STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155298	A. BUILDING 00 B. WING	10/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PYRAMID POINT POST-ACUTE REHABILITATION CENTER	8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: October 3, 4, 5, 6, 7 and 11, 2016 Facility number: 000195 Provider number: 155298 AIM number: 1002676690 Census bed type: SNF/NF: 34 Total: 34 Census payor type: Medicare: 5 Medicaid: 28 Other: 1 Total: 34 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality Review was completed by 21662 on October 17, 2016.	F 0000	Plan of Correction for Annual Recertification and State Licensure Survey completed on 10/11/2016. Craig A. Hestand Executive Director Pyramid Point Post Acute Rehabilitation	
F 0246	483.15(e)(1)			

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

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SS=D Bldg. 00	REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Based on observation and interview, the facility failed to have residents' call lights accessible to alert staff they required assistance for 3 out of 3 residents reviewed for accommodation of needs (Residents #12, #9, and #21). Findings include: 1. On 10/4/16 at 2:16 p.m., Resident #12 was laying in bed and her call light was attached to her privacy curtain. RN #4 indicated the resident was able to use her call light, but she was unable to come to the resident's room at that time to observe the call light placement. The DON (Director of Nursing) came to the resident's room and removed the call light from the privacy curtain. The DON gave the resident her call light indicating the call light was not within reach of the resident. 2. On 10/4/16 at 10:36 a.m., Resident #9 indicated he did not have a call light available to him in his room to call for assistance when he needed help. At that	F 0246	This plan of correction constitutes the facility's written credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusion set forth on the Statement of Deficiencies. This plan of correction is prepared and/or executed solely because required by the provisions of the health and safety code section 1280 and 42 CFR 483. **Identifying Prefix Tag 246 :** ***Immediate corrective action(s) for those Residents affected by the deficient practice;*** Resident #12 call light was placed in reach. Resident #9 call light was placed in resident room ***Plan / Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken;*** All residents are at risk ***Facility measures and systemic changes to ensure the deficient practice does not recur;*** 10/4/16 facility audit was done to	11/10/2016

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	time, there was no call light observed in the resident's room for him to call for assistance. At that time, Resident #9 indicated he moved into that room two to three months ago and he told several nurses and CNA's since then, he did not have a call light to call for assistance, but no one had gotten him a call light. He indicated he transferred himself out of bed into his wheelchair and wheeled himself into the bathroom to pull the bathroom emergency cord when he needed assistance. At that time, Resident #9's roommate indicated he pushed his call light for assistance at least once for Resident #9. On 10/4/16 at 10:38 a.m., the Director of Operations and the Director of Clinical Reimbursement was notified Resident #9 did not have a call light in his room to call for assistance, since he had been transferred to this room. Both these Directors looked at the wall behind the resident's bed and the Director of Clinical Reimbursement indicated he did not have a call light and she got the Maintenance man immediately to install a call light. Resident #9's record was reviewed on 10/11/16 at 4:47 p.m. The resident's record indicated he was moved into his current room on 6/8/16.		ensure all residents had call lights and they were in reach Nursing staff in-serviced on 10/1ml3/16,10/14/16 by DON on ensuring residents call lights are in reach when residents are in their rooms Quality rounds are done 5x a week by IDT to ensure call lights are in reach ***Facility plan to monitor corrective actions & sustain compliance; Integrate QA Process;*** *DON or designee will do random audits of 10 residents a week to ensure call lights are in place x4 weeks then monthly x2 then quarterly x2 then* ***will review through QAPI to determine if audit needs to continue*** ***Completion Date(s):*** 11/10/16	

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	3. On 10/7/16 at 10:35 a.m., the Maintenance Supervisor was in attendance during the Environmental tour. Resident #21's call light was observed attached to her roommate's bed sheet along with her roommate's call light. The Maintenance Supervisor indicated he did not know how Resident #21's call light got clipped onto her roommate's bed sheet. He removed one of the call lights from the roommate's bed sheets and attached it to Resident #21's bed within her reach to enable her to call for assistance. 3.1-3(v)(1)			
F 0279 SS=D Bldg. 00	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical,			

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	mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on interview and record review, the facility failed to develop and implement a Care Plan for range of motion services for a resident with a contracture (Resident #8) and for antidepressant use for a resident prescribed an antidepressant (a medication to treat depression) (Resident #7) for 2 of 20 residents reviewed for Care Plans. Findings include: 1. On 10/07/2016 at 12:01 p.m., the record review was completed for Resident #8. Diagnoses included, but were not limited to, dementia, muscle weakness, contracture of unspecified hand and paraplegia. An IDT (Interdisciplinary Team) note dated 7/13/16, indicated, "...Attends exercise. Is unable to follow exercise, but she will count out the reps...." A quarterly MDS (Minimum Data Set) dated 7/13/16, indicated functional limitation in range of motion impairment	F 0279	This plan of correction constitutes the facility's written credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusion set forth on the Statement of Deficiencies. This plan of correction is prepared and/or executed solely because required by the provisions of the health and safety code section 1280 and 42 CFR 483. **Identifying Prefix Tag 279 :** ***Immediate corrective action(s) for those Residents affected by the deficient practice;*** Resident C is discharged Resident # 7 care plan was updated ***Plan / Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken;*** All residents can be affected ***Facility measures and systemic changes to ensure the deficient practice does not recur;*** 1.Social Service was in-serviced by director of quality reimbursement on 10/27/16 on	11/10/2016

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	on both sides of the upper and lower extremities. An IDT note dated 10/7/16, indicated "...Attends exercise. Is unable to follow exercise, but she will count out the reps...." During an interview on 10/04/2016 at 2:42 p.m., the DON (Director of Nursing) indicated the resident had a hand contracture and did not receive range of motion services and did not have a splint in place. During an interview on 10/11/2016 at 11:44 a.m., the Activity Supervisor indicated the resident attended group exercise and stretch daily. She indicated the resident would stretch her hands, arms and legs when instructed. She indicated the resident actively participated in this activity. During an interview on 10/11/2016 at 2:54 p.m., CNA #5 indicated the CNA's tried to do range of motion (ROM) during a.m., care. During an interview on 10/11/2016 at 5:09 p.m., the Director of Clinical Reimbursement indicated the resident did not have a Care Plan for ROM to be performed to the extremities.		care planning process 2.Audit completed on residents to ensure care plan in place when receiving an antidepressant medication New orders 5x a week any new antidepressant order will be check to ensure care plan is in place ***Facility plan to monitor corrective actions & sustain compliance; Integrate QA Process;*** Social Service or designee will randomly audit 5 residents care plans to ensure care plans are current for any antidepressant usage, weekly x4, then monthly x2 then quarterly x2. Then will review through QAPI to determine if audit needs to continue ***Completion Date(s):11/10/16***	

