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	04/18/2016

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 the Recertification and State Licensure Survey. Survey dates: April 11, 12, 13, 14, 15 and 18, 2016. Facility number: 000195 Provider number: 155298 AIM number: 100267690 Census bed type: SNF/NF: 33 Total : 33 Census payor type: Medicare: 2 Medicaid: 30 Other: 1 Total: 33 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed by 14454 on April 26, 2015.	F 0000	This plan of correction is thefacility's credible allegation ofcompliance. Preparation and/orexecution of this plan ofcorrections does not constituteadmission or agreement by theprovider of the truth of the factsalleged or conclusions set forth inthe statement of deficiencies. Theplan of correction is preparedand/or executed soley because itis required by the provisions offederal and state law.	
F 0157 SS=D	483.10(b)(11) NOTIFY OF CHANGES			

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

Any defiencystatement 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.

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	04/18/2016

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
Bldg. 00	(INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on observation, interview and record review, the facility failed to notify a resident's Physician in a timely manner regarding a significant weight loss for 1 of 30 residents being reviewed for Physicians being notified of condition changes (Resident #23).	F 0157	F157 1. Resident #23 family and MD were notified of the weight loss. Resident # 23 was placed on hospice care on 4-22-16. 2. No other residents were affected. Significant weight loss will	05/13/2016

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	04/18/2016

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
	Finding includes: Resident #23's record was reviewed on 4/15/16 at 9:56 a.m. Diagnoses included, but were not limited to, diabetes mellitus type 2, hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side, dysphagia, and major depressive disorder. The resident's weights for the last 180 days were as follows: 10/2/15--126 pounds 11/11/15-126 pounds 12/11/15--121 pounds 1/4/16--125 pounds 2/5/16--130 pounds 3/3/16--128 pounds 4/7/16--117 pounds 4/8/16--117 pounds A Dietary progress note, dated 4/12/16, indicated "Resident's weight [on] 4/8/16 [was] 116.6 lbs [pounds], which was down 8.9% [percent] x [times] 30 days and 10.6% x 180 days, triggered a significant weight loss > [greater than] 5% x 30 days and >10% x 180 days. Resident is on a soft diet due to dysphagia [difficulty swallowing] and consumes 25-100% most meals. She enjoys Danishes and cinnamon rolls.		be reported timely to the MD and Family if this occurs. 3. Weights will be reviewed by the clinical team timely and assure MD and family are notified. DON or designee will verify weight documentation is complete and verified on the monthly and weekly weight logs. Nurse consultant reviewed weight policy with clinical team on 4-15-16. 4. DON or designee will report to the QA Committee monthly of any untimely weight notifications until 3 months of 90% or greater is achieved.	

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	04/18/2016

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
	Started health shakes 120 ml [milliliter] BID [two times a day] few days ago. On Lasix [diuretic medication] may see weight fluctuations. Resident was unable to answer questions and kept stating she wanted out of here. She is able to say she drinks the shakes. May suggest health shakes with meals to provide 600 extra calories. estimated nutrition needs at 1325-1590 calories per day, protein 53 g [grams]/day, fluid at 1484-1590 ml/day...." A Change of Condition progress note, dated 4/13/16 at 12:40 p.m., indicated, "...the resident is experiencing a change of condition weight loss. MD [physician] notified...." During an interview on 4/15/16 at 1:00 p.m., the Director of Nursing (DON), with the Regional Director of Clinical Operations (RDCO)in attendance, indicated the Physician was notified of the weight loss on 4/13/16, when the SBAR (Situation, Background, Assessment and Review and Notify) was filled out because she wanted to wait for the Registered Dietician (RD) to assess the resident and determine what interventions needed put into place before she notified the Physician. During an interview on 4/15/16 at 3:57			

