15/15 at 8:55 a.m. the Director of				given immediately.	
	Nursing (DON)	provided an undated			,	
	policy titled, Sta	t Orders, and indicated it			Weekend Manager/Director of	
		arrently used by the			Nursing will review Physicians	
		icy indicated, "4. If a			Orders and Progress notes on	
		•			Saturday and Sunday to ensure STA	Г
		ibes a medication not			orders that arrive are given	
		acility emergency			immediately.	
	supply, inform th	ne physician that the				
	medication is no	t readily available. Be			Director of Nursing/Director of	
	sure the physicia	n is aware that his/her			Education/Unit Managers/Weekend	ł
		available until it is			Supervisor will audit by visual	
		he pharmacy and the			observation catheter tubing is not	
		•			touching the floor 3xs a day 3 days a	i
	_	exceed two-hours. 5.			week x 4 weeks, 2xs a day 3 days a	
	DO NOT FAX a	stat order. Call the			week x 4 weeks, 1x a day 3 days a	
	pharmacy directl	y to give the stat			week for 4 weeks, then monthly	
	medication order	to the pharmacist"			thereafter to ensure bags are	
					covered at all times.	
	2 The clinical r	ecord review of Resident				
		on 7/14/15 at 10:45			Director of Nursing/Director of	
	_				Education/Unit Managers/Weekend	I
	· ·	ne resident had diagnoses			Supervisor will audit each new	
	including, but no	t limited to, urinary			admission chart for dialysis	
	obstruction.				treatment and ensure orders are in	
					place for fistula assessment and pre	
	A physician's or	der dated 6/15/15, and			and post dialysis orders to correlate	
		indicated a indwelling			with care plan with 24 hours after	
		· ·			admission or start of dialysis	
	_	was necessary due to			treatment.	
	_	on (blockage of the			Discount of Number of Harts NATIO	
	urinary tract) and	d unmanageable urinary			Director of Nursing/Unit Manager	
	retention, (a con-	dition in which the			with audit Observations (pre and	
		ompletely empty urine).			post dialysis format) daily after each	1
		F 222-3 22			dialysis treatment per care plan.	
			1			l

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY  COMPLETED
		155196	B. WING		07/21/2015
	PROVIDER OR SUPPLIER		3525 E	ADDRESS, CITY, STATE, ZIP COE E HANNA AVE NAPOLIS, IN 46237	DE
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	CTION (X5)  JLD BE COMPLETION  ROPRIATE DATE
	A care plan date resident had an is catheter related to Interventions incompart of the drainar floor.  During an observe 7/14/15 at 9:50 and drainage bag, concern was laying on the cloudy yellow was ediment. The rewith eyes closed During an interve Nursing Assistant at 9:55 a.m., CN catheter bag shows side of the bed and During an interve Nursing (DON) the DON indicate for a catheter to floor.	d 6/17/15, indicated the indwelling urinary to urinary obstruction. Cluded, but were not it allow the tubing or any age system to touch the vation of the resident on it.m., the catheter vered in a pillow case, ie floor under the middle fluid in the tubing was with clumps of white esident was in the bed		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APP DEFICIENCY)  EMARS (electronic medical rewill be audited daily to ensure assessment of fistula is performed per care plan.  The results of these reviews with discussed at the monthly facil Quality Assurance Committee meeting monthly for 3 month then quarterly thereafter one compliance is at 100%. Frequent and duration of reviews will be increased as needed, if complibelow 100%.  Compliance date: 8/14/2015. Administrator at Altenheim H and Living Community is respin ensuring compliance in this of Correction.	cords) e rmed  vill be lity e is and e liency be liance is  The lealth onsible
	was reviewed on Diagnoses for th	a 7/15/15 at 12:12 p.m. e resident included, but to, end stage renal			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155196		ľ í	UILDING	nstruction <u>00</u>	(X3) DATE COMPL 07/21/	ETED			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  3525 E HANNA AVE INDIANAPOLIS, IN 46237						
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE		
	indicated Reside hemodialysis tre Wednesday, and a process by whit tube out of the b machine filter for returned to the b blood is accessed is a surgically crobetween a vein at A careplan for R 6/12/15 and currindicated a probleat risk for complicated included, monitor bruit every shift, for signs and/or bleeding. Whooshing soundstethoscope over vibration felt are site.  A physician's ordindicated, "Compassessment Obstreatment, Mon., indicated assessment of the site of the si	esident #118, originating ent through 10/14/15, tem of the resident being ications related to s treatments for end							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155196		A. BU	JILDING	nstruction <u>00</u>	COMPL	ETED
ROVIDER OR SUPPLIER		•	3525 E	HANNA AVE		
EIM HEALTH & LIV	ING COMMUNITY		INDIAN	APOLIS, IN 46237		
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
temperature, resp	piratory status.					
A physician's ordindicated, "Compassessment Obstreatment, Mon[a Fri[day]." this for of the fistula, her respiratory status communications  A physician's ordindicated the result auscultated (lister palpated (touche checked for sign infection.  A review of Preassessment Obstfollowing:  June 12: only proposed June 15: no assessment of June 15: no assessment Obstfollowing:  June 19: no postfollowing in postfollowing:  June 19: no postfollowing in p	der dated 6/23/15 plete the Post Dialysis ervation AFTER day], Wed[nesday], orm indicated assessment art rate, blood pressure, and any reports or from the dialysis center.  der dated 6/26/15, ident's fistula was to be ened to) for bruit, and d) for thrill every shift, and symptoms of  and Post Dialysis ervations indicated the  reassessment done essments done tassessment done tassessment done tassessment done tassessment done sessments done sessment done					
July 10: no posta	assessment done					
	SUMMARY S' (EACH DEFICIEN REGULATORY OR temperature, resp.  A physician's ordindicated, "Comp. Assessment Obstreatment, Mon[a Fri[day]." this for of the fistula, hearespiratory status communications  A physician's ordindicated the respiratory status communications  A review of Pre Assessment Obstollowing:  June 12: only proposed June 15: no assessment Obstollowing:  June 15: no assessment Obstollowing:  June 16: no postollowing in proposed June 29: no postollowing in preasure 29: no postollowing 29: no postollowing 29: no postollo	DENTIFICATION NUMBER: 155196  PROVIDER OR SUPPLIER  EIM HEALTH & LIVING COMMUNITY  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  temperature, respiratory status.  A physician's order dated 6/23/15 indicated, "Complete the Post Dialysis Assessment Observation AFTER treatment, Mon[day], Wed[nesday], Fri[day]." this form indicated assessment of the fistula, heart rate, blood pressure, respiratory status and any reports or communications from the dialysis center.  A physician's order dated 6/26/15, indicated the resident's fistula was to be auscultated (listened to) for bruit, and palpated (touched) for thrill every shift, checked for signs and symptoms of infection.  A review of Pre and Post Dialysis Assessment Observations indicated the	IDENTIFICATION NUMBER: 155196  ROVIDER OR SUPPLIER  EIM HEALTH & LIVING COMMUNITY  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  temperature, respiratory status.  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A review of Pre and Post Dialysis Assessment Observations indicated the following:  June 12: only preassessment done June 15: no assessments done June 19: no postassessment done June 24: no preassessment done June 29: no postassessment done July 1 no assessments done July 3: no preassessment done July 6: no preassessment done July 8: no assessments done July 8: no assessments done	ROVIDER OR SUPPLIER  EIM HEALTH & LIVING COMMUNITY  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Temperature, respiratory status.  A physician's order dated 6/23/15 indicated, "Complete the Post Dialysis Assessment Observation AFTER treatment, Mon[day], Wed[nesday], Fri[day]." this form indicated assessment of the fistula, heart rate, blood pressure, respiratory status and any reports or communications from the dialysis center.  A physician's order dated 6/26/15, indicated the resident's fistula was to be auscultated (listened to) for bruit, and palpated (touched) for thrill every shift, checked for signs and symptoms of infection.  A review of Pre and Post Dialysis Assessment Observations indicated the following:  June 12: only preassessment done June 15: no assessments done June 17: no assessments done June 19: no postassessment done June 22: no postassessment done June 24: no preassessment done June 29: no postassessment done July 1 no assessments done July 3: no preassessment done July 3: no preassessment done July 6: no preassessment done July 8: no assessments done July 8: no assessments done	DEFORECTION IDENTIFICATION NUMBER: 155196  ROVIDER OR SUPPLIER  EIM HEALTH & LIVING COMMUNITY  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  temperature, respiratory status.  A physician's order dated 6/23/15 indicated, "Complete the Post Dialysis Assessment Observation AFTER treatment, Mon[day], Wed[nesday], Fri[day]." this form indicated assessment of the fistula, heart rate, blood pressure, respiratory status and any reports or communications from the dialysis center.  A physician's order dated 6/26/15, indicated the resident's fistula was to be auscultated (listened to) for bruit, and palpated (touched) for thrill every shift, checked for signs and symptoms of infection.  A review of Pre and Post Dialysis Assessment Observations indicated the following:  June 12: only preassessment done June 17: no assessments done June 19: no postassessment done June 29: no postassessment done June 29: no postassessment done July 3: no preassessment done July 4: no assessment done July 5: no preassessment done July 8: no assessments done	ROYUDER OR SUPPLIER  ROYUDER OR SUPPLIER  EIM HEALTH & LIVING COMMUNITY  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  temperature, respiratory status.  A physician's order dated 6/23/15 indicated, "Complete the Post Dialysis Assessment Observation AFTER treatment, Monifasy], Wed[nesday], Fri[day]," this form indicated assessment of the fistula, heart rate, blood pressure, respiratory status and any reports or communications from the dialysis center.  A physician's order dated 6/26/15, indicated the resident's fistula was to be auscultated (listened to) for bruit, and palpated (touched) for thrill every shift, checked for signs and symptoms of infection.  A review of Pre and Post Dialysis Assessment Observations indicated the following:  June 12: only preassessment done June 19: no postassessment done June 19: no postassessment done June 21: no preassessment done June 22: no postassessment done July 3: no preassessment done July 3: no preassessment done July 4: no assessments done July 5: no assessments done July 6: no preassessment done July 6: no preassessment done July 8: no assessments done