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	2. Resident #7's record was reviewed on 10/6/16 at 10:18 a.m. Diagnoses included, but were not limited to, dementia without behavioral disturbance, psychotic disorder with delusions due to known physiological condition, and cognitive communication deficit. The resident's Medication Administration Record dated October 2016, included, but was not limited to, the following order: 8/9/16--Mirtazapine (a medication used to treat depression) 7.5 mg (milligrams) give one tablet by mouth at bedtime for depression and anxiety. The resident's record lacked a Care Plan for the use of Antidepressants.. During an interview on 10/11/16 at 12:46 p.m., the Social Service Director indicated she could not locate a Care Plan for the use of Antidepressants for Resident #7. 3.1-35(a) 3.1-35(c)(1)			

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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 interview and record review, the facility failed to invite and include a family member to participate in Care Plan meetings for 1 of 1 resident reviewed for family participation in care planning (Resident #27). Finding includes: During an interview on 10/05/2016 at 3:44 p.m., Resident #27's family member indicated the facility had not included her in the care plan process. During an interview on 10/07/2016 at	F 0280	This plan of correction constitutes the facility's written credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusion set forth on the Statement of Deficiencies. This plan of correction is prepared and/or executed solely because required by the provisions of the health and safety code section 1280 and 42 CFR 483. **Identifying Prefix Tag 280 :** ***Immediate corrective action(s) for those Residents affected by the deficient practice;*** Resident B care conference	11/10/2016

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	3:41 p.m., the Social Services Director (SSD) indicated no Care Plan conferences had been done inviting the resident's daughter. She indicated the last IDT (Interdisciplinary Team) meeting was done in June of this year and no family members were present for the resident. She indicated she was unable to locate any documentation regarding past invitations of family to discuss the resident's plan of care. The SSD indicated the IDT meetings were done quarterly and addressed the care issues of each resident. On 10/06/2016 at 10:08 a.m., Resident #27's record review was completed. Diagnoses included, but were not limited to, contracture of unspecified elbow, muscle weakness, cerebrovascular disease, type 2 Diabetes Mellitus, anxiety, hypertensive heart disease, anxiety, major depressive disorder, and dementia with behavioral disturbance. 3.1-3(n)(3)		scheduled with the family 10/27/16 ***Plan / Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken;*** All residents could be affected ***Facility measures and systemic changes to ensure the deficient practice does not recur;*** 1. Social Service will send out invites letters to families for care conference. A binder will be kept with a copy of the invite that was sent to the family ***Facility plan to monitor corrective actions & sustain compliance; Integrate QA Process;*** Social Service or designee will audit Care Conference 2 invites weekly x4, then monthly x2, then quarterly x2 then will review through QAPI to determine if audit needs to continue	

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			Completion Date(s):11/10/16	
F 0309 SS=D Bldg. 00	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on interview and record review, the facility failed to provide accurate pre/post-dialysis assessments for 1 of 1 dialysis resident reviewed for dialysis (Resident #36). Finding includes: Resident #36's record review was completed on 10/11/16 at 3:04 p.m. Diagnoses included, but were not limited to, end stage renal disease, anemia in chronic kidney disease, hypertensive chronic kidney disease with stage 5 chronic kidney disease, and obstructive sleep apnea. Physician orders, dated October 2016,	F 0309	This plan of correction constitutes the facility's written credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusion set forth on the Statement of Deficiencies. This plan of correction is prepared and/or executed solely because required by the provisions of the health and safety code section 1280 and 42 CFR 483. **Identifying Prefix Tag 309 :** ***Immediate corrective action(s) for those Residents affected by the deficient practice;*** Resident #36 Dialysis form completed going forward ***Plan / Process to identify other***	11/10/2016

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	indicated Dialysis treatments three times a week at 10 a.m. - 3 p.m. on Mondays, Wednesdays, and Fridays. A Dialysis communication binder, located at the nurses station, contained the "Dialysis Care Communication/Coordination" sheets. During an interview on 10/11/16 at 4:24 p.m., the Director of Nursing (DON)indicated the communication sheets were used to communicate important information between the dialysis center and the facility staff. Before dialysis, the form was filled out by facility staff and included vitals signs, any significant changes after the last treatment, any medication changes, diet changes, and falls/incidents. A copy of the resident's facesheet, medication list and this form was sent with the resident to dialysis. The treatment report sections on the form were filled out by dialysis. When the resident returned to the facility the post assessment section was filled out by the facility nurse caring for the resident and included vital signs, reviewing the dialysis report and checking the access site and dressing inspection. During review of the communication forms on 10/11/16 at 4:00 p.m., the		***residents potentially affected by the same deficient practice and corrective action(s) to be taken;*** All residents could be affected ***Facility measures and systemic changes to ensure the deficient practice does not recur;*** 1.Nurses in-serviced on completion of dialysis pre and post op on 11/1-2/2016 by DON 2.Nurses will review dialysis forms are completed for pre and post dialysis ***Facility plan to monitor corrective actions & sustain compliance; Integrate QA Process;*** DON or designee will audit dialysis communications forms for completion weekly x4, then monthly x2, then quarterly x2 then will review through QAPI to determine if audit needs to continue	

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	following were observed for September and October 2016: 1. The form dated 9/2/16, did not contain a pre or post assessment. 2. The form dated 9/5/16, did not contain a pre or post assessment. 3. The form dated 9/7/16, did not contain a pre or post assessment. 4. The form dated 9/16/16, did not contain a post assessment. 5. The form dated 9/26/16, did not contain a post assessment. 6. The form dated 10/3/16, did not contain a post assessment. 7. The form dated 10/516, did not contain a post assessment. 8. The form dated 10/7/16, did not contain a post assessment. During an interview on 10/11/16 at 3:59 p.m., LPN #29 indicated when Resident #36 returned from dialysis, a CNA weighed the resident and the nurse reviewed the dialysis communication form. She indicated Dialysis took his vitals right before he was returned to the floor. He had dialysis on the second floor in this building. LPN #29 stated, "I do not retake his vitals just review the vitals from dialysis. His bruit/thrill is checked every day on every shift at some point during the shift. [Name of Resident] is alert and oriented and can communicate		***Completion Date(s):*** 11/10/16	

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	if something feels wrong." During an interview on 10/11/16 at 4:51 p.m., the Director of Clinical Reimbursement indicated there was not a specific facility policy and procedure related to pre/post dialysis assessments. She indicated the policy was to use the communication form and it was the expectation of the facility for the form to be completed as soon as possible after the return of a dialysis resident. 3.1-37(a)			
F 0312 SS=D Bldg. 00	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, interview and record review, the facility failed to provide nail care and remove facial hair for 2 of 3 residents reviewed for Activities of Daily Living (ADL's). (Residents #27 and #8) Findings include: 1. During an interview with Resident #27's daughter on 10/05/2016 at 3:51	F 0312	This plan of correction constitutes the facility's written credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusion set forth on the Statement of Deficiencies. This plan of correction is prepared and/or executed solely because required by the provisions of the health and safety code section 1280 and 42 CFR 483. **Identifying Prefix Tag 312 :**	11/10/2016