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	04/18/2016

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
	p.m., the DON, with the RDCO in attendance, indicated she had to do her report on 4/9/16, for the month and she notified the RD she had three actual weight losses for the month of April. She indicated she notified the RD she needed her to come to the facility and assess the three residents with the weight losses to assess them for interventions. The DON indicated she did not complete the SBAR or the Change in Condition Assessment the day the weight loss was discovered on 4/8/16, because she was waiting until the RD seen the resident's on 4/12/16. She indicated the Physician was notified once the SBAR or Interact change or Condition assessment was completed. The DON indicated she had planned to completed the SBAR on 4/11/16, then wait until the RD came in on 4/12/16, and gave her recommendations to notify the Physician to get orders for Resident #23 for her weight loss, but ISDH (Indiana State Department of Health) entered the facility for a survey and she forgot about completing the three SBAR's. She indicated she realized she had not completed the SBAR's on 4/13/16 and she asked RN #3 to complete the SBAR's and notify the Physicians and families. A current policy titled "Condition Change of the Resident (observing,			

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	04/18/2016

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
	recording and reporting)," undated, provided by the Regional Director of Clinical Operations on 4/15/16 at 3:50 p.m., indicated "...PURPOSE: To observe, record and report any condition change to the attending physician so proper treatment will be implemented...PROCEDURE:.. 4. Assess the resident and notify the attending physician of the resident's condition Compare the residents' current condition to his or her prior level of function...7. Notify resident's responsible party...." 3.1-5(a)(2)			
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, mental, and psychosocial well-being as			

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	04/18/2016

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
	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 observation, interview and record review, the facility failed to have a plan of care developed for a resident with contractures to her upper extremities for 1 of 30 residents reviewed for plans of care (Resident #27). Finding includes: During a staff interview on 4/12/16 at 10:52 a.m., RN (Registered Nurse) #6 indicated Resident #27 had a contracture of her right arm and she did not receive range of motion (ROM) services or have a splint device in place. On 4/13/16 at 10:14 a.m., the resident was observed in the small activity lounge with the TV playing and she did not have a splint on her right arm, which was bent up in a flexed position at the elbow. On 4/14/16 at 10:03 a.m., the resident was sitting in the small activity room with her eyes closed and she did not have a splint on her right arm, which was bent up in a flexed position at the elbow. On 4/14/16 at 1:35 p.m., CNA (Certified	F 0279	F279 1. Resident # 27 refuses ROM other than the slight PROM received during bathing and dressing. Resident # 27 care plan was updated to reflect the resident's wishes. 2. No other residents were affected. If any other residents are admitted or identified their care plans will be updated to reflect the residents wishes. 3. Licensed nursing staff was inserviced on 5/9/16 regarding care plans. At the time of admission or significant change, DON or designee will initiate, review, and update care plans. Care plans will be monitored on a quarterly basis by MDS coordinator or designee. CNA assignment sheets will be updated with current care plan information as needed by DON or designee 4. Care plans for any other residents who refuse ROM will be updated at the time residents inform staff of their wishes. Care plans will be reviewed quarterly to assure residents with contractures are receiving the care they desire and will be documented by the MDSC. Care plan information is placed on the c.n.a. assignment sheet and the c.n.a.'s document care in the resident's record. Clinical	05/13/2016

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	04/18/2016

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
	Nursing Assistant) #4 was observed attempting to straighten out Resident #6's right arm and it would not straighten out. She indicated at that time the resident's right arm could not be straightened out. She indicated the resident did not have a splint nor was she getting ROM to her right arm as far as she knew because the Restorative program was stopped about two to three weeks ago. Resident #6's record was reviewed on 4/15/16 at 1:21 p.m. Diagnoses included, but were not limited to, abnormal posture and contracture. A quarterly MDS (Minimum Data Set) assessment, dated 3/21/16, indicated the resident had a functional limitation in ROM to the upper and lower extremity to one side. The resident's record lacked a Care Plan indicating she had contractures of her upper extremities. During an interview on 4/18/16 at 11:34 a.m., the Regional Director of Clinical Operations (RDCO) indicated Resident #27 did not have a Care Plan to address the contractures of the upper extremities. During an interview on 4/18/16 at 11:44 a.m., the Director of Nursing indicated		team will report monthly any resident's refusal of ROM and care plan match. Findings will be reported to the QA Committee monthly until 3 months of 90% or greater is achieved.	