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			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  00			(X3) DATE SURVEY COMPLETED	
		155196	B. W		00	07/21/	
	PROVIDER OR SUPPLIER		•	3525 E	.DDRESS, CITY, STATE, ZIP CODE HANNA AVE APOLIS, IN 46237		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE
	July 13: no prea July 15: no post	ssessment done assessment done					
	for June, 2015, in	Administration Records ndicated the facility did ck the resident's fistula					
	Nursing (DON) sure why the residence of the checked for bruit symptoms of information careplan. She in	45 p.m. the Director of indicated she was not ident's fistula was not it, thrill, and signs and ection, according to his dicated the above ents, "apparently weren't					
	dated April 2008 policy currently policy indicated, Complete the Di Sheet prior to dia Dialysis will con and after return t	y titled Hemodialysis, s, and indicated it was the used by the facility. The "Assessment: 1. alysis Communication alysis, send to dialysis. applete their section to the sheet to the facility. then complete the final					
	3.1-35(g)(2)						
F 0309 SS=D	483.25 PROVIDE CARE/S	SERVICES FOR					

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Facility ID: 000103

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i '		` <i>′</i>	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		A. BUILDING <u>00</u> B. WING			ETED
		155196	B. WI	NG		07/21/	2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  3525 E HANNA AVE  INDIANAPOLIS, IN 46237			
(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	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
Bldg. 00	must provide the r services to attain or practicable physic psychosocial well-the comprehensive care.  Based on record the facility failed assessments were resident receivin (Resident #118) insulin was admit for a resident whinjections (Resident whinjections (Resident whinjections (Resident whinjections (Resident whinjections (Resident whinjections (Resident was reviewed on Diagnoses for the were not limited disease.  The current July ordered indicated hemodialysis tre Wednesday, and a process by whit tube out of the bemachine filter for returned to the bemachine filter for returned to the bemachine filter for the service was reviewed to the bemachine filter for returned for the filter for returned filter for returned for the filter for returned filter for return	st receive and the facility necessary care and or maintain the highest al, mental, and being, in accordance with e assessment and plan of review and interview, I to ensure pre and post e completed for a g dialysis treatments and failed to ensure inistered as prescribed to was prescribed insulin lents #78).  Execord of Resident #118 at 7/15/15 at 12:12 p.m. the resident included, but to, end stage renal  2015, physician's desident #118 received atments every Monday, Friday. Hemodialysis is cheblood flows through a rody, goes through a releaning, and then is ody. The resident's definition of the resident's design and the stage of through a fistula, which	F 03	309	F309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?  Resident #118 pre/post dialysis assess completed on 7/17/15 and resident #118 has not had any adverse outcome related to this deficient practice.  Resident #78 blood sugar and vitals checked every 4 hours x 2, then every shift x 2 shifts. No adverse outcomes related to deficient practice. Medication Error form filled out by DNS. MD notified. Resident own responsible party.  How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?  All residents receiving dialysis treatment have the potential to be		08/14/2015

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3)			(X3) DATE SUI	RVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPLETI	ED
		155196	B. WI	NG		07/21/20	15
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	R			HANNA AVE		
AI TENHI	EIM HEALTH & LIV	ING COMMUNITY			APOLIS, IN 46237		
ALILINIII	LIWITILALITI & LIV			INDIAN	AI OLIO, IN 40237		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE C	OMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	between a vein a	and an artery.			affected by the deficient practice.		
					Audit of residents on dialysis		
	A careplan for R	tesident #118, originating			performed and order for Pre and		
	6/12/15 and curr	rent through 10/14/15,			Post assessment completed.		
	indicated a probl	lem of the resident being			All residents on hall that RN worked		
	at risk for complications related to				on 7/13/15 had the potential to be		
	receiving dialysis treatments for end				affected by the deficient practice. A	II	
		se. Approaches			MARs for 7/13/15 reviewed and		
	_	or fistula for thrill and			MD/family were notified of any		
	-				missed insulin administrations.		
		observe fistula site daily					
	_	symptoms of infection			What measures will be put into		
	_	A bruit is abnormal			place or what systemic changes wil	l	
	whooshing soun	d heard when placing a			be made to ensure that the		
	stethoscope over	the fistula. A thrill is a			deficient practice does not recur?		
	vibration felt arc	ound the fistula access			Licensed nursing staff educated on		
	site.				Pre and Post Dialysis Assessment		
					Policy.		
	A physician's or	der dated 6/23/15			•		
		plete the Pre Dialysis			RN placed back in orientation on		
		ervation BEFORE			7/14/15 and checked off on Diabetic	c	
					Screen in Matrix (electronic medical		
	· ·	, Wed., Fri." This form			administration record).		
		ment of the fistula, the					
	resident's heart r	ate, blood pressure,			Licensed Nurses re-educated on		
	temperature, resp	piratory status.			Diabetic Screen in Matrix.		
					How the corrective actions will be		
	A physician's or	der dated 6/23/15			monitored to ensure the deficient		
	indicated, "Com	plete the Post Dialysis			practice will not recur, what quality	,	
	Assessment Observation AFTER				assurance program will be put into		
	treatment, Mon[day], Wed[nesday],				place?		
	Fri[day]." This form indicated assessment						
		art rate, blood pressure,			Director of Nursing/Unit Manager		
	=				with audit Observations (pre and		
		s and any reports or			post dialysis format) daily after each	n	
	communications	from the dialysis center.			dialysis indefinitely.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETED
		155196	B. W	ING		07/21/2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	l .
NAME OF F	PROVIDER OR SUPPLIE	R		3525 E	HANNA AVE	
ALTENH	EIM HEALTH & LI\	ING COMMUNITY		INDIAN	APOLIS, IN 46237	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		R LSC IDENTIFYING INFORMATION)	+	TAG	·	DATE
	1 2	der dated 6/26/15,			Staff Development	
		sident's fistula was to be			Coordinator/Director of Nursing wil perform a medication check off,	
	auscultated (list	ened to) for bruit, and			including Diabetic Screen, with each	,
	palpated (touched) for thrill every shift,				new Licensed Nurse during	'
	checked for sign	checked for signs and symptoms of			orientation to ensure understanding	<u> </u>
	infection.	infection.			that Diabetic Treatments are under	
					a separate administration tab from	
	A review of Pre	and Post Dialysis			routine medications.	
	A review of Pre and Post Dialysis Assessment Observations indicated the					
					The results of these reviews will be	
	following:				discussed at the monthly facility	
					Quality Assurance Committee	
		reassessment done			meeting monthly for 3 months and	
	June 15: no ass				then quarterly thereafter once	
	June 17: no ass	essments done			compliance is at 100%. Frequency and duration of reviews will be	
	June 19: no post	tassessment done			increased as needed, if compliance	ic
	June 22: no pos	tassessment done			below 100%.	
	June 24: no prea	ssessment done			2000	
	June 29: no pos	tassessment done			Compliance date: 8/14/2015. The	
	July 1 no assess				Administrator at Altenheim Health	
	July 3: no preas				and Living Community is responsible	e
	July 6: no preas				in ensuring compliance in this Plan	
	July 8: no asses				of Correction.	
		assessment done				
	July 13: no prea					
	July 15: no pos	t assessment done				
	The Medication	Administration Records				
		indicated the facility did				
	not begin to check the resident's fistula site until June 26.					
	Site until Julie 20	υ.				
	On 7/16/15 at 3:	45 p.m. the Director of				
	Nursing (DON)	indicated she was not				
	sure why the res	sident's fistula was not				

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f ´		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING 00 COMPLETED					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00		
		155196	B. W	ING		07/21/	2015
NAME OF P	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					HANNA AVE		
ALTENH	EIM HEALTH & LIV	ING COMMUNITY		INDIAN	APOLIS, IN 46237		
(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 APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	checked for brui	t, thrill, and signs and					
	symptoms of inf	ection, according to his					
	careplan. She in	dicated the above					
	missing assessm	ents, "apparently weren't					
	done."						
	On 7/16/15 at 4:0	00 p.m. the DON					
		y titled Hemodialysis,					
		s, and indicated it was the					
	•	used by the facility. The					
	1 2	"Assessment: 1.					
		alysis Communication					
	•	alysis, send to dialysis.					
	•	nplete their section to					
	_	-					
		the sheet to the facility.					
		then complete the final					
	assessment post	dialysis"					
		ord review for Resident					
		at 4:29 p.m., indicated a					
	_	betes mellitus. Diabetes					
	is a condition wh	nere the body is not able					
	to produce enoug	gh insulin to draw sugar					
	out of the blood	and into the cells.					
	A quarterly Mini	imum Data Assessment					
	for Resident #78	indicated he was					
	cognitively intac	t and independent in his					
	decision making						
		J					
	A recapitulated r	physician's order for July,					
		iginal date of 4/27/15,					
	· ·	nt #78 was to receive					
	Lantus Solostal	insulin, 58 units twice a					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155196		ľ	UILDING	nstruction <u>00</u>	(X3) DATE COMPL <b>07/21</b>	ETED			
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE  3525 E HANNA AVE INDIANAPOLIS, IN 46237						
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) and 5:00 p.m.		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E IATE	(X5) COMPLETION DATE		
	A recapitulated partial 2015, with an orindicated the residual blood sugar check purchase per day, and insulin depending blood sugar check purchase	chysician's order for July, iginal date of 4/26/15, ident was to have has eked with a finger stick 4 and receive NovoLog go on the results of his eks, at 4:00 p.m. and 8:00 diew on 7/15/13 at 3:15 diew on 7/15/13 at 3:15 diew on receive his eked or receive his executed and for Resident #78 indicated for any insulin or blood diew on the high many insulin or blood diew on the executed for the executed							

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155196		A. BUILDING B. WING	00	COMPLETED 07/21/2015
	ROVIDER OR SUPPLIER EIM HEALTH & LIVING COMMUNITY	3525 E	ADDRESS, CITY, STATE, ZIP CODE HANNA AVE IAPOLIS, 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
F 0322 SS=D Bldg. 00	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that  (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident 's clinical condition demonstrates that use of a naso gastric tube was unavoidable; and  (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.  Based on observation, record review, and interview, the facility failed to ensure a resident with a gastrostomy tube received appropriate treatment and services during medication administration, according to current standards of practice and facility policy for 1 resident who was observed receiving medications through a gastrostomy tube. (Resident #172.)  Findings include:  The clinical record of Resident #172 was reviewed on 7/14/15 at 2:05 p.m.	F 0322	F322 483.25(g)(2) NG TREATMENT SERVICES-RESTORE EATING SKILLS  What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?  Resident #172 given medications per gastrostomy tube as ordered. Tube flushed and not clogged and resident #172 is receiving medications per the gastrostomy tube routinely and has had no negative outcome related to this incident.	er