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PYRAMID POINT POST-ACUTE REHABILITATION CENTER	8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260

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	p.m., she indicated the resident often had facial hair present when she came to visit. On 10/05/2016 at 10:57 a.m., Resident #27 was observed to have facial hair present to her chin. On 10/06/2016 at 9:55 a.m., Resident #27 was observed to have chin hair. On 10/06/2016 at 3:22 p.m., Resident #27 was observed to have chin hair. On 10/07/2016 at 9:08 a.m., Resident #27 was observed to have curly chin hair present. On 10/07/2016 at 1:40 p.m., Resident #27 was observed to have curly chin hair present. On 10/11/2016 at 9:46 a.m., Resident #27 was observed to have black debris beneath her nails on both hands. On 10/06/2016 at 10:08 a.m., Resident #27's record review was completed. Diagnoses included, but were not limited to, contracture of unspecified elbow, muscle weakness, cerebrovascular disease, type 2 Diabetes Mellitus, anxiety, hypertensive heart disease, anxiety, major depressive disorder, and dementia with behavioral disturbance.		***Immediate corrective action(s) for those Residents affected by the deficient practice;*** Resident B nails were cleaned and chin was shaved Resident C nails were cleaned ***Plan / Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken;*** All residents can be affected ***Facility measures and systemic changes to ensure the deficient practice does not recur;*** 1.Residents were assessed to ensure nails were clean and facial hair was shaved appropriately 2.Nursing staff in-serviced on nail care and facial hair on 10/13-14/2016 by DON 3.License nurse to observe their residents to ensure nail care and facial hair is being attend to 4. Residents were be observed by IDT quality rounds 5x a week to ensure nail care and facial hair is being addressed ***Facility plan to monitor corrective actions & sustain compliance; Integrate QA Process;*** DON or designee will audit 5 residents nails and facial hair weekly x2, then monthly x2, then	

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	155298	A. BUILDING 00 B. WING	10/11/2016

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	2. On 10/03/2016 at 11:39 a.m., Resident #8 was observed to have long, painted nails with dark debris beneath the nails. On 10/04/2016 at 11:08 a.m., Resident #8 was observed to have long, painted nails with dark debris beneath nails. Facial hairs were present to her chin. On 10/05/2016 at 11:18 a.m., Resident #8 was observed to have long, painted nails with dark debris beneath the nails. Facial hairs were present to her chin. On 10/06/2016 at 3:18 p.m., Resident #8 was observed to have long, painted nails with black debris beneath her nails. 10/06/2016 at 12:15 p.m., . Resident #8 was observed to have long, orange-painted nails with dark debris beneath her nails. On 10/07/2016 at 9:10 a.m., Resident #8 was observed to have long, painted nails with dark debris beneath her nails. On 10/07/2016 at 1:41 p.m., Resident #8 was observed to have dry beige debris on her mouth. Her nails were long, orange-painted nails with dark debris beneath them.		quarterly x2. Will then review through QAPI to determine if audit needs to continue ***Completion Date(s):*** 11/10/16	

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	During an interview on 10/07/2016 at 2:22 p.m., the DON, (Director of Nursing) indicated the females who have chin hair were to asked and if chin hair could be removed on a daily basis and if so then removed by the CNA's. She indicated at the "very least" the female residents with chin hair were to asked on shower days if chin hair could be removed and them completed. During an interview on 10/07/2016 at 2:32 p.m., the DON indicated the residents nails needed "work." She indicated she had instructed the CNA's to soak Resident #8's nails and she would attempt to trim the resident's nails. During an interview on 10/11/2016 at 9:45 a.m., the DON indicated she did not believe the facility had a policy/procedure in regards to a schedule or frequency of nail care or removal of facial hair for female residents. During an interview on 10/11/2016 at 9:46 a.m., CNA #5 indicated resident nail care was done as needed. She indicated there were no specific schedules in regards to nail care or removal of facial hair that she was aware of. 3.1-38(a)(3)(D) 3.1-38(a)(3)(E)			

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F 0318 SS=D Bldg. 00	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Based on interview and record review, the facility failed to provide range of motion services to a resident with a contracture for 1 of 3 residents reviewed for range of motion services (Resident #8). Finding includes: During an interview on 10/04/2016 at 2:42 p.m., the DON (Director of Nursing) indicated Resident #8 had a hand contracture and did not receive range of motion services and did not have a splint in place. During an interview on 10/11/2016 at 11:44 a.m., with the Activity Supervisor indicated the resident attended group exercise and stretch daily. She indicated the resident would stretch her hands,	F 0318	This plan of correction constitutes the facility's written credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusion set forth on the Statement of Deficiencies. This plan of correction is prepared and/or executed solely because required by the provisions of the health and safety code section 1280 and 42 CFR 483. **Identifying Prefix Tag 318 :** ***Immediate corrective action(s) for those Residents affected by the deficient practice;*** Resident C discharged ***Plan / Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken;*** All residents could be affected	11/10/2016

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	arms and legs when instructed. She indicated the resident actively participated in this activity. During an interview on 10/11/2016 at 2:54 p.m., CNA #5 indicated the CNA's tried to do range of motion (ROM) during a.m., care. During an interview on 10/11/2016 at 5:09 p.m., the Director of Clinical Reimbursement indicated the resident did not have a Care Plan for ROM to be performed to the extremities. On 10/07/2016 at 12:01 p.m., the record review was completed for Resident #8. Diagnoses included, but were not limited to, dementia, muscle weakness, contracture of unspecified hand and paraplegia. An IDT (Interdisciplinary Team) note dated 7/13/16 indicated "...Attends exercise. Is unable to follow exercise, but she will count out the reps...." A quarterly MDS (Minimum Data Set) dated 7/13/16, indicated functional limitation in range of motion impairment on both sides of the upper and lower extremities. An IDT note dated 10/7/16 indicated		***Facility measures and systemic changes to ensure the deficient practice does not recur;*** 1.Residents reviewed to ensure ROM and care plans are in place if appropriate 2.Resident reviewed minimally quarter in IDT walking rounds for ROM needs and care plans reviewed ***Facility plan to monitor corrective actions & sustain compliance; Integrate QA Process;*** DON or designee will audit 5 residents for ROM needs and supporting care plan weekly x4, then monthly x2 then quarterly x2, Will then review through QAPI to determine if audit needs to continue. ***Completion Date(s):*** 11/10/16	