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	04/18/2016

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
	the right arm was bent at the elbow and could not be straightened out and the resident's left arm was straight and could not be bent or raised very high, which is the arm she had the most pain. She indicated the resident could not raise either arm. 3.1-35(a)			
F 0311 SS=D Bldg. 00	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. Based on observation, interview and record review, the facility failed to assist a resident with poor vision to cut up the food on her plate for 1 of 4 residents being observed for ADL's (Activities of Daily Living) (Resident #6). Finding includes: On 4/11/16 at 12:36 p.m., Resident #6 was observed at lunch with her plate in front of her. She had a solid piece of fish she was trying to cut with a fork and she	F 0311	F311 1. Residents # 6 food is cut up or given finger foods for independence. Resident #6 has limited vision but requires only set up asst. 2. No other residents were affected. If residents would decline or be admitted, they will be assessed for the level of assistance required by the clinical team. 3. If any residents are observed to be needing assistance the charge nurse will assist or direct staff to assist the resident then report it to the clinical team using the dinning room monitoring tool. All nursing	05/13/2016

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	04/18/2016

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
	indicated she was having trouble with her teeth. Resident #6 had her fork and was pulling at the piece of fish trying to tear pieces of the fish off to eat. The resident was observed to have poor vision as heard staff explain to the resident where the food was on her plate, but no staff member cut the solid piece of fish for the resident. Resident #33 was sitting next to her and he indicated the piece of fish was too big and needed to be cut up for Resident #6. The resident had only eaten one-fourth of the piece of fish in front of her when she left the dining room. On 4/15/16 at 8:39 a.m., RN (Registered Nurse) #11 was observed transporting Resident #6 to the dining room in her wheelchair. While transporting her into the dining room, the resident indicated "I can't see." RN #11 indicated to the resident she knew she could not see, but she was going to get her breakfast for her. At that time, the resident grabbed RN #11 hands and she was trembling, asking the nurse not to leave her and repeating to the nurse she could not see. The nurse squatted down to eye level with the resident and talked to her and the resident indicated to the nurse when RN #11 told Resident #6 she was going to get her breakfast. On 4/15/16 at 8:43 a.m., RN #11		staff was in-serviced regarding assisting residents with meals and reporting changes to DON or designee. 4. The clinical team will do random dinning room observations weekly until 90% or greater is achieved times three audits. The clinical team will report any findings to the QA Committee monthly until 90% or greater is achieved for three months.	

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	04/18/2016

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
	delivered her tray and the resident indicated she could not see. RN #11 told her she had french toast, cinnamon apples and scramble eggs on her tray to eat, while uncovering her plate and pouring syrup on her french toast, but she did not cut the french toast up for the resident. She handed the resident her silverware. After RN #11 left, the resident started eating and she tore pieces of the french toast off the whole piece of Texas toast with syrup on it piece by piece to eat it. The resident left 2 pieces of the crust of the french toast on her plate. Resident #6's record was reviewed on 4/18/16 at 9:22 a.m. Diagnoses included, but were not limited to, difficulty in walking, anxiety disorder, glaucoma and cognitive communication deficit. A quarterly MDS (Minimum Data Set) assessment, dated 2/10/16, indicated the resident required limited assist with one person physical assist for eating. The resident had a Care Plan, dated 5/26/15, which addressed the problem she had a self-care deficit as evidenced by: needs extensive assistance with ADL'S of one staff related to CV (Cerebrovascular Accident) and weakness. Interventions included, "...5/26/15--Eating--Setup help			