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 00 COMPLETED 155196 B. WING 07/21/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3525 E HANNA AVE ALTENHEIM HEALTH & LIVING COMMUNITY INDIANAPOLIS. IN 46237 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG  $\mathsf{TAG}$ Diagnoses for the resident included, but How other residents having the were not limited to, aspiration pneumonia potential to be affected by the and gastrostomy tube. same deficient practice will be identified and what corrective A gastrostomy tube is a tube placed action will be taken? surgically through the abdominal wall All resident with gastrostomy tubes into the stomach, used for feeding and/or as means of medication administering medications. administration have the potential to be affected by the alleged deficient During a medication administration practice. Resident #172 the only observation on 7/13/15 at 7:22 a.m., resident with gastrostomy tube as Licensed Practical Nurse (LPN) #3 means of medication administration. There were no adverse outcomes placed the following medication tablets, related to the deficient practice. ordered by the resident's physician to be given through the gastrostomy tube, into What measures will be put into a clear plastic envelope: place or what systemic changes will be made to ensure that the amlodipine 5 milligrams (mg) medication deficient practice does not recur? used to treat high blood pressure LPN #3 immediately educated on calcium 600 mg + vitamin D(3) 400 units gastrostomy tube medication cranberry fruit tablet 500 mg administration by Nurse Consultant vitamin B12 1000 micrograms on 7/14/15. digoxin 125 micrograms medication used All Licensed nursing staff including to treat heart failure LPN #3 educated on g-tube furosemide 20 mg medication used to medication administration with treat heart failure and high blood pressure documented completion of hydralazine 25 mg medication used to understanding by successful return treat high blood pressure demonstration. lutein 10 mg a vitamin How the corrective actions will be monitored to ensure the deficient LPN #3 then placed the envelope with all practice will not recur, what quality the medications into a pill crusher and assurance program will be put into ground them up until they were a place? powdery substance.

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155196		ľ	UILDING	DNSTRUCTION  00	(X3) DATE COMPL <b>07/21</b> /	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  3525 E HANNA AVE INDIANAPOLIS, IN 46237					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	mixture into the unclamped the e gastrostomy tube (ml) syringe into flushed the tube When all the wa tube into the resipoured the dry president's medicand poured some mixture. The droughinto the resident' picked up a plun some of the mixwater, plunged a syringe and pour cup to try to get which had stuck syringe. When a were in the cup, syringe back into gastrostomy tube remaining medic kept adding water was through.	nd of the resident's e, inserted a 30 milliliter to the end of the tube, and with 30 ml of water. ter had drained out of the ident's stomach, LPN #3 owdery mixture of the ations into the syringe e water on top of the dry ry mixture of medications oottom of the syringe and gh the gastrostomy tube is stomach. LPN #3 then ger and gently pushed ture through, added more again, removed the red water through it into a the medication clumps to the side of the all the medication clumps LPN #3 then put the to the end of the			Director of Nursing, SCD, UM with observe when gastrostomy tube available medication administration by Licensed Nursing Staff 3 xs a week x 4 weeks, 1x a week x 4 weeks, 1x a week x 4 weeks, then monthly thereafter. If gastrostomy tube is not available for return demonstration the above monitoring will continue using propin clinical lab.  The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance below 100%.  Compliance date: 8/14/2015. Administrator at Altenheim He and Living Community is responsible in ensuring compliance in this Plan of Correction	s is The		
	1 Toparo medicat	iono foi udilimistituton.						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l í	ULTIPLE CO. UILDING	NSTRUCTION 00	(X3) DATE COMPL		
11.12 12.11	or condition,	155196	B. W		<u>00                                   </u>		
NAME OF PROVIDER OR SUPPLIER  ALTENHEIM HEALTH & LIVING COMMUNITY  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  a. Crush immediate-release tablets into a		B. W	3525 E	ADDRESS, CITY, STATE, ZIP CODE HANNA AVE APOLIS, IN 46237  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE	
	fine powder ther warm water, or proper immediate contents into a fine in 30ml of warm amount. c. Aspiremove contents syringe, and miximal be needed in warm water, or proper into the contents of the contents	release capsules, crush ine powder, and dissolve in water, or prescribed rate soft gelatin capsules, using a needle and with 10-30ml (30ml f contents are viscous) of prescribed amount. d. dications with 10-30ml eded if contents are in water, or prescribed Put 15-30ml of water in in tubing using gravity bing after the syringe is water to remain in the					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ í	LTIPLE CO LDING	nstruction 00	(X3) DATE S COMPL		
111,12,12,111	or condition	155196	B. WIN		<u>00                                   </u>	07/21/	
	ROVIDER OR SUPPLIER			3525 E	ADDRESS, CITY, STATE, ZIP CODE HANNA AVE APOLIS, IN 46237		
(X4) ID PREFIX TAG	this was regarded administering me gastrostomy tube indicated, "12.1 separately, 20. C separately42. C separately to pretube with 5-10 cu water between m On 7/13/15 at 9:2 Clinical Consulta medication pills crushed separate	23 a.m. the DON and ant indicated the should have been by and mixed with water	P	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
F 0323 SS=D Bldg. 00	crushed separately and mixed with water prior to putting the medication in the gastrostomy tube.  3.1-44(a)(2)  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, interview, and record review, the facility failed to ensure identification of root cause for falls and failed to ensure fall prevention interventions had been documented on		F 032	23	F323 483.25 (h) FREE OF ACCIDENT HAZARDS/SUPERVISION DEVICES  What corrective actions will be accomplished for those residents		08/14/2015
	care assignment	I been documented on sheets to prevent falls for eviewed for accidents.					

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETED
		155196	B. W	ING		07/21/2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIEF	8		1	HANNA AVE	
ALTENH	EIM HEALTH & LIV	ING COMMUNITY			IAPOLIS, IN 46237	
(X4) ID	SUMMARYS	TATEMENT OF DEFICIENCIES	1	ID	T	(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	(Resident #166)	,				
	(resident #100)				Resident #166 falls reviewed for roo	ot
	Eindings include				cause analysis resident #166 has had	d
	Findings include	···			no negative outcomes related to thi	s
					deficient practice.	
		ord review of Resident				
	#166, completed	l on 7/14/15 at 10:45			Resident #166 Care Assignment	
	a.m., indicated the	he resident had diagnoses			Sheet updated with all fall	
	including, but not limited to, Alzheimer's				prevention interventions	
	disease (a progre	ess neurological disease			How other residents having the	
	causing severe dementia).				potential to be affected by the	
	An Admission Minimum Data Set (MDS) assessment completed 6/23/15,				same deficient practice will be	
					identified and what corrective	
					action will be taken?	
	· ·	-				
		dent as having a BIMS			All residents who sustain a fall have	
	`	for Mental Status) of 2			the potential to be affected by the	
	_	e 15, indicating severe			same deficient practice. Audit of all	
	cognitive impair	ment. The assessment			falls for last 30 days completed and	
	indicated the res	ident required extensive			root cause analysis reviewed and	
	assistance of 2 s	taff for bed mobility and			care plans/care assignment sheets	
	transfers.	-			updated as needed.	
					Audit of all resident fall prevention	
	A care plan date	d 6/15/15, indicated the			interventions listed on care plan	
	_	isk for falling and fall			reviewed for accuracy and	
		related to weakness and			effectiveness and care assignment	
	l -	ty. Interventions			sheet updated as needed.	
	•	•				
	-	ere not limited to,			What measures will be put into	
		lent to utilize call light to			place or what systemic changes wil	ı
		as needed, keep call light			be made to ensure that the	
		ersonal items and			deficient practice does not recur?	
	frequently used	items within reach, and			All Linemand museum and the state of the sta	
	provide non-skie				All Licensed nursing staff educated	
	-				on the Fall Policy. The Director of  Nursing will be notified immediately	,
	A Fall Event for	m dated 7/4/15 at 4:30			of each fall and ensure that the fall	'
					incident report and the 5 Why's	
p.m., indicated Resident #166 was in the				moldent report and tile 5 willy s		

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETED
		155196	B. W	ING		07/21/2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIER	t			HANNA AVE	
AI TENH	EIM HEALTH & LIV	ING COMMUNITY			IAPOLIS, IN 46237	
					GE16, III 1626.	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	DATE
1710		ting for dinner and		1710	(facility root cause analysis tool) is	DATE
	_ ~	seat of the "broad"			completed promptly at the time of	
					fall.	
	· '	the foot area of the chair,				
		esident's bottom. An			How the corrective actions will be	
	·	pleted at the time of the			monitored to ensure the deficient	
		e resident was alert and			practice will not recur, what quality	
	oriented, was ch	air bound, had no			assurance program will be put into	
	injuries, and had	no interventions in place			place?	
	for fall prevention	on at the time of the fall.			IDT to review each fall root cause	
	The immediate intervention was to have				analysis tool Monday through Friday	,
	foot pedals applied to the chair. The				to ensure appropriate intervention	
	assessment did not identify a root cause				and assessment. Weekend Manager	
	for the fall.				to review fall root cause analysis for	
	for the fair.				falls occurring on weekend and	
	A novy ooro nlon	intervention dated			ensure appropriate intervention.	
		Resident #166 would be			Care plan and care assignment shee	t
	laid down after r	neais.			will be updated in morning clinical	
					meeting by IDT after reviewing root	
		ess note dated 7/9/15 at			cause analysis.	
	7:35 a.m., indica	ited the resident had			IDT will perform second review	
	attempted to clir	nb out of bed several			weekly during IDT weekly meeting t	0
	times and had be	een up in a chair for			ensure all documentation.	
	supervision.					
					The results of these reviews will be	
	A Fall Event for	m dated 7/9/15 at 9:44			discussed at the monthly facility	
	p.m., indicated t	he resident was found on			Quality Assurance Committee	
	1 1	the bed on a non-skid			meeting monthly for 3 months and	
		nent indicated no			then quarterly thereafter once compliance is at 100%. Frequency	
					and duration of reviews will be	
	injuries, intermittent confusion, chair				increased as needed, if compliance	s
	bound, and the intervention in place at				below 100%.	
	the time of the fall was noted as a					
		the bedside. The			Compliance date: 8/14/2015. The	
		not identify a root cause			Administrator at Altenheim Health	
	for the fall. The	new intervention was to	1		and Living Community is responsible	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155196		l í	UILDING	onstruction  00	(X3) DATE COMPL 07/21	ETED	
	PROVIDER OR SUPPLIER		•	3525 E	ADDRESS, CITY, STATE, ZIP CODE HANNA AVE APOLIS, IN 46237		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
		r drink, clear pathways, resident in to the hallway			in ensuring compliance in this Plan of Correction.		
	indicated the res	evention dated 7/10/15, ident would be moved to comment in sight of staff at was restless.					
	B Wing CNA (C Assistant) Assign 7/12/15, indicate required 2 assist the column for p turn and reposition assignment sheet interventions incompatter meals, move environment in second	nment Sheet dated ad Resident #166 for transfers and under recautions indicated to on. The CNA t lacked fall prevention					
	7/14/15 at 3:30 p all of the fall pre	iew with the DON on o.m., the DON indicated vention interventions on the CNA assignment					
	Nursing (DON) policy titled Fall and indicated the	10 p.m., the Director of provided an undated Management Program, e policy was the one y the facility. The policy					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155196		(X2) MULTIPLE  A. BUILDING  B. WING	CONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 07/21/2015	
	ROVIDER OR SUPPLIER		3525	T ADDRESS, CITY, STATE, ZIP CODE E HANNA AVE NAPOLIS, IN 46237	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL  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
F 0333 SS=G Bldg. 00	identified on the Nursing Assistant listing the fall inteach fall the plan with the intervent cause of the fall.  3.1-45(a)(2)  483.25(m)(2)  RESIDENTS FRE ERRORS The facility must efree of any signific Based on record the facility failed experiencing about "stat" (immediate indicated by phy resident reviewed medication error Findings include  The clinical record reviewed on 7/10 Diagnoses for the were not limited.  A care plan dated.	E OF SIGNIFICANT MED  Insure that residents are ant medication errors.  I to ensure a resident are are a resident are are a resident are are a resident are	F 0333	F333 483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS  What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?  Resident #79 was sent to the 5/10/15 and returned to facility on 5/13/15.  Licensed Nurse given counseling for late administration of STAT (immediate) medication.  How other residents having the potential to be affected by the same deficient practice will be	e