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	"...Attends exercise. Is unable to follow exercise, but she will count out the reps...." 3.1-42(a)(2)			
F 0323 SS=D Bldg. 00	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 a 5 point butterfly safety harness was in proper working order to prevent a potential accident for 1 of 1 resident reviewed for accidents (Resident #1). Finding includes: Resident #1's record review was completed on 10/7/16 at 11:31 a.m. Diagnoses included, but were not limited to, Cerebral Palsy, abnormal posture, convulsions, aphasia, and dysphagia. The Physician orders, dated 10/2016, indicated Resident #1 was to wear a five point seatbelt harness at all times when up in the wheelchair. Check every two hours and as needed for positioning.	F 0323	This plan of correction constitutes the facility's written credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusion set forth on the Statement of Deficiencies. This plan of correction is prepared and/or executed solely because required by the provisions of the health and safety code section 1280 and 42 CFR 483. **Identifying Prefix Tag 323 :** ***Immediate corrective action(s) for those Residents affected by the deficient practice;*** Resident #1 harness was replaced ***Plan / Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken;***	11/10/2016

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	Care Plans included, but were not limited to, 1. "At risk for falls and injuries r/t [related/to] pain meds/other medications, medical factors: Incontinence, Seizure disorder, Cognitive Impairment... Interventions: 5 point harness at all times when up in w/c [wheelchair] d/t [due/to] poor trunk control. Check and reposition every 2 hours..." 2. "The resident has potential for pressure ulcer development r/t dehydration, immobility... Interventions: Reposition at least every 2 hours while in bed/chair. Specialized wheel chair with 5 point seat belt to keep hips and trunk in place due to poor trunk control...." On 10/5/16 at 11:52 a.m., Resident #1 was observed sitting up in his wheelchair with five point butterfly harness over to the left side of his chest and the top of it was under his neck. The upper right strap was tied in a slip knot due to the strap was missing a three prong buckle to connect to the adapter in order to hold it into place. On 10/5/16 at 11:56 a.m., RN #4 was asked to look at the resident's butterfly harness and she indicated she did not know if the five point butterfly harness was on the resident appropriately or not. She tried to loosen the right top strap and		All residents can be affected ***Facility measures and systemic changes to ensure the deficient practice does not recur;*** 1.Nursing staff in-serviced 10/13-14/2016 on proper apply harness devices by DON 2.License nurses to observe resident when up to ensure harness is applied properly 3.IDT quarterly will access proper placed of harness ***Facility plan to monitor corrective actions & sustain compliance; Integrate QA Process;*** DON or designee will observe resident up in harness for proper placement weekly x4, then monthly x2 then quarterly x2, Will then review through QAPI to determine if audit needs to continue.	

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	realized it did not have a buckle clasp to hold the strap. She untied the strap and indicated the strap should not have been tied. She tried to readjust the top harness straps, then indicated she needed to get a CNA. She took the right upper strap with the clasp connected and placed it through the other strap, which had a ring on it, then retied the slip knot to attach the straps back together and went to get a CNA. On 10/5/16 at 12:00 p.m., the Regional Director for Therapy, Director of Nursing (DON), and RN #4 came into the small resident activity room. The Regional Director for Therapy indicated she "didn't know anything about this harness and how it should properly be applied to the resident." She indicated she was going to get a Certified Occupational Therapy Assistant (COTA) who was the "expert" on these harnesses to explain how the harness should be properly placed on the resident. On 10/5/16 at 12:03 p.m., COTA #31 arrived to the small resident lounge and indicated she had never seen this type of harness setup before. She indicated if she had to "guess" the proper placement of the harness would be the chest support piece should be directly in the middle of the resident's chest and there should be a		***Completion Date(s):*** 11/10/16	

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	buckle clasp on each strap to connect the straps together. On 10/5/16 at 12:07 p.m., the DON came into the room and indicated she expected the nursing staff to inform their manager when equipment was not in appropriate working order. She indicated it was the facilities responsibility to check the manufacturers guidelines and make sure the harness fit the residents appropriately. She indicated this harness was not appropriate for the resident to use at that time and he was placed back to bed. The DON indicated there would be a new harness shipped in the next 24 hours. On 10/5/16 at 12:09 p.m., CNA #12 indicated she got the resident up that morning with the assistance of the Regional Director of Reimbursement. The CNA indicated she did not fasten any of the straps except for the ones in front. She indicated she did not know how long the right top strap had been without a clasp and tied in a slip knot. On 10/11/16 at 4:45 p.m., the DON indicated she could not locate a policy and procedure regarding inspecting and checking restraints. She indicated the facility had quarterly Interdisciplinary Team Care Plan meetings to discuss the continued need of a restraint and the			

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	equipment was inspected at that time to ensure it was in working order. 3.1-45(a)(2)			
F 0329 SS=D Bldg. 00	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on interview and record review, the facility failed to monitor for side effects for the use of an antidepressant medication and an anticoagulant medication for 2 of 5 residents reviewed for unnecessary medications (Residents	F 0329	This plan of correction constitutes the facility's written credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusion set forth on the Statement of Deficiencies. This plan of correction is prepared and/or executed solely because required by the provisions of the health	11/10/2016

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	#30 and #7). Findings include: 1. During record review on 10/11/16 at 8:35 a.m., Diagnoses included, but were not limited to, heart failure, hypotension, kidney failure, and atrial fibrillation. The Physician orders, dated 10/2016, indicated Resident #30's medications included, but were not limited to, Lasix (a diuretic medication used to remove excess fluid from the body) 20 mg (milligrams) every morning for edema, Celebrex (an non-steroidal anti-inflammatory medication) 100 mg once a day, and Xarelto (an anticoagulant medication used to prevent blood from clotting) 15 mg once every evening for atrial fibrillation. Resident #30's record did not indicate to monitor for side effects of his medications. Care Plans included, but were not limited to, "The resident has Atrial Fibrillation... Interventions/Tasks: Give all cardiac meds as ordered by the physician. Monitor and document side effects. Report Adverse reactions to MD PRN [as needed]. Monitor/document/report PRN any s/sx [signs and symptoms] of CAD [Coronary Artery Disease]: chest pain or pressure especially with activity,		and safety code section 1280 and 42 CFR 483. **Identifying Prefix Tag 329 :** ***Immediate corrective action(s) for those Residents affected by the deficient practice;*** Resident #30 Side effect tracking was started and care plan updated Resident #7 Side effect tracking was started ***Plan / Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken;*** All residents can be affected ***Facility measures and systemic changes to ensure the deficient practice does not recur;*** 1.Audits were conducted to ensure side effect tracking was in place when warranted 2.Nurses in-serviced on 11/1-2/2016 for ensuring side effecting tracking is in place when warranted 3.New orders reviewed Monday through Friday to ensure side effect tracking is started when warranted ***Facility plan to monitor corrective actions & sustain compliance; Integrate QA Process;*** Social Service or designee will	

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	heartburn, nausea and vomiting, shortness of breath, excessive sweating...." A Pharmacy Recommendation, dated 8/31/16, indicated "...rivaroxaban [Xarelto]15 mg daily along with Celecoxib [Celebrex] 100 mg daily...may increase the risk of bleeding...If this therapy is to continue, it is recommended that a) the prescriber document an assessment of risk versus benefit, indicating that it continues to be a valid therapeutic intervention for this individual; and b) the facility interdisciplinary team ensure ongoing monitoring for effectiveness and potential adverse consequences such as unusual bruising, bloody or black tarry stools, red or dark brown urine, abdominal pain or swelling, bleeding from eyes, gums or nose. Any of these symptoms should be reported to the prescriber immediately...Physician's Response: ... I decline the recommendation above...Rationale: benefits outweigh the risks; will monitor for bleeding...." The form was signed and dated by the Physician on 9/2/16. During an interview on 10/11/16 at 11:07 a.m., the Director of Nursing (DON) indicated she was unable to locate a specific place where bleeding or bruising		audit 5 residents charts to ensure side effect tracking is in place when warranted for weekly x4, then monthly x2 then quarterly x2, Will then review through QAPI to determine if audit needs to continue.	