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	04/18/2016

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
	only/Cueing required...." The resident had a Care Plan, dated 5/27/15, which addressed the problem related to hearing deficit. Interventions included, "5/27/15--Anticipate and meet needs, Be conscious of resident position when in groups, activities, dining room to promote proper communication with others, COMMUNICATION: Allow adequate time to respond. Repeat as necessary, Do not rush, Request clarification from the resident to ensure understand. Face when speaking, make Ask yes/no questions if appropriate, Use simple, brief, consistent words/cues, Use alternative communication tools as needed. Discuss with resident/family concerns or feelings regarding communication difficulty, Ensure hearing aid (left) is in place, Ensure/provide a safe environment... Avoid isolation... Monitor/document for physical /nonverbal indicators of discomfort or distress and follow-up as needed...." The resident had a Care Plan, dated 8/12/15, which addressed the behavior she exhibited increased paranoia and refused meals and medications as she thought she was being poisoned, she would hide and/or spit out her meds, hallucinations where she saw things not here per family history being			

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	04/18/2016

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
	germaphobic. Interventions included, "6/30/15--Allow resident to express her feelings. Provide reassurance and validate her feelings, Anticipate and meet the resident's needs, Caregivers to provide opportunity for positive interaction, attention. Stop and talk with him/her as passing by, Explain all procedures to the resident before starting and allow the resident time to adjust to changes...." An Optometry Exam report, dated 3/22/16, indicated, "...Presenting problem/Chief Complaint evaluated: Blurry vision in both eyes...Quality-Blur, Timing-Constantly, Location Both eyes, Severity-Mild Duration-Always... Diagnosis: Primary Open-angle Glaucoma, Moderate Stage...Glasses Plan: No new glasses and Will not improve vision." The resident had a Care Plan, dated 5/26/15 and revised on 4/14/16, which addressed the problem she had anxiety exhibited by nervousness, repetitive questions, grabbing onto others arms or wheelchairs, attention seeking. She would repeatedly say, 'i can't see, I need help" or "Help me I can't see". Interventions included, "...6/30/15--Provide calm, quiet environment & [and] approach, 5/27/15--Provide explanations prior to implementing care			

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	04/18/2016

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
	or procedures, Provide reassurance...." During an interview on 4/18/16 at 11:50 a.m., RN #11 indicated she would expect the staff to setup Resident #6's tray, which meant salt and pepper her food, tell her where her food was, hand her the silverware and cut up her food. She indicated she was capable of doing it, but with her behaviors of saying "I can't see I can't see" she will not do it. 3.1-38(a)(2)(D)			
F 0315 SS=D Bldg. 00	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on interview and record review, the facility failed to prevent the possibility and actual infection for 1 of 1 residents reviewed for anchored catheter	F 0315	F315 1. Resident #24 catheter drainage bag was replaced on 4-13-16. 2. No other residents were	05/13/2016

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	04/18/2016

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
	placement (Resident #24). Finding includes: On 4/13/16 at 10:14 a.m., CNA (Certified Nursing Assistant) #10 and CNA #12 transferred Resident #24 from her bed to her wheelchair. CNA #10 and CNA #12 took the stand up lift sling and placed it around the resident's mid back area and the resident's waist. CNA #12 took the Foley catheter bag out of the dignity bag and laid it on the bed as there was no hook on the drainage bag to attach to anything. The resident placed her hands on the handles and CNA #10 took the remote and pushed the button lifting the resident up off of the bed. As the resident was being lifted up, the foley drainage bag was dropped on the floor before they transferred the resident from her bed to her wheelchair. CNA #12 took the Foley drainage bag and laid it on the stand up lift between the leg rest of the resident. CNA #10 indicated they could not hang the catheter on the residents wheelchair as they usually did as there was no clip for the Foley drainage bag. Resident #24's record was reviewed on 4/14/16 at 9:57 a.m. Diagnoses included, but were not limited to, history of ESBL (Extended Spectrum Beta Lactamases - a		affected. Any other resident with a catheter drainage bag will have the drainage bag replaced if the clip breaks. 3. C.N.A.'s will be in-serviced on 5-10-16 on proper technique of handling catheter drainage bags and when to notify of a damaged catheter drainage bag. 4. Resident #24 no longer has a Foley catheter anchored. Charge nurses will monitor residents with a catheter drainage bag daily to assure the catheter drainage bags are intact and document on the residents TAR. Clinical team will randomly observe a transfer of a resident with a catheter drainage bag weekly until 90% or greater is achieved times 3 audits. Any findings will be reported to QA Committee monthly until 90%or greater is achieved for three months.	