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETED
		155196	B. W	ING		07/21/2015
				STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIEF	2			HANNA AVE	
ALTENHI	EIM HEALTH & LIV	ING COMMUNITY			IAPOLIS, IN 46237	
(X4) ID	SUMMARYS	TATEMENT OF DEFICIENCIES	1	ID	· I	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	was at risk for co	onstipation related to			identified and what corrective	
		Approaches included			action will be taken?	
		and medications per				
		•			All residents with STAT (immediate)	
	physician orders	•			ordered medications have the	
					potential to be affected by the	
	Nurses' notes inc	dicated:			deficient practice.	
					Physicians Orders reviewed for	
	5/9/15 at 2:30 a.:	m., Resident #79's			month for past 30 days reviewed for	
	abdomen was distended and she was				STAT (immediate) orders and time	
	complaining of abdominal pain. The				given. MD notified of all late	
	physician was notified and ordered an				administrations.	
	X-ray which was done at 4:31 a.m. The					
	_	ray indicated, "Colonic			What measures will be put into	
		ng term irritation of			place or what systemic changes wil	I
					be made to ensure that the	
		y] type patternmay			deficient practice does not recur?	
	represent clinica	l constipation."				
					Licensed Nursing staff educated on	
	5/9/15 at 6:20 a.:	m., Resident #79's			the admiration of STAT orders per	
	physician was no	otified of the X-ray			policy.	
	results. A new o	rder was received for the			Director of Nursing will be notified	
	resident to have	only clear liquids for 24			by Licensed Nursing staff of all	
		given a bisacodyl rectal			physicians' orders that are ordered	
	suppository to st	•			STAT (immediate).	
	movement.	initiation a bower				
	movement.				Director of Nursing to be notified	
		1			when STAT medication arrives and i	s
		dministration Record for			administered.	
		dicated the resident				
	received the sup	pository at 9:22 a.m.			Licensed Nurse to document time o	f
					administration in nursing progress	
	Further nurses' n	otes indicated:			noted.	
					How the corrective actions will be	
	5/9/15 at 1:33 p.m., the bisacodyl				monitored to ensure the deficient	
	_	ineffective and the			practice will not recur, what quality	,
					assurance program will be put into	
	physician was notified. The physician				account of partition	

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	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	î ´		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		UILDING	00	COMPL	
		155196	B. W	ING		07/21/	/2015
NAME OF E	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF F	ROVIDER OR SUFFLIER			3525 E	HANNA AVE		
ALTENH	EIM HEALTH & LIV	ING COMMUNITY		INDIAN	IAPOLIS, IN 46237		
(X4) ID	SUMMARY S	FATEMENT 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
	gave new orders	for other laxatives and			place?		
	another supposit	ory.					
					Physicians Orders and Progress		
	5/9/15 at 9:25 p.	m., the resident had still			noted will be reviewed Monday		
	not had a bowel movement and the				through Friday in clinical meeting to ensure STAT orders that arrive are	)	
	physician was contacted. "Writer				given immediately.		
		received stat order for (2) [brand name]			g. I i i i i i i i i i i i i i i i i i i		
	enemaswriter has faxed order to				Weekend Manager/Director of		
					Nursing will review Physicians		
		at order and is currently			Orders and Progress notes on		
	waiting arrival for administration."				Saturday and Sunday to ensure STA	Т	
					orders that arrive are given		
	The next nurse's note, dated 5/10/15 at				immediately.		
	6:14 a.m. indicated, "Pharmacy delivered						
	enemawriter at	tempted give enema			The results of these reviews will be		
	resident screami	ng in pain unable to give			discussed at the monthly facility		
	enema, resident	stated send me home or			Quality Assurance Committee meeting monthly for 3 months and		
		et me die" The nurse			then quarterly thereafter once		
	-	d placed a call to the			compliance is at 100%. Frequency		
		e to notify them of			and duration of reviews will be		
					increased as needed, if compliance	is	
	resident being ui	nable to tolerate enema.			below 100%.		
	On 7/15/15 :4.2	20 m m 4h a DOM					
		30 p.m., the DON			Compliance date: 8/14/2015. The		
	-	ery slip from the facility			Administrator at Altenheim Health		
		indicated the enemas			and Living Community is responsible	е	
		ed to the facility on			in ensuring compliance in this Plan of Correction.		
	5/10/15 at 1:05 a	.m. The DON indicated			or correction.		
	she did not know	why the nurse waited					
	until 6:14 a.m., t	o attempt to administer					
	· ·	it had been ordered stat					
		pharmacy at 1:05 a.m.					
	and denivered by	primirino, at 1.00 a.m.					
	A nurse's note de	ated 5/10/15 at 6:49 a.m.,					
		vsician wanted Resident					
	#/9 to be sent to	the hospital emergency					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ í	ULTIPLE CO. JILDING	NSTRUCTION 00	(X3) DATE COMPL		
		155196	B. W	ING		07/21/	
	PROVIDER OR SUPPLIER			3525 E I	DDRESS, CITY, STATE, ZIP CODE HANNA AVE APOLIS, IN 46237	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
		nted 5/10 15 at 7:14 a.m., nt #79 was taken in an e hospital.					
	5/10/15 at 7:47 a Impression 1. Al Pseudo-obstructi	on of intestine [the tines to contract and push ir through the					
	5/10/15, indicate "womantrans [extended care fa progressive abdo has had difficulty constipationfor	ry and Physical, dated od, sferred from ECF acility] in the setting of ominal distention. She y with progressive r the past 2-3 weeks, now painshe is admitted for					
	5/13/15.  On 7/15/15 at 8::  Nursing (DON)  policy titled, Sta  was the policy cr  facility. The pol  physician prescr	urned to the facility on  55 a.m. the Director of provided an undated to Orders, and indicated it currently used by the icy indicated, "4. If a libes a medication not facility emergency					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION		B. W	JILDING ING	00	COMPL	
		155196	B. W		_	07/21/	2015
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ΔΙ ΤΕΝΙΗΙ	EIM HEALTH & LIV	ING COMMUNITY			HANNA AVE APOLIS, IN 46237		
				<u> </u>	Al OLIO, IIV 40237		
(X4) ID PREFIX		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
	·	CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
F 0441 SS=D Bldg. 00	supply, inform the medication is not sure the physicial order will not be confirmed with the timeframe may be defined as a pharmacy directly medication order.  3.1-48(c)(2)  483.65 INFECTION CONTYPREAD, LINENSYTHE facility must be infection Control provide a safe, safe environment and the development and infection.  (a) Infection Control Program of the facility must be control to the facility mu	TROL, PREVENT Separate stablish and maintain an Program designed to nitary and comfortable to help prevent the transmission of disease of Program stablish an Infection ander which it controls, and prevents cility; procedures, such as a paplied to an individual cord of incidents and related to infections.		TAG	DEFICIENCY)		DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		l í	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:				COMPL	
		155196	B. W	ING		07/21/	2015
	PROVIDER OR SUPPLIEF			3525 E	ADDRESS, CITY, STATE, ZIP CODE HANNA AVE IAPOLIS, IN 46237		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY 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
	a communicable of lesions from direct their food, if direct disease.  (3) The facility must their hands after of their hands after of the which hand was accepted profession (c) Linens Personnel must have transport linens so of infection.	ist prohibit employees with disease or infected skin to contact with residents or to contact will transmit the list require staff to wash each direct resident contact ashing is indicated by onal practice.  andle, store, process and on as to prevent the spread					
	Based on record review and interview,		F 04	141	FAA1 A02 CE INFECTION CONTROL		08/14/2015
		d to ensure employees			F441 483.65 INFECTION CONTROL,		
	were free of a co	ommunicable disease			PREVENT SPREAD, LINENS		
	(Licensed Practi	cal Nurses #7 and #8) for			What corrective actions will be		
	2 of 15 employe	es whose records were			accomplished for those residents		
	reviewed.				found to have been affected by the	•	
					deficient practice?		
	Findings include				All employees administered a two step tuberculin test and determined	i	
	_	ployee records on 7/15/15			free from communicable disease.		
	at 10:00 a.m. inc	licated the following:			How other residents besides the		
		(T. D.) (T. D.) (T. D.)			How other residents having the potential to be affected by the		
		ctical Nurse (LPN) #7			same deficient practice will be		
		21/15. The 1st step of her			identified and what corrective		
	•	ılin skin test was			action will be taken?		
		5/21/15. A 2nd step was					
	not found in her	record.			All employees of the Altenheim hav	e	
					the potential to be affected by the		
		hired on $4/2/15$ . The 1st			same deficient practice.		
	step of her two-s	step tuberculin skin test			All employee files audited to ensure	<u>.</u>	
	was administere	d on $3/31/15$ . The 2nd			two step tuberculin test was presen		
	step was not adn	ninistered 7/9/15.			in employee file.		