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	were monitored for Resident #30. During an interview on 10/11/16 at 4:47 p.m., the DON indicated she could not locate a policy and procedure related to monitoring for side effects of medications. 2. Resident #7's record was reviewed on 10/6/16 at 10:18 a.m. Diagnoses included, but were not limited to, dementia without behavioral disturbance, psychotic disorder with delusions due to known physiological condition, and cognitive communication deficit. The resident's Medication Administration Record dated October 2016, included, but was not limited to, the following order: 8/9/16--Mirtazapine (a medication used to treat depression) 7.5 mg (milligrams) give one tablet by mouth at bedtime for depression and anxiety. The resident's record lacked documentation of monitoring of side effects of an antidepressant medication. During an interview on 10/11/16 at 12:02 p.m., the SSD (Social Services Director) indicated she would have to check the resident's record for documentation of monitoring for side effects of antidepressants.			

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	During an interview on 10/11/16 at 12:46 p.m., the SSD indicated she could not find any side effects being monitored for antidepressants. 3.1-48(a)(3)			
F 0356 SS=C Bldg. 00	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to			

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	155298	A. BUILDING 00 B. WING	10/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PYRAMID POINT POST-ACUTE REHABILITATION CENTER	8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260

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	exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation and interview, the facility failed to ensure timely posting of the daily nursing staff information for 4 of 6 days observed during the survey. This deficient practice had the potential to affect 34 of 34 residents and visitors. Finding includes: During the initial tour, on 10/3/16 at 9:30 a.m., and various times throughout the day, the nurse staffing information was not located. On 10/4/16, at various times throughout the day, the nurse staffing information was not located. On 10/5/16 at 9:23 a.m., the nurse staffing information was not located. During an interview, at that time, the Human Resources staff member reached behind the receptionist desk and retrieved two plastic sleeves. One plastic sleeve contained a piece of paper titled "Pyramid Point Post-Acute Rehab Center Daily Nurse Staffing" dated 4/18/16. Plastic sleeve number two contained a duplicate sheet of that paper, dated	F 0356	This plan of correction constitutes the facility's written credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusion set forth on the Statement of Deficiencies. This plan of correction is prepared and/or executed solely because required by the provisions of the health and safety code section 1280 and 42 CFR 483. **Identifying Prefix Tag 356 :** ***Immediate corrective action(s) for those Residents affected by the deficient practice;*** Nursing staff data was posted ***Plan / Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken;*** No residents were affected ***Facility measures and systemic changes to ensure the deficient practice does not recur;*** Nursing hours will be posted daily by nursing schedule ***Facility plan to monitor corrective actions & sustain compliance; Integrate QA***	11/10/2016

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	4/19/16. She indicated "the posting should be located around the corner from the desk, on a door, hung by velcro, but the velcro had fell off a while back." She indicated she "did not know the last time it was posted." On 10/9/16 at 1:00 a.m., the Director of Nursing (DON) was informed the Nursing staffing was observed posted upon entrance into the facility on 10/9/16 at 10:42 p.m., dated for 10/8/16. At that time, the DON observed the Nursing staffing posted, dated 10/8/16. She indicated the Nursing staffing posting was dated 10/8/16, and pulled the posting for 10/9/16, from behind the 10/8/16 posting. She indicated there was a facility staff member assigned to assure the Nursing staffing posting was up to date each day.		***Process;*** ED or designee will audit to ensure nursing hours are posted weekly x4, then monthly x2 then quarterly x2, Will then review through QAPI to determine if audit needs to continue. ***Completion Date(s):*** 11/10/16	
F 0371 SS=E Bldg. 00	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions			

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	Based on observation, interview and record review, the facility failed to ensure sanitary plating of food during meal service. This deficient practice had the potential to affect 13 of 31 residents who received food from the kitchen. Finding includes: On 10/03/2016 at 12:20 p.m., the following was observed during lunch meal service: Cook #11 was observed retrieving 13 individual plates from the plate warmer with bare hands. She placed her right thumb in the center of each plate, then placed the noon meal food item in the center of each plate over the area she had previously touched. The Registered Dietician (RD) informed Cook #11 she should use the suction cup located on top of the plate warmer to remove the plates. Cook #11 indicated "I didn't know I needed that." The RD instructed Cook #11 on the use of the suction cup at that time. Cook #11 began to use the suction cup for three plates, then continued to use her bare hands and again placed her right thumb in the center of two plates. Cook #11 stopped herself, at that time and indicated, "it's a habit." Cook #11 discarded the two plates she	F 0371	This plan of correction constitutes the facility's written credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusion set forth on the Statement of Deficiencies. This plan of correction is prepared and/or executed solely because required by the provisions of the health and safety code section 1280 and 42 CFR 483. **Identifying Prefix Tag 371 :** ***Immediate corrective action(s) for those Residents affected by the deficient practice;*** ***1. Dietary manager or designee will in-service dietary staff on proper handling of plates on the tray line. In-service on Policy 604 to be completed on Safe and Food Handling. To be completed by November 4, 2016.*** ***Plan / Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken;*** ***2. RD or designee will complete a tray line audit form on handling dishes in such a way to avoid touching surface for which food will be in contact once a Three times weekly visit for 2 months and then 1 time a month x 3***	11/10/2016

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	had touched in the center of the plate with her thumb. A current policy titled, "Title: SAFE FOOD HANDLING" dated 2/09, provided by the RD on 10/3/16 at 3:57 p.m., indicated, "...PROCEDURE...Preparation. 1. Food should be prepared and served with clean tongs, scoops, forks, spoons, spatulas, or other suitable implements to avoid manual contact of prepared foods...11. Utensils, cups, glasses and dishes must be handled in such a way as to avoid touching surfaces for which food or drink will come in contact...." 3.1-21(i)(3)		***months.*** ***Facility measures and systemic changes to ensure the deficient practice does not recur;*** ***3. If corrective action needs to be taken on each tray line audit for the first month then continued in-servicing will be taken after the first month of audits.*** ***Facility plan to monitor corrective actions & sustain compliance; Integrate QA Process;*** ***4. Observation audit forms will be kept on file in the Dietary Office and reviewed at monthly QAPI/ QA meetings to be kept in binder.***	

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			Completion Date(s): 11/10/16	
F 0441 SS=D Bldg. 00	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact			