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	04/18/2016

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
	type of bacteria) and stroke with hemiplegia. The Progress notes from November 2015 through April 2016, indicated: 2/21/16--resident received Bactrim (an antibiotic medication) due to positive UTI (Urinary Tract Infection) results 4/2/16--Urine specimen collected and was placed in refrigerator for lab to pick up. 4/5/16--MD (physician) aware of UA (Urine Analysis) and received no orders. 4/6/16--MD aware of final UA results, New order received for Bactrim. . The labs indicated the resident had a urine culture on 2/19/16, as well as 3/16/16, and both indicated Escherichia Coli ESBL (Extended Spectrum Beta Lactamases) > (greater than) 100,000CFU/ml. Confirmed ESBL producing organisms are enzymes that mediate resistance to extended spectrum (3rd generation) cephalosporins (antibiotics) During an interview on 4/15/16 at 3:56 p.m., the Director of Nursing indicated the CNA's should not have allowed the urinary drainage bag to touch the floor. 3.1-41(a)(2)			

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	04/18/2016

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 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 observation, interview and record review, the facility failed to ensure interventions were in place to prevent right extremity contractures from worsening for 1 of 1 resident reviewed for Range of Motion (ROM) (Resident #27). Finding includes: During a staff interview on 4/12/16 at 10:52 a.m., RN (Registered Nurse) #6 indicated Resident #27 had a contracture of her right arm and she did not receive range of motion (ROM) services or have a splint device in place. On 4/13/16 at 10:14 a.m., the resident was observed in the small activity lounge with the TV playing and she did not have	F 0318	F318 1. Resident # 27 refuses ROM other than the slight PROM received during bathing and dressing. Resident # 27 care plan was updated to reflect the resident's wishes. 2. No other residents were affected. If any other residents are admitted or identified their care plans will be updated to reflect the residents wishes. 3. Care plans for any other residents who refuse ROM will be updated at the time residents inform the staff of their wishes. Care plans will be reviewed quarterly to assure residents with contractures are receiving the care they desire and will be documented. C.N.A's will be in-serviced on completing ROM per the residents care plan by 5-13-16. Care plan information is on the C.N.A. assignment sheets and	05/13/2016

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	04/18/2016

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
	a splint on her right arm, which was bent up in a flexed position at the elbow. On 4/14/16 at 10:03 a.m., the resident was sitting in the small activity room with her eyes closed and she did not have a splint on her right arm, which was bent up in a flexed position at the elbow. On 4/14/16 at 1:35 p.m., CNA (Certified Nursing Assistant) #4 was observed attempting to straighten out Resident #6's right arm and it would not straighten out. She indicated at that time the resident's right arm could not be straightened out. She indicated the resident did not have a splint nor was she getting ROM to her right arm as far as she knew because the Restorative program was stopped about two to three weeks ago. She indicated the nursing staff had received an inservice yesterday from a Physical Therapist regarding what the nursing staff should and should not do with splints, but she did not know who was suppose to be performing the ROM on the residents who had contractures and required ROM. During an interview on 4/14/16 at 2:12 p.m., CNA #10 indicated she had been the Restorative CNA up until approximately two weeks ago when the facility placed her back on the floor as a CNA. She indicated it was her		documented on the residents adl record. Licensed nursing staff was inserviced on 5/9/16 regarding care plans. At the time of admission or significant change, DON or designee will initiate, review, and update care plans. Care plans will be monitored on a quarterly basis by MDS coordinator or designee. CNA assignment sheets will be updated with current care plan information as needed by DON or designee ongoing basis 4. DON or Designee will report monthly any resident's refusal of ROM and care plan match. Findings will be reported to the QA Committee monthly until 90% or greater is achieved times three months.	