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPLETED
		155196	B. WI	NG		07/21/2015
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIEF	₹			HANNA AVE	
ALTENHI	EIM HEALTH & LIV	ING COMMUNITY		l	IAPOLIS, IN 46237	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	,	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)	DATE
					What measures will be put into	
	On 7/15/15 at 10				place or what systemic changes wil	i
		dicated all nursing staff			be made to ensure that the	'
	work on both on	the skilled units and on			deficient practice does not recur?	
	the Residential of	eare unit.				
					Staff Development Coordinator and	
	The Centers for	Disease Control at			Human Resources educated on Pre	
	www.cdc.gov. ii	ndicates in an article			and Post-Employment Health	
	dated 11/26/14,				Screening Policy.	
		Section: A Guide for			New orientation process	
	Primary Health Care Providers, if the 1st				implemented by Human Resources.	
	1	a 2nd step should be			First tuberculin skin test given on	
	administered 1-3 weeks later."				Monday before orientation and rea	d l
	administered 1-2	weeks later.			on Wednesday, first day of	
	On 7/17/15 at 10	):20 a.m. the Director of			orientation.	
	• • •	provided an undated			Staff Development Coordinator to	
		and Post-Employment			ensure second step is given,	
	· `	g and indicated it was the			recorded and placed in employee file.	
		used by the facility. The			Tile.	
		, "Testing for active			How the corrective actions will be	
	tuberculosis is a	ccomplished using the			monitored to ensure the deficient	
	two-step Mantou	ux tuberculin test method			practice will not recur, what quality	,
	recommended by	y the Centers for Disease			assurance program will be put into	
	Control. At min	imum, the 1st Step will			place?	
	be administered	and read prior to, or on,			Discrete of Novel	
		late of hire (i.e. the first			Director of Nursing to perform a	
	day of work incl	,			month end review monthly of all new employees hired in that month	
	Orientation)"				to ensure first and second PPD are	
	Ononwhom				present in employee file.	
	On 7/17/15 at 10	):20 a.m. the DON			r - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	
					The results of these reviews will be	
	_	r undated policy titled			discussed at the monthly facility	
	-	tion and indicated it was			Quality Assurance Committee	
		ntly used by the facility.			meeting monthly for 3 months and	
	The policy indic	ated, "PPD [tuberculin			then quarterly thereafter once	

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AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155196	B. WING		07/21/2015
			STREET /	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PI	ROVIDER OR SUPPLIER	8		HANNA AVE	
		ING COMMUNITY		IAPOLIS, IN 46237	
ALTENIIE	INTICALITI & LIV	ING COMMONT I	INDIAN	AFOLIS, 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
	skin test] Testing	g for Active		compliance is at 100%. Frequency	
	Tuberculosis: T	he first ppd step		and duration of reviews will be	
		the employee must be		increased as needed, if compliance	is
	-	the employee's hire date.		below 100%.	
	•	2 2		Compliance date: 8/14/2015.	
		date is only attendance of		Administrator at Altenheim He	alth
		tion the employee is still		and Living Community is	
	in the facility and	d in the presence of the		responsible in ensuring compliance in this Plan of	
	residents"			Correction	
				Correction	
	On 7/17/15 the I	OON indicated she was			
		the 2nd step tuberculin			
		•			
		V #7 or a 2nd step for			
	LPN #8 adminis	tered 2-3 weeks after the			
	1st step.				
	3.1-18(k)				
i i					
F 0456	483.70(c)(2)				
SS=E	<b>ESSENTIAL EQU</b>	IPMENT, SAFE			
Bldg. 00	OPERATING COM	NDITION			
	The facility must n	naintain all essential			
		rical, and patient care			
	• •	operating condition.			
	Based on observ	ation, interview, and	F 0456		08/14/2015
	record review, th	ne facility failed to ensure		F456 483.7 Essential Equipment,	
	the dishwasher r	inse temperature was		Safe opering condition	
	maintained acco	-		111	
		uidelines for proper		What corrective actions will be	
	•			accomplished for those residents	
	•	itizing of dishes and		found to have been affected by the	1
	utensils.			deficient practice?	
				The dishwasher was taken out of	
	Findings include	<del>:</del>		service at the time the deficient	
				service at the time the dendent	

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Event ID:

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Facility ID: 000103

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETED	
		155196	B. W	ING		07/21/2015	
NAME OF I	DROVADED OD GLIDDI IE	S.D.		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	CR.		3525 E	HANNA AVE		
ALTENH	EIM HEALTH & LI	VING COMMUNITY		INDIAN	IAPOLIS, IN 46237		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		N
TAG		R LSC IDENTIFYING INFORMATION)		TAG	·	DATE	
	_	rvation on 07/14/2015 at			practice was identified. An outside		
	10:22 A.M., the dishwashing machine				vendor was contacted to place a booster heater on the machine to		
	1	hed 176 degrees			ensure proper tempratures.		
		e manufacturer's					
	guidelines locat	ted on the side of the			How other residents having the		
	dishwashing ma	achine indicated the rinse			potential to be affected by the		
	cycle needed to	reach 180 degrees			same deficient practice will be		
	Fahrenheit.				identified and what corrective		
					action will be taken?		
	During an inter	view on 07/14/2014 at			All residents have the potential to b	Δ	
		e Dining Manager			affected by the deficient practice.		
	-	nse cycle did not reach			The dishmachine was taken off line		
		hrenheit to properly wash			and repairs made.		
	_	hes and utensils at that					
					What measures will be put into		
		ng Manager indicated			place or what systemic changes wil	ı	
	maintenance wo				be made to ensure that the		
	dishwashing ma	achine.			deficient practice does not recur?		
	A review of the	Dishmachine			All associate were inserviced related	d l	
		hart dated June, 2015, and			to the deficient practice, and the		
		cated the dishmachine			steps to be taken if the rinse		
	1				temperature is not met. The		
		g properly on June 14 and			systemic change will be that the		
	15, 2015, and J	uly 6 and 7, 2015.			dishmahine's temps will be monitored during each use to		
					ensure proper temperature. The		
	1	view on 07/21/2015 at			dishmachine has also had a booster		
	· ·	e Administrator indicated			heater added in order to ensure		
	the Dishmachin	e Temperature Chart			proper tempratures.		
	completed by d	ietary three times a day					
	were unavailab	le for months prior to June			How the corrective actions will be		
	2015.				monitored to ensure the deficient		
					practice will not recur, what quality		
	A review of the	maintenance water			assurance program will be put into		
		s, provided by the			place?		
		on 07/21/2015 at 11:44			The dishmachine will be monitored		

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155196	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 07/21/2015
	PROVIDER OR SUPPLIER		3525 E	ADDRESS, CITY, STATE, ZIP CODE HANNA AVE IAPOLIS, IN 46237	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	on February 16, June 5, 8, 22, and On 7/21/15 at 11 Administrator pr titled Warewashi Dishmachine), ar policy currently policy indicated, dishmachine cert Sanitation Found manufacturer's g washing and san utensils2. The following standa sanitizing agents	rovided an undated policy ring (Commercial and indicated it was the used by the facility. The "A commercial tified by the National ring dation is used following uidelines for proper ritizing of dishes and right dishmachine is operated rds for temperatures and ras follows: achine Wash Cycle 150 -		dialy by the Dining Services Director or designee 3 times per day for 15 days, then 5 days per week for 30 days, and lastly 3 times per week for 30 days. The results will be reviewed at the Community's QAPI meeting monthly. The Community will then monitor tempratures quarterly as part of the Community QAPI program.  Compliance date: 8/14/2015.	r
F 9999					
Bldg. 00	3.1-14 Personnel (k) There shall b	e an organized ongoing	F 9999	F9999	08/14/2015
	inservice educati	ion and training planned l personnel. This		What corrective actions will be accomplished for those residents found to have been affected by the	3

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155196	B. WI	ING		07/21/	2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	<b>t</b>		3525 E	HANNA AVE		
ALTENH	EIM HEALTH & LIV	ING COMMUNITY		INDIAN	APOLIS, IN 46237		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	·		DATE
	_	clude, but not be limited			deficient practice?		
	to, the following				No resident was found to be		
	(6) Care of cogn	itively impaired			affected by the deficient practice.		
	residents.				ancested by the denoising procince.		
					All employees completed yearly		
	This State rule was not met as evidenced				dementia and abuse training.		
	by:						
	-				How other residents having the		
	Based on record	review and interview,			potential to be affected by the		
		d to ensure nursing staff			same deficient practice will be identified and what corrective		
		uired 3 hours of annual			action will be taken?		
		entia and annual training			action will be taken:		
		•			All residents residing in facility have	<u>:</u>	
	_	dar year for 2 of 12			the potential to be affected by the		
		ployee files reviewed.			deficient practice.		
	`	ng Assistants #4 and #6,					
	Qualified Medic	ation Aide #5)			All employee files audited by Staff		
					Development Coordinator to ensure	е	
	Findings include	e:			completion of annual abuse and 3		
					hours of dementia training.  Employees updated as needed.		
	1	were reviewed on 7/15/15			Employees updated as needed.		
	at 10:00 a.m. wi	th the following findings:			What measures will be put into		
					place or what systemic changes wi	II	
	1. Certified Nurs	sing Assistant (CNA) #6			be made to ensure that the		
	was hired on 8/6	5/2010. One hour of			deficient practice does not recur?		
	dementia trainin	g was documented on					
		er dementia training was			Staff educated on the dementia and	d	
	documented in 2	•			abuse requirements.		
	20001111110011110				Abuse training and dementia		
	2 Qualified Med	dication Assistant #5 was			training to be completed prior to		
	-	One hour of dementia			training for employee position.		
	_	rumented on 4/16/15 and			Staff Development Coordinator will		
		5. No other dementia			track abuse and dementia training		
	_	rumented in her employee			ensuring that employee files are up		
	file.				to date.		