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	for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview and record review, the facility failed to ensure a resident's room was cleaned in a sanitary manner preventing cross contamination (Residents #19 and #33) for 2 residents randomly observed for infection control. Findings include: 1. After being summoned to Resident #19 and #33's room on 10/03/2016 at 1:20 p.m., by housekeeper #28, she called attention to a large amount of a dried beige substance on the floor, IV pole, wall and the feeding pump adjacent to Resident #19's bed. Without donning gloves, she was observed to retrieve a white, plastic holder that contained a white toilet bowl brush and a white bottle with blue lettering from the housekeeping cart, at the door of the residents' room and brought it into the room. She identified the substance in the bottle as toilet bowl cleaner. She squirted a blue liquid from the bottle onto the wall, IV pole base and floor	F 0441	This plan of correction constitutes the facility's written credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusion set forth on the Statement of Deficiencies. This plan of correction is prepared and/or executed solely because required by the provisions of the health and safety code section 1280 and 42 CFR 483. **Identifying Prefix Tag 441 :** ***Immediate corrective action(s) for those Residents affected by the deficient practice;*** 1.Resident #19,33 rooms were immediately deep cleaned 2.Resident #9 received a Chest x-ray 3.Staff members were given new mantoux ***Plan / Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken;*** All residents can be affected ***Facility measures and systemic changes to ensure the deficient practice does not recur;***	11/10/2016

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	adjacent to Resident #19's bed. She removed the toilet bowl brush from the holder and began to scrub the wall, followed by the IV pole base and finally the floor with the brush. She indicated the solution was the "only thing" that would remove the dried beige substance. She identified the beige substance as Resident #19's tube feeding. She placed the toilet bowl brush and toilet bowl cleaner into the holder and placed it back on the housekeeping cart and retrieved a white wash cloth. She returned to the residents' room and without using gloves, she used a white wash cloth to wipe the wall beside Resident #19's bed, swiped across the floor and baseboard, scrubbed the IV pole base, followed by wiping the top of the over-bed table of Resident #19. Using the same washcloth she wiped Resident #33's over-bed table again, then wiped the top of Resident #19's over-bed table and scrubbed the Kangaroo feeding pump of Resident #19. A current policy titled, "Title; Resident Room and Bathroom Cleaning" dated 8/14, provided by the Executive Director on 10/11/16 at 6:03 p.m., indicated, "...Supplies Quaternary disinfectant cleaner. General purpose cleaner. Window cleaner. Tile/tub		1.Housekeeping was educated on 10/3/16 by supervisor 2.Housekeepers were in-service on proper way to clean a room on 10/19/16 House keeping supervisor 3.Nurses were in-serviced on mantoux process on 11/1-2/2016 by DON 4.RN #4 was in-serviced on 9/28/16 proper process of mantoux by DON Nurse will be certified on giving mantoux by 12/1/16 ***Facility plan to monitor corrective actions & sustain compliance; Integrate QA Process;*** Housekeeping supervisor will audit 1 housekeeper for proper cleaning of residents room weekly x4, then monthly x2 then quarterly x2, Will then review through QAPI to determine if audit needs to continue. DON or designee will audit 5 residents and 5 staff members to ensure proper staff members have given and read mantoux weekly x4, then monthly x2 then quarterly x2, Will then review through QAPI to determine if audit needs to continue. IDR-American Lung Association certified staff member to give TB's, per regulations licensed personnel able to give TB's our staff member was certified by the	

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	cleaner...Procedure 1. Fill spray bottle with quaternary disinfectant for room cleaning...7. With a clean cloth and spray bottle of disinfectant solution: a. Damp dust...all areas higher than the resident's bed...8. Check walls and spot wash as needed. Dried soil may need to be sprayed with diluted general purpose cleaner and allowed to stand before removing...11. Wipe off the fixtures with a damp cloth using the brush and general purpose cleaner to remove any residue as needed. General purpose cleaner should be used on any stains in the basin not previously removed by wiping with disinfectant solution...." 3.1-18(b)(1)		American Lung Association. Per Room cleaning only one room affected. ***Completion Date(s):*** 11/10/16	
F 0463 SS=D Bldg. 00	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. Based on observation and interview, the facility failed to ensure a call light system was functioning properly to alert staff a resident required assistance for 1 of 19 residents on the 3 South hallway (Resident #21).	F 0463	This plan of correction constitutes the facility's written credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusion set forth on the Statement of Deficiencies. This plan of correction is prepared and/or executed solely because	11/10/2016

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	Finding includes: During an observation on 10/4/16 at 11:09 a.m., Resident #21's call light was pressed three times and it did not function on any of the three attempts. CNA #30 indicated the resident's call light should work and the white dome light outside of the resident's room, in the hallway should light up and it should alarm at the nurses station. When CNA #30 pressed the resident's call light button the white dome light outside of the her room in the hallway did not light up. CNA #30 pulled on the gray cord attached to the resident's call light, which was stuck between the resident's night stand and the wall, so she pulled it out. She pushed the resident's call light again and the white dome light outside her room lit up. CNA #30 indicated the resident's call light was pinched between the wall and her night stand and that was the reason it did not function properly. 3.1-19(u)(1)		required by the provisions of the health and safety code section 1280 and 42 CFR 483. **Identifying Prefix Tag 463 :** ***Immediate corrective action(s) for those Residents affected by the deficient practice;*** Resident #21 call light was moved with in reach ***Plan / Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken;*** All residents can be affected ***Facility measures and systemic changes to ensure the deficient practice does not recur;*** 10/4/16 facility audit was done to ensure all residents had call lights and they were in reach Nursing staff in-serviced on 10/13-14/2016 by DON on ensuring residents call lights are in reach when residents are in their rooms Quality rounds are done 5x a week by IDT to ensure call lights are in reach ***Facility plan to monitor corrective actions & sustain compliance; Integrate QA Process;*** *DON or designee will do random audits of 10 residents a week to*	

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			*ensure call lights are in place x4 weeks then monthly x2 then quarterly x2 then**will review through QAPI to determine if audit needs to continue***	
F 0496 SS=E Bldg. 00	483.75(e)(5)-(7) NURSE AIDE REGISTRY VERIFICATION, RETRAINING Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or the individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must			