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155196	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/21/2015
ALTENH	PROVIDER OR SUPPLIEF		3525 E	ADDRESS, CITY, STATE, ZIP CODE E HANNA AVE NAPOLIS, IN 46237	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	Nursing provide Inservice Educat the policy currer The policy indic All employees w complete a mini- each month in th Courses will be	2:20 a.m. the Director of d an undated policy titled tion and indicated it was atly used by the facility. ated, "Ongoing Training will be required to mum of two (2) courses a meLearning System. assigned in the following		How the corrective actions will be monitored to ensure the deficient practice will not recur, what qualit assurance program will be put interplace?  Director of Nursing will audit abuse and dementia training monthly for second check to ensure all employin-services are current.	tty o
	Needs of Spec	hroughout the year: ialized Populations nentia (minimum three per year)."		The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance below 100%.	ı
				Compliance date: 8/14/2015. The Administrator at Altenheim Health and Living Community is responsib in ensuring compliance in this Plan of Correction.	le
R 0000					
Bldg. 00	This visit was for Licensure Surve		R 0000	This plan of correction is to s as Altenheim Health and Livin Community's credible allegat of compliance. Submission of this plan of correction does no constitute an admission by Altenheim Health and Living	ng ion of

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		X1) PROVIDER/SUPPLIER/CLIA			NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI		00	COMPL	ETED
		155196	B. WIN	G		07/21/	2015
	ROVIDER OR SUPPLIER			3525 E	DDRESS, CITY, STATE, ZIP CODE HANNA AVE APOLIS, IN 46237		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	<del></del>	ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	D	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	1	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE
TAG		· · · · · · · · · · · · · · · · · · ·	+	IAG	·		DATE
	Residential Samp These State findi accordance with	ngs are cited in			Community or its management company that the allegations contained in the survey report a true and accurate portrayal of the provision of nursing care a other services in this facility. Notes this submission constitute an agreement or admission of survey allegations.	are of nd lor	
R 0117	410 IAC 16.2-5-1.4 Personnel - Deficie	• •					
Bldg. 00	qualifications, and with applicable state the twenty-four (24 unscheduled need services provided. qualifications, and depend on skills respecific needs of t	ufficient in number, training in accordance ate laws and rules to meet 4) hour scheduled and ls of the residents and The number, training of staff shall equired to provide for the he residents. A minimum staff person, with current					
	CPR and first aid of site at all times. If of the facility regul nursing services of medication, or both staff person shall be Residential facilities (100) residents regresidential nursing of medication, or bone (1) additional awake and on duty additional fifty (50) shall be assigned they are trained to shall conform with	certificates, shall be on fifty (50) or more residents arly receive residential r administration of h, at least one (1) nursing one on site at all times. The ses with over one hundred gularly receiving a services or administration both, shall have at least nursing staff person y at all times for every or residents. Personnel only those duties for which perform. Employee duties written job descriptions.	P 01	17	What corrective actions will	ha	08/14/2015
		review and interview, I to ensure 1 awake staff	R 01	17	What corrective actions will accomplished for those residents found to have been		08/14/2015

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155196	B. W	ING		07/21/	2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	t			HANNA AVE		
AI TENILI	EIM HEALTH & LIV	ING COMMUNITY			APOLIS, IN 46237		
				INDIAN	AI OLIO, III 40237		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	person with curr	ent cardiopulmonary			affected by the deficient		
	resuscitation (CI	PR) and first aid			practice? No resident was for	und	
	certificates was	on site at all times for 20			to be affected by the deficient		
	of 42 shifts revie				practice. How other residents	5	
	01 42 Sillits ICVIC	wed.			having the potential to be		
					affected by the same deficier		
	Findings include	<b>:</b>			practice will be identified and		
					what corrective action will be		
	A review of dail	y staffing sheets (which			taken? All residents residing of	ווע	
		rho actually worked)			the Assisted Living have the potential to be affected by the		
		19/15 indicated the			deficient practice. Audit of all		
		19/13 marcated the			nurses, certified nursing		
	following:				assistants, and QMAs for CPR		
					and First Aid completion. Wha		
	7/6: 2nd shift - 1	no first aid coverage			measures will be put into pla		
	3rd shift - n	o first aid or CPR			or what systemic changes wi		
	coverage				be made to ensure that the		
	55,524,85				deficient practice does not		
	7/7: 2md abift m	no first aid or CPR			recur? All Assisted Living state	ff	
		io first aid of CPK			educated about CPR and First		
	coverage				Aid requirements. CPR class		
					held for Assisted Living staff or		
	7/8: 2nd shift - 1	no first aid or CPR			7/23/15. Assisted Living staff		
	coverage				be First Aid Certified by 8-14-1		
	3rd shift - n	o first aid or CPR			Staff Development Coordination to track CPR and First Aid	on	
	coverage						
	Joverage				completion to ensure all staff working on Assisted Living has	,	
	7/10 1 / 1:0	C 1			timely renewal. How the	<b>_</b>	
		no first aid coverage			corrective actions will be		
		no first aid coverage			monitored to ensure the		
	3rd shift -	no first aid or CPR			deficient practice will not rec	ur,	
	coverage				what quality assurance	,	
					program will be put into plac	e?	
	   7/11 · 1 ct chift _ r	no first aid coverage			Staffing Sheet to be checked		
		no first aid or CPR			daily by Staffing Coordinator w		
		no msi aiu oi CPK			CPR and First Aid written by s		
	coverage				member name that is working		
					shift to ensure at least one sta		
	7/12: 1st shift - 1	no first aid or CPR			on all shifts has completed bot	.11	

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STATEMENT OF AND PLAN OF C		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155196	(X2) MUL A. BUIL B. WING	LDING	NSTRUCTION  00	(X3) DATE : COMPL <b>07/21</b> /	ETED
	VIDER OR SUPPLIER	ING COMMUNITY		3525 E I	ddress, city, state, zip code HANNA AVE APOLIS, IN 46237		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERNCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
color of the color	overage  /15: 2nd shift - 3rd shift - overage  /16: 2nd shift - 3rd shift - overage  /17: 2nd shift - overage  /17: 2nd shift - overage  /18: 2nd shift - overage  /18: 2nd shift - overage  /19: 2nd shift - overage	no first aid coverage no first aid coverage no first aid coverage no first aid or CPR  same the Clinical ated the above shifts R and/or first aid adicated the facility has a ent Action Plan certification coverages t into place as soon as Staff Development			components. DON will review staffing sheets daily indefinitely. The results of these reviews who discussed at the monthly facility Quality Assurance. Committee meeting monthly formonths and then quarterly thereafter once compliance is 100%. Frequency and duration reviews will be increased as needed, if compliance is below 100%. Compliance date: 8/14/2015. The Administrator Altenheim Health and Living Community is responsible in ensuring compliance in this Plat of Correction.	y. ill or 3 at n of / at	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155196	(X2) MULTIPLE CC A. BUILDING B. WING	onstruction  00	(X3) DATE ( COMPL 07/21/	ETED
ALTENH	PROVIDER OR SUPPLIEF		3525 E	ADDRESS, CITY, STATE, ZIP COD HANNA AVE APOLIS, IN 46237	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE
R 0120 Bldg. 00	education and trai advance for all per at least annually. Is not limited to, reand control of infersafety, accident properly specialized popular administration, an appropriate, as for (1) The frequency education and train accordance with the facility personation of the facility	an organized inservice ning program planned in rsonnel in all departments Training shall include, but esidents' rights, prevention ction, fire prevention, revention, the needs of ations served, medication d nursing care, when flows: and content of inservice ning programs shall be in the skills and knowledge of nel. For nursing personnel, at least eight (8) hours of ndar year and four (4) per calendar year for nnel. the above required taff who have contact with the a minimum of six (6) the specific training within six tree (3) hours annually the needs or preferences, thely impaired residents gain understanding of the of care for residents with the shall be maintained the following: the instructor. the participants. content of inservice.				
	(E) The program of					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155196		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 07/21/2015	
	PROVIDER OR SUPPLIER			3525 E	ADDRESS, CITY, STATE, ZIP CODE HANNA AVE IAPOLIS, IN 46237		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	the facility failed received the requiral training for demotor abuse during of 12 nursing stareviewed. (Certifut 44 and #6, Qualifut 45)  Findings included Employee files wat 10:00 a.m. with 1. Certified Nursing was hired on 5/1 training was documented on 3 dementia training 2013.  3. Qualified Median documented on 3/14. Training was documented on 3/14. Training was documented on 3/19/1 training was documented	review and interview, It to ensure nursing staff aired 3 hours of annual entia and annual training the calendar year for 3 Iff employee files fied Nursing Assistants fied Medication Aide  evere reviewed on 7/15/15 If the following findings: Ising Assistant (CNA) #4 I/2010. Her last abuse umented on 7/8/14.  hired on 8/6/2010. One	RO	120	R120 What corrective action will be accomplished for the residents found to have bee affected by the deficient practice? No resident was for to be affected by the deficient practice. All employees completed yearly abuse and dementia training. How other residents having the potentit to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents residing in facility has the potential to be affected by deficient practice. All employers files audited by Staff Development Coordinator to ensure completion of annual abuse and 3 hours of dement training. Employees updated an eeded. What measures will be put into place or what systemic changes will be mat to ensure that the deficient practice does not recur? Staff Development Coordinator to training and dementia training employee position. Staff Development Coordinator will track abuse and dementia training ensuring that employer files are up to date. How the corrective actions will be monitored to ensure the deficient practice will not reconstructed to the surrent the deficient practice will not reconstructed to the surrent the deficient practice will not reconstructed to the surrent the deficient practice will not reconstructed to the surrent the deficient practice will not reconstructed to the surrent the deficient practice will not reconstructed to the surrent the deficient practice will not reconstructed to the surrent the deficient practice will not reconstructed the surrent training the surrent	se n und al ve ave the ee as II ade aff d to for ee	08/14/2015

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/11/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING		(X3) DATE COMPI		
AND PLAN	OF CORRECTION	155196	B. WING	00	07/21	
		100100	_	ADDRESS CITY STATE ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE HANNA AVE	L	
	EIM HEALTH & LIV	ING COMMUNITY		NAPOLIS, IN 46237		
(X4) ID		FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	TION	(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ROPRIATE	COMPLETION DATE
IAG	Nursing provided Inservice Educat the policy current The policy indicated All employees we complete a mining each month in the Courses will be a subject matters the Residents' Rights Prevention Nee Populations Alz	d an undated policy titled ion and indicated it was tly used by the facility. ated, "Ongoing Training ill be required to num of two (2) courses eLearning System. assigned in the following broughout the year:	IAU	program will be put into Director of Nursing will au abuse and dementia train monthly for second check ensure all employee in-seare current. The results of reviews will be discussed monthly facility Quality As Committee meeting mont months and then quarterly thereafter once compliant 100%. Frequency and dureviews will be increased needed, if compliance is the 100%. Compliance date: 8/14/2015. The Administ Altenheim Health and Livi Community is responsible ensuring compliance in the of Correction.	idit ing to ervices of these at the esurance hly for 3 y ce is at uration of as oelow rator at ing e in	DAIL
R 0121 Bldg. 00	employee of a faci contact. The scree tuberculin skin tes method (5 TU, PP positive reaction c result shall be reco induration with the and by whom adm assure the followin (1) At the time of e (1) month prior to annually thereafter	ompliance a shall be required for each lity prior to resident en shall include a t, using the Mantoux D), unless a previously an be documented. The orded in millimeters of date given, date read, inistered. The facility must				

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155196	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 07/21/2015
ALTENH	PROVIDER OR SUPPLIER	ING COMMUNITY	3525 E INDIAN	ADDRESS, CITY, STATE, ZIP CODE E HANNA AVE NAPOLIS, IN 46237	- avo
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL 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
	must be read prior work. For health of had a documented test result during to months, the basel should employ the first step is negative performed one after the first step testing will depend with tuberculosis.  (2) All employees reaction to the sking have a chest x-ray laboratory examinal a diagnosis.  (3) The facility should be employeed employment elated (4) An employeed employment elated (4) An employeed employees is ruled to cough, fever, in loss) shall not be tuberculosis is ruled based on record the facility failed employees received employees whose for receiving the sking test as indiced. Licensed Practive Findings included A review of employees.	review and interview, d to ensure newly hired wed the 2nd step of their alin skin tests for 2 of 5 the records were reviewed air two-step tuberculin tested by facility policy.	R 0121	R121  How the corrective actions will be monitored to ensure the deficient practice will not recur, what qualit assurance program will be put into place?  No resident was found to be affected by the deficient practice.  All employees administered a two step tuberculin test and determined free from communicable disease.	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			URVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u> COMPLETED			ETED	
		155196	B. W	ING	_	07/21/2	2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	<b>{</b>		3525 E	HANNA AVE		
ALTENH	EIM HEALTH & LIV	ING COMMUNITY		INDIAN	APOLIS, IN 46237		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	ì ·	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG			DATE
					How other residents having the		
		ctical Nurse (LPN) #7			potential to be affected by the same deficient practice will be		
		1/15. The 1st step of her			identified and what corrective		
	two-step tuberculin skin test was				action will be taken?		
	administered on 5/21/15. A 2nd step was						
	not found in her record.				All employees of the Altenheim have	e	
					the potential to be affected by the		
	b. LPN #8 was hired on 4/2/15. The 1st				same deficient practice.		
	step of her two-s	step tuberculin skin test					
	was administered on 3/31/15. The 2nd				All employee files audited by Staff		
	step was not administered 7/9/15.				Development Coordinator to ensure		
	step was not aan	ministered 779/13.			two step tuberculin test was presen in employee file.	١	
	On 7/15/15 at 10	):00 a m tha			in employee me.		
					What measures will be put into		
		dicated all nursing staff			place or what systemic changes wil	.	
		the skilled units and on			be made to ensure that the		
	the Residential c	care unit.			deficient practice does not recur?		
	The Centers for	Disease Control at			Staff Development Coordinator and		
	www.cdc.gov. ir	ndicates in an article			Human Resources educated on Pre		
	dated 11/26/14,	titled, "Latent	and Post-Employment Health				
		Section: A Guide for			Screening Policy.		
		Care Providers, if the 1st			New orientation process		
	<u>-</u>	a 2nd step should be			implemented by Human Resources.		
	administered 1-3	*			First tuberculin skin test given on		
	administered 1-2	meens inter.			Monday before orientation and read	d	
	On 7/17/15 of 10	20 a.m. the Director of			on Wednesday, first day of		
					orientation.		
		provided an undated					
	1 * *	and Post-Employment			Staff Development Coordinator to		
	l '	g and indicated it was the			ensure second step is given,		
	1	used by the facility. The			recorded and placed in employee file.		
	policy indicated, "Testing for active				me.		
	tuberculosis is accomplished using the				How the corrective actions will be		
	two-step Mantou	ux tuberculin test method			monitored to ensure the deficient		
	recommended by	y the Centers for Disease			practice will not recur, what quality	,	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. Bl	UILDING	00	COMPL	ETED
		155196	B. W	ING		07/21/	2015
(E. O.E. P.				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			3525 E	HANNA AVE		
	EIM HEALTH & LIV	ING COMMUNITY			APOLIS, IN 46237		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	· · · · · · · · · · · · · · · · · · ·		DATE
		imum, the 1st Step will			assurance program will be put into		
	be administered	and read prior to, or on,			place?		
	the employee's d	ate of hire (i.e. the first			Director of Nursing to perform a		
	day of work incl	uding General			month end review of all new		
	Orientation)"				employees hired in that month to		
	Ź				ensure first and second PPD are		
	On 7/17/15 at 10	20 a.m. the DON			present in employee file.		
		r undated policy titled			·		
	_	tion and indicated it was			The results of these reviews will be		
					discussed at the monthly facility		
the policy currently used by the facility.					Quality Assurance Committee		
		ated, "PPD [tuberculin			meeting monthly for 3 months and		
	skin test] Testing				then quarterly thereafter once		
	Tuberculosis: T	he first ppd step			compliance is at 100%. Frequency		
	administered by	the employee must be			and duration of reviews will be		
	complete before	the employee's hire date.			increased as needed, if compliance below 100%.	IS	
	Even if the hire of	date is only attendance of			below 100%.		
		ion the employee is still			Compliance date: 8/14/2015. The		
		d in the presence of the			Administrator at Altenheim Health		
	residents"	a m mo prosence or me			and Living Community is responsible	e	
	residents				in ensuring compliance in this Plan		
	On 7/17/15 the T	OON indicated she was			of Correction.		
		he 2nd step tuberculin					
		I #7 or a 2nd step for					
	LPN #8 adminis	tered 2-3 weeks after the					
	1st step.						

State Form Event ID: JVTX11 Facility ID: 000103 If continuation sheet Page 77 of 85

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED		
		155196	B. WING 07/21/2015				
			STREE	T ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER		3525 E HANNA AVE				
ALTENHE	EIM HEALTH & LIV	ING COMMUNITY		NAPOLIS, IN 46237			
(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		
R 0148	410 IAC 16.2-5-1.	` /` /					
		fety Standards - Deficiency					
Bldg. 00	• •	ıll maintain buildings,					
	grounds, and equi	•					
		repair, and free of hazards y affect the health and					
	•	dents or the public as					
	follows:	acino di uno pasilo do					
	(1) Each facility sh	all establish and					
	implement a writte	n program for					
maintenance to ensure the continued upkeep of the facility.  (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems,							
	·	shall be maintained to guarantee safe					
		mpliance with state					
	electrical codes.	impliance with state					
		nall function properly and					
	comply with state						
		heating and ventilating					
	systems shall be in	-					
		ervation, interview, and	R 0148		08/14/2015		
	record review, th	e facility failed to ensure		R148 Sanitation and Safety standards			
	the dishwasher ri	inse temperature was		standards			
	maintained accor	rding to the		What corrective actions will be			
	manufacturer's g	uidelines for proper		accomplished for those residents			
	washing and san	itizing of dishes and		found to have been affected by the			
	•	ed to maintain ceiling		deficient practice?			
		walls in the pantry areas					
		n and good repair for 2		The dishwasher was taken out of			
		· ·		service at the time the deficient			
	of 2 pantry areas			practice was identified. An outside			
				vendor was contacted to place a			
	Findings include	:		booster heater on the machine to			
				ensure proper tempratures.			
	1.) During an observation on 07/14/2015		How other regidents having the				
at 10:22 A.M., the dishwashing machine rinse cycle reached 176 degrees			How other residents having the				
		· ·		potential to be affected by the same deficient practice will be			
				Jame dendent practice will be			

State Form Event ID: JVTX11 Facility ID: 000103 If continuation sheet Page 78 of 85

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			COMPLETED
		155196	B. W	ING		07/21/2015
				CTDEET /	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIEF	₹		1	HANNA AVE	
AI TENIL	EIM HEALTH & LIV	ING COMMUNITY			APOLIS, IN 46237	
	_			INDIAN	AFOLIS, IN 40237	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	Fahrenheit. The	manufacturer's			identified and what corrective	
	guidelines locate	ed on the side of the			action will be taken?	
	dishwashing ma	chine indicated the rinse			l	
	cycle needed to	reach 180 degrees			All residents have the potential to b	e
	Fahrenheit.				affected by the deficient practice.  The dishmachine was taken off line	
	1 difference.					
	D	. 07/14/2014			and repairs made. The panties in question have been cleaned	
	During an interview on 07/14/2014 at				according to standards.	
	10:45 A. M, the Dining Manager				according to standards.	
	indicated the rinse cycle did not reach				What measures will be put into	
	180 degrees Fahrenheit to properly wash				place or what systemic changes wil	ı
	and sanitize dishes and utensils at that				be made to ensure that the	
	time. The Dining Manager indicated				deficient practice does not recur?	
	maintenance wo	0 0				
	dishwashing ma				All associate were inserviced related	d l
	dishwashing ina	Cililie.			to the deficient practice, and the	
					steps to be taken if the rinse	
	A review of the				temperature is not met, and the	
	Temperature Ch	art dated June, 2015 and			cleaning schedules for the panties	
	July, 2015, indic	cated the dishmachine	identified during the survey. The			
	was not working	g properly on June 14 and	systemic change will be that the			
	15, 2015, and Ju	lly 6 and 7, 2015.			dishmahine's temps will be	
					monitored during each use to	
	During an interv	riew on 07/21/2015 at			ensure proper temperature. The	
	_	Administrator indicated			dishmachine has also had a booster heater added in order to ensure	
					proper tempratures. A cleaning	
		e Temperature Chart			schedule related to the panties and	
		etary three times a day			standards of practice have been	
	were unavailable	e for months prior to June			instituted to ensure the deficient	
	2015.				practice does not recur.	
					,	
	A review of the	maintenance water			How the corrective actions will be	
		s, provided by the			monitored to ensure the deficient	
	1	. 1			practice will not recur, what quality	,
	Administrator on 07/21/2015 at 11:44 A.M., indicated the dish machine rinse				assurance program will be put into	
					place?	
	1 -	180 degrees Fahrenheit				
	on February 16,	March 9, 23, April 6,			The dishmachine will be monitored	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	OO	(X3) DATE SURVEY  COMPLETED	
		155196	B. WING		07/21/2015
	PROVIDER OR SUPPLIER		3525 E	ADDRESS, CITY, STATE, ZIP CODI HANNA AVE NAPOLIS, IN 46237	E
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR June 5, 8, 22, 29)  On 7/21/15 at 11 Administrator pr Warewashing (C Dishmachine) an policy currently policy indicated dishmachine cert Sanitation Found manufacturer's g washing and san utensils2. The following standard sanitizing agents	ovided a policy titled ommercial di indicated it was the used by the facility. The "A commercial diffied by the National dation is used following uidelines for proper disting of dishes and dishmachine is operated rds for temperatures and as follows: achine Wash Cycle 150 -	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPR DEFICIENCY)  dialy by the Dining Services Din or designee 3 times per day for days, then 5 days per week for days, and lastly 3 times per week for days, and lastly 3 times per week for days. The results will be reviewed at the Community's meeting monthly. The Common will then monitor tempratures quarterly as part of the Common QAPI program.  The pantried will be monitored by the Dining Services Director designee 5 days per week for days, and 3 times per week for days. The results will be review the Community's QAPI meetin monthly. The Community will monitor sanitation records quas part of the Community's QAPI program.	COMPLETION DATE  Cector r 15 r 30 rek for  QAPI unity unity's  d daily r or so so wed at g then arterly
R 0349 Bldg. 00	on each resident. maintained under employee of the fa responsibility. The follows: (1) Complete. (2) Accurately doc (3) Readily access (4) Systematically	Noncompliance st maintain clinical records These records must be the supervision of an acility designated with that records must be as  umented. sible.	R 0349	Compliance date: 8/14/2015.	08/14/2015