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	complete a new training and competency evaluation program or a new competency evaluation program. Based on interview and record review, the facility failed to ensure a nursing assistant in the facility had the necessary certification to work with residents (NA #1) . This deficient practice affected up to 13 residents the CNA was assigned to care for, while working 26 of 369 available shifts since the CNA's certification expired. Finding includes: The employee documentation for the certified nursing assistants were reviewed on 10/11/16 at 10:00 a.m. An "Indiana Online Licensing" document dated 8/31/15, indicated NA #1's Certified Nurse Aide license was expired on 5/9/2016. During an interview on 10/11/16 at 12:49 pm., the Human Resources (HR) staff member with the Executive Director (ED) in attendance indicated she was responsible for getting the CNA's certifications renewed. She indicated NA #1 was currently employed by the facility and her CNA certification had expired on 5/9/16. She indicated she renewed it today. A copy of her schedules from	F 0496	This plan of correction constitutes the facility's written credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusion set forth on the Statement of Deficiencies. This plan of correction is prepared and/or executed solely because required by the provisions of the health and safety code section 1280 and 42 CFR 483. **Identifying Prefix Tag 496 :** ***Immediate corrective action(s) for those Residents affected by the deficient practice;*** C.N.A certification was updated ***Plan / Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken;*** No other staff members had expired certifications ***Facility measures and systemic changes to ensure the deficient practice does not recur;*** Reviewed to ensure all C.N,A have current certification All staff with certification/license were enter in to smart links for tracking ***Facility plan to monitor***	11/10/2016

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	5/9/16 was requested from the ED. NA #1 worked the following dates providing care to residents in the facility when her certification was expired: May 2016: 5/10/16, 5/12/16, 5/16/16, 5/18/16, 5/21/16, 5/24/16, 5/30/16 June 2016: 6/4/16, 6/5/16, 6/7/16, 6/14/16, 6/18/16, 6/23/16, 6/27/16, 6/28/16, July 2016: 7/2/16, 7/3/16, 7/5/16, 7/7/16, 7/11/16, 7/13/16, 7/18/16, 7/24/16, 7/25/16, 7/26/16, August 2016: 8/1/16 During an interview on 10/11/16 at 2:31 p.m., the ED indicated he looked on the time clock ins on the computer to determine when NA #1 worked since 5/9/16, and highlighted those shifts on the schedules, which he provided. 3.1-14(e)		***corrective actions & sustain compliance; Integrate QA Process;*** ED or Designee will audit 5 staff members for current certifications weekly x4, then monthly x2 then quarterly x2, Will then review through QAPI to determine if audit needs to continue. IDR request as CNA worked a regular schedule and regular wing/hall from May-Aug. This did not effect all 34 residents on the floor as she cared for 8//9 residents that was consistent ***Completion Date(s):*** 11/10/16	
F 0514	483.75(l)(1)			

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	155298	A. BUILDING 00 B. WING	10/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PYRAMID POINT POST-ACUTE REHABILITATION CENTER	8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
SS=D Bldg. 00	RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on interview and record review, the facility failed to ensure the documentation for an Annual Mantoux PPD (Purified Protein Derivative) test was accurate for 1 of 20 resident records reviewed for accurate documentation (Resident #9). Finding includes: An "Indiana State Department of Health Survey Report System" document dated 10/5/16, indicated a Mantoux PPD test was administered to Resident #9 on 9/28/16, by the Human Resource staff member (HR) while RN #4 observed the HR staff member administering the injection. A Medication Administration Record (MAR) dated September 2016, indicated	F 0514	This plan of correction constitutes the facility's written credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusion set forth on the Statement of Deficiencies. This plan of correction is prepared and/or executed solely because required by the provisions of the health and safety code section 1280 and 42 CFR 483. **Identifying Prefix Tag 514 :** ***Immediate corrective action(s) for those Residents affected by the deficient practice;*** Resident received chest xray ***Plan / Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken;*** No other residents affected	11/10/2016

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	Resident #9 received his Annual Mantoux PPD test on 9/28/16, in the right arm and RN #4's initials were in the documentation box on the MAR. During an interview on 10/11/2016 at 8:52 a.m., the HR staff member indicated in September 2016, when she administered Resident #9's Mantoux PPD test she was the only person in the facility certified to give Mantoux PPD tests. She indicated the nurses' certifications had expired and she administered the PPD test to Resident #9 with RN #4 observing her. During an interview on 10/11/16 at 4:30 p.m., RN #4 indicated in a phone interview she watched the HR staff member administer the Mantoux PPD test to Resident #9 because she was not certified to administer the test. She indicated she initialed the resident's MAR as if she administered the injection to him when she did not. RN #4 indicated the check mark on the MAR indicated the medication was administered. She indicated she was instructed by RN #27 to watch the injection be administered by the HR staff member, then sign if off on the MAR to indicate the PPD test was given. 3.1-50(a)(2)		***Facility measures and systemic changes to ensure the deficient practice does not recur;*** .1.Nurses were in-serviced on mantoux process on 11/1-2/2016 by DON .2.RN #4 was in-serviced on 9/29/16 proper process of mantoux by DON 3.Nurse will be certified on giving mantoux by 12/1/16 ***Facility plan to monitor corrective actions & sustain compliance; Integrate QA Process;*** DON or designee will audit 5 residents to ensure proper staff members have given and read mantoux weekly x4, then monthly x2 then quarterly x2, Will then review through QAPI to determine if audit needs to continue.	

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F 9999 Bldg. 00	3.1-14 Personnel (u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This State rule is not met as evidenced by: Based on interview and record review, the facility failed to provide 3 hour Dementia training for 1 of 5 employees reviewed for annual Dementia training (Cook #11).	F 9999	***Completion Date(s):*** 11/10/16 This plan of correction constitutes the facility's written credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusion set forth on the Statement of Deficiencies. This plan of correction is prepared and/or executed solely because required by the provisions of the health and safety code section 1280 and 42 CFR 483. **Identifying Prefix Tag F9999 :** ***Immediate corrective action(s) for those Residents affected by the deficient practice;*** Employee received annual Dementia Training ***Plan / Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken;*** No other residents affected ***Facility measures and systemic changes to ensure the deficient practice does not recur;*** Employee completed annual	11/10/2016

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	Finding includes: On 10/11/16 at 10:00 a.m., the employee records were reviewed. Cook #11 had her dementia training completed on 10/8/16, but her last dementia training documented was 11/13/12. During an interview on 10/11/16 at 10:50 a.m., the Human Resources staff member indicated she did not have any further dementia training for Cook #11. She indicated Cook #11 transferred from another facility in the corporation and she was out of compliance when she came to this facility. She indicated she completed Cook #11's dementia training as soon as she realized Cook #11 was out of compliance. 3.1-14 Personnel (p) Initial orientation of all staff must be conducted and documented and shall include the following: (1) instructions on the needs of the specialized populations served in the facility, for example: (A) aged, (B) developmentally disabled; (C) mentally ill; (D) children; or		Dementia Training, Audit of all personnel files to ensure all employees received Annual Dementia Training. ***Facility plan to monitor corrective actions & sustain compliance; Integrate QA Process;*** HR/Payroll or designee will audit 5 Personnel files for annual Dementia related training weekly x4, then monthly x2 then quarterly x2, Will then review through QAPI to determine if audit needs to continue. ***Completion Date(s):*** 11/10/16	

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	(E) care of cognitively impaired, residents. (2) A review of residents' rights and other pertinent portions of the facility's policy manual. (3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures and universal precautions. (4) A detailed review of the appropriate job description including a demonstration of equipment and procedures required of the specific position to which the employee with be assigned. (5) Review of ethical considerations and confidentiality in resident care and records. (6) For direct care staff, instruction in the particular needs of each resident to whom the employee will be providing care. This State rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure new employees' specific orientations were completed for 5 of 5 employees (RN #4, LPN #10, CNA #3, CNA #5 and Housekeeper #7). Findings include: The employee records were reviewed on			

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	10/11/16 at 10:00 a.m., and the following employees lacked job specific orientation documentation in their employee records: a. RN #4 was hired on 7/26/16. b. LPN #10 was hired on 8/3/16. c. CNA #3 was hired on 8/30/16. d. CNA #5 was hired on 8/2/16. e. Housekeeper #7 was hired on 9/6/16. During an interview on 10/11/16 at 12:49 p.m., the Human Resources staff member with the Executive Director in attendance, the Human Resources staff member indicated the job descriptions, which were blank, in the employees records were the same as the job specific orientation check off lists. The Executive Director indicated there had to be a job specific orientation checklist in each employee file for each job title. The Human Resources staff member indicated she did not realize there had to be a job specific checklist for each job title in each employee file. 3.1-18 Infection Control (h) All skin testing for tuberculosis shall be done using the Mantoux method (5TU			

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	PPD) administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading and recording. This State Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure Tuberculosis testing was administered and read by a licensed, Tuberculosis certified staff member affecting 1 of 1 residents and 24 of 24 employees reviewed for Tuberculosis testing. (Resident #9 and Staff Members RN #4, LPN #10, LPN #20, CNA #12, CNA #14, CNA #17, CNA #3, CNA #22, CNA #5, Dietary Aide #18, Housekeeper #7, Executive Director, CNA #2, CNA #13, CNA #15, CNA #16, CNA #21, CNA #24, Dietary Aide #6, Janitor/Floor Technician #23, Laundry staff member #8 and Laundry staff member #19, Receptionist # 25, CNA #9). This deficient practice had the potential to affect 34 of 34 residents residing in the facility. An "Indiana State Department of Health Survey Report System" document dated 10/5/16, indicated a Mantoux PPD (Purified Protein Derivative) test was administered to Resident #9 on 9/28/16,			

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	by the Human Resources staff member (HR) while RN #4 observed the HR staff member administering the injection. A Medication Administration Record (MAR) dated September 2016, indicated Resident #9 received his Annual Mantoux PPD test on 9/28/16, in the right arm and RN #4's initials were in the documentation box on the MAR indicating he received the Mantoux test. During an interview on 10/05/2016 at 4:10 p.m., the Director of Operations indicated he contacted the ISDH (Indiana State Department of Health) office regarding whether a non-licensed staff member who was certified to give Mantoux PPD tests by the American Lung Association was permitted to give the injection in a Long Term Care (LTC) Facility. He indicated he was informed by the ISDH office a licensed nurse must administer the Mantoux PPD tests in the LTC facilities. During an interview on 10/11/2016 at 8:52 a.m., the HR staff member indicated in September 2016, when she administered Resident #9's Mantoux PPD test she was the only person in the facility certified to give Mantoux PPD tests. She indicated the nurses' certifications had expired and she administered the PPD			

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	test to Resident #9 with RN #4 observing her. The HR staff member indicated she did not realize she was not allowed to administer the PPD test to residents or employees. She indicated she had given PPD tests to approximately 50 new and current employees, since she was certified in January 2016. On 10/11/16 at 10:00 a.m., the employee records were reviewed. a. The following new employees were given a PPD test or their PPD test was read by the HR staff member, who had a Tuberculosis PPD certification, but was not a licensed nurse. 1. RN #4 was hired on 7/26/16, and her second step PPD test was given on 7/22/16, and read on 7/25/16. 2. LPN #10 was hired on 8/3/16, and her second step PPD test was given on 7/25/16, and read on 7/27/16. 3. LPN #20 was hired on 6/28/16, and her first step PPD test was read on 6/23/16, and her second step PPD test was given on 7/13/16, and read on 7/15/16. 4. CNA #12 was hired on 8/2/16, and her first step PPD test was given 7/26/16, and read on 7/28/16, and her second step PPD			

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	test was read on 8/19/16. 5. CNA #14 was hired on 8/30/16, and her first step PPD test was read on 8/25/16, and her second step PPD test was given on 9/6/16, and read on 9/9/16. 6. CNA #17 was hired on 9/15/16, and her first step PPD test was read on 9/15/16, and her second step PPD test was given on 9/27/16, and read on 9/29/16. 7. CNA #3 was hired on 8/30/16, and her first step PPD test was given on 8/24/16 and read on 8/26/16. 8. CNA #22 was hired on 8/30/16, and her first step PPD test was given on 8/24/16, and read on 8/26/16, and her second step PPD test was read on 9/19/16. 9. CNA #5 was hired on 8/2/16, and her first step PPD test was read on 8/1/16, and her second step PPD test was read on 8/19/16. 10. Dietary Aide #18 was hired on 4/21/16, and his first step PPD test was read on 4/21/16. 11. Housekeeper #7 was hired on 9/16/16, and his second step PPD test			

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	was read on 9/15/16. 12. The Executive Director was hired on 8/29/16, and his first step PPD test was given on 8/29/16, and read on 9/1/16, and his second step PPD test was given on 9/14/16, and read on 9/16/16. b. The following employees were given an annual PPD test or their PPD test was read by the HR staff member, who had a Tuberculosis PPD certification, but was not a licence nurse. 1. CNA #2 was given her PPD test on 5/16/16, and read on 5/18/16. 2. CNA #13 was given her PPD test on 8/5/16, and read on 8/8/16. 3. CNA #15 was given her PPD test on 5/18/16, and read on 5/20/16. 4. CNA #16 was given her PPD test on 9/23/16, and read on 9/26/16. 5. CNA #21 was given her PPD test on 7/8/16, and read on 7/11/16. 6. CNA #24's PPD test was read on 7/22/16. 7. Dietary Aide #6 was given his PPD test on 5/18/16, and read on 5/21/16.			

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	8. Janitor/Floor Technician #23 was given his PPD test on 7/11/16, and read on 7/13/16. 9. Laundry staff member #8's PPD test was read on 9/9/16. 10. Laundry staff member #19 was given her PPD test on 5/24/16, and read on 5/26/16. 11. Receptionist #25 was given her PPD test on 5/6/16, and read on 5/8/16. 12. CNA #9 was given her PPD test on 5/17/16, and read on 5/19/16. During an interview on 10/11/16 at 12:49 p.m., the HR staff member with the Executive Director in attendance indicated she did not have any other PPD tests for the employees with the first step, second step or annual PPD tests, which she had given and read. During an interview on 10/11/16 at 4:30 p.m., RN #4 indicated in a phone interview she watched the HR staff member administer the Mantoux PPD test to Resident #9 because she was not certified to administer the test. She indicated she was instructed by RN #27 to watch the injection be administered by the HR staff member.			

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