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPLI	
		155196	B. W	ING		07/21/	2015
NAME OF I	DDOMDED OD CHIDDI IEI		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIER			3525 E	HANNA AVE		
ALTENH	EIM HEALTH & LIV	ING COMMUNITY		INDIAN	IAPOLIS, IN 46237		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	+	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	_ ·	d to ensure resident					
	clinical records	were documented with			How the corrective actions will be		
	physician notific	cation of weights and			monitored to ensure the deficient	_	
	blood sugars out	side physician call			practice will not recur, what quality assurance program will be put into	·	
		of 7 records reviewed			place?		
	for documentation (Resident # 509) and the facility failed to accurately document				F		
					Resident #509 blood sugars and		
	_	-			daily weights were reported to MD.		
the code status for a resident requesting a DNR (Do Not Resuscitate) status for 1 of					Daily weights discontinued on #509	.	
7 residents reviewed (Resident #353).				No adverse outcomes related to			
	/ residents revie	ewed (Resident #353).			deficient practice.		
	Findings include	·			Resident #535 Do Not Resuscitate		
	l manigs merado	•			(DNR) was clarified by Physicians		
	1) The clinical s	record of Resident #509			Order, updated on Face Sheet,		
	, , , , , , , , , , , , , , , , , , ,				updated on the Continuity of Care		
		n 7/20/15 at 10:00 a.m.			page, Service Plan and Functional		
		e resident included, but			Assessment.		
		to diabetes mellitus and					
	end stage kidney	disease.			How other residents having the		
					potential to be affected by the same deficient practice will be		
	A current physic	cian's order, dated			identified and what corrective		
	6/13/15, indicate	ed the resident was			action will be taken?		
	•	weighed daily and the			action will be taken:		
		ed if the resident gained			Audit of residents on daily weight		
		nds (lbs) in 1 day or 5 lbs			performed x past 30 days. MD		
	in 1 week.	(100) III 1 day 01 0 100			notified of any weight required by		
	m i week.				call parameters.		
	Review of the re	esident's daily weights for			Audit of diabetic residents blood		
		eated he gained 4.4 lbs			sugar readings x past 30 days. MD		
		and 7/3/15, and he gained			notified of any blood sugar required		
		/11/2015 and 7/12, 2015.			by call parameters.		
		, 11, 2010 and 1/12, 2010.					
	There was no do	ocumentation in the			Audit of Code Status to ensure		
		which indicated the			Physicians Order, Face Sheet,		
					Continuity of Care page, Service Pla	n	
	physician had be	een notified of these			and Functional Assessment are the		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DAT		(X3) DATE	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u> COMPLE			ETED	
		155196	B. Wl	NG		07/21/2015	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	8			HANNA AVE		
AI TENH	EIM HEALTH & LIV	ING COMMUNITY			APOLIS, IN 46237		
			1			1	(7/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	l `	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE		DATE
1710				1110	same for all residents.		DITTE
	~ ~	ich were over the 3 lbs			same for all residents.		
	per day call orde	er parameter.			What measures will be put into		
					place or what systemic changes wil	I	
	A current physic	eian's order dated 6/13/15,			be made to ensure that the		
	indicated the resident was supposed to				deficient practice does not recur?		
	have his blood sugar checked with a						
	finger stick bloo	d test before meals and at			Licensed Nursing staff educated on		
	"	nysician was to be			Code Status Policy.		
	notified if the blood sugar test results were less than 70 or over 300.						
					Licensed Nursing Staff educated on		
were resp than 70 or over 500.				call parameters related to blood			
	D	.: 1			sugar and daily weight.		
		sident's blood sugar			What measures will be put into		
		and July, 2015, indicated			place or what systemic changes wil	1	
	the following:				be made to ensure that the		
					deficient practice does not recur?		
	6/16 at bedtime	- blood sugar (bs) = $317$			·		
	6/18 at bedtime	- bs = 321			Unit Manager/Director of Nursing		
	6/20 at bedtime	- bs = 345		will audit blood sugar parameters			
	6/23 at bedtime	- bs = 326			and daily weights for call order		
	6/25 at 4:00 p.m				parameters 5xs a week for 4 weeks,		
	6/26 at bedtime				4xs a week for 4 weeks, 3xs a week		
	6/27 at bedtime				for weeks, then monthly.		
					Unit Manager/Director of Nursing		
	6/29 at bedtime				will ensure residents code status and	d	
	6/30 at 11:00 a.n				proper documentation of code	<b>~</b>	
	7/2 at 4:00 p.m.				status is in place at time of		
	7/3 at bedtime -				admission.		
	7/5 at bedtime -	bs = 313					
	7/11 at bedtime	- bs = 305			Unit Manager will bring new		
	7/16 at bedtime	- bs = 314			admission charts and/or any		
					resident who changed code status to	0	
	There was no do	cumentation in the			morning clinical meeting to review		
		which indicated the			for accuracy the morning after		
					admission/change in status.		
		een notified of the above			Discountry of November 2/1 lets NATE		
	blood sugars ove	er 300.			Director of Nursing/Unit Manager		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u> COMPLETED			TED	
		155196	B. W	ING		07/21/2	2015
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER			1	HANNA AVE		
ALTENHI	EIM HEALTH & LIV	ING COMMUNITY			APOLIS, IN 46237		
			ı	ID	-,		(V5)
(X4) ID PREFIX		FATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
TAG	REGULATORT OR	ESC IDENTIFY FING INFORMATION)	+	IAG	will perform 10 audits of charts 3x a		DATE
	0 7/00/15 + 0 :	10 4 5 11 21			week for 4 weeks, 2x a week for 4	'	
		10 p.m., the Residential			weeks, and weekly x 4 weeks.		
		dicated she was unable			weeks, and weekly X 4 weeks.		
	to find where the	physician was notified			Director of Nursing will audit all		
	of the above bloc	od sugars and weights			Assisted Living Charts for Code		
	which were outsi	ide the physician's call			Status at months end x 3 months.		
		2.2. The clinical record					
	•	ent #535, completed on			The results of these reviews will be		
		a.m., indicated the			discussed at the monthly facility		
		*			Quality Assurance Committee		
	·	noses including, but not			meeting monthly for 3 months and		
	limited to, high b	blood pressure.			then quarterly thereafter once		
					compliance is at 100%. Frequency		
	The admission P	hysician's History and			and duration of reviews will be	.	
	Physical dated 1	1/18/14, did not address			increased as needed, if compliance	IS	
	a code status for	the resident.			below 100%.		
					Compliance date: 8/14/2015. The		
	The admission of	hysician's orders dated			Administrator at Altenheim Health		
	•	ted the code status for the			and Living Community is responsible	<u> </u>	
	•	Full Code." A Full Code			in ensuring compliance in this Plan	-	
					of Correction.		
		he cardiopulmonary					
		uld be performed in the					
	event the heart sl	hould stop.					
	The electronic he	ealth record for Resident					
	#535 indicated a	full code status on the					
		the Continuity of Care					
	page under advar	•					
	page under auvai	nice directives.					
	The recomitulesis	on of physicianis and and					
	•	on of physician's orders					
	·	indicated "Do Not					
Resuscitate (DNR)" under code status							
	with an order dat	te of 11/28/14.					
	The Service Plan	dated and signed on					

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/11/2015 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION			COMPLETED 07/21/2015	
	ROVIDER OR SUPPLIER		3525 E	ADDRESS, CITY, STATE, ZIP CODE HANNA AVE IAPOLIS, IN 46237	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL 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
	· ·	unctional Assessment ked an indication of code			
	Manager of Resi 7/20/15 at 3:20 p the resident had a the form had been physician so the physician's order status from full of form was signed 3/6/15. The UM determine when was changed in the During an interv Nursing (DON) a Consultant on 7/2 Clinical Nurse Consultant on 7/2 Clinical Nurse Consultant on The hard chart (pandament) Advance Directive the code status for the Nursing (DON) at 120/15 at 4:20/15	facility did not write a to change the code code to DNR. The DNR by the physician on was not able to or how the code status he physician's orders.  iew with the Director of and the Clinical Nurse 20/15 at 4:20 p.m., the onsultant indicated the d to look under the tab in aper chart) titled wes in order to determine or the resident.			
	Status Policy dat indicated the pol used by the facil "The attending notified of each	t provided the Code red March 31, 2014, and ricy was the one currently rity. The policy indicated, physician will be resident's resuscitative rse will write a doctor's			

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155196	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 07/21/2015		
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 APPROPRI DEFICIENCY)	(EACH CORRECTIVE ACTION SHOULD BE ROSS-REFERENCED TO THE APPROPRIATE		
	order in the chartThe nurse will write a doctor's order for a full code or DNR even when a completed POST [Physician's Orders For Scope of Treatment] form is present upon admissionIt is [Corporation Name] policy to routinely review the code status of each resident with the resident or responsible party when the plan of care is reviewed"							

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