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	04/18/2016

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
	understanding the CNA's were suppose to be performing the Restorative programs for the residents who required them and they were to document they had done them in the computer. She indicated the nursing staff had been inserviced on the Restorative programs being the CNA's responsibilities on 4/12/16. She indicated she did not know who had been performing the Restorative program exercises since the program was discontinued. During an interview on 4/15/16 at 1:05 p.m., the Director of Nursing indicated the resident's Restorative program was discontinued in February 2016. She indicated Resident #27 was not receiving ROM to her right arm because she did not like to have her right arm touched and that was care planned. Resident #6's record was reviewed on 4/15/16 at 1:21 p.m. Diagnoses included, but were not limited to, abnormal posture and contracture. A document titled "RNA [Restorative Nursing Assistant] Monthly Functional Maintenance," dated 1/27/16 at 4:32 p.m., indicated the treatments provided were not applicable for the upper extremity range of motion for January 2016. There was no splinting to the			

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	04/18/2016

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
	upper extremity. The overall status indicated the resident had contractures to the elbows. A quarterly MDS (Minimum Data Set) assessment, dated 3/21/16, indicated the resident had a functional limitation in ROM to the upper and lower extremity to one side. The resident's record lacked documentation of ROM or splinting to the right extremity. The resident's record lacked a Care Plan for her being resistive to ROM or refusal of ROM to her right arm. During an interview on 4/18/16 at 11:34 a.m., the Regional Director of Clinical Operations (RDCO) indicated Resident #27 only had the Restorative program performed to her bilateral lower extremities in January to February 2016 ending on 2/11/16. She indicated she did not have a Care Plan to address the contractures of the upper extremities. (RDCO) indicated the CNA's indicated the resident would only do Passive ROM during showers, bathing and getting dressed and would not allow them to raise her arm to do 20 repetitions of ROM because she refused due to pain in her arm, but she did not know where this			

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	04/18/2016

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
	was documented in the resident's record. She indicated the resident was taken off the Restorative program on February 11, 2016 for her lower extremities only. She indicated the IDT (Interdisciplinary Team) did walking rounds and indicated she had upper and lower extremity ROM limitations, but they had not required interventions at that time. During an interview on 4/18/16 at 11:44 a.m., the Director of Nursing indicated the right arm was bent at the elbow and could not be straightened out and the resident's left arm was straight and could not be bent or raised very high, which is the arm she had the most pain. She indicated the resident could not raise either arm. During an interview on 4/18/16 at 12:19 p.m., the Therapy Manager indicated there was no therapy performed on the upper extremity contractures. He indicated in November 2015, Occupational Therapy was working with the contractures of her fingers, but not the contractures of her upper extremities. 3.1-42(a)(2)			

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	04/18/2016

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 0325 SS=D Bldg. 00	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on observation, interview and record review, the facility failed to follow prevention interventions once implemented for a resident experiencing a significant weight loss (Resident #23) for 1 of 3 residents reviewed for nutrition. Resident #23 experienced a 10.3 % weight loss in 30 days and 7.8% weight loss in 90 days. Finding includes: On 4/14/15 at 9:01 a.m., the resident had two pieces of toast for breakfast with butter and jelly on them, which she had only taken 4 bites out of one piece of the toast. She ate 10% of her toast. She pulled the front of her shirt up over her face to cover her face and her forehead. The Executive Director brought the resident a vanilla Healthshake and offered it	F 0325	F325 1. Resident #23 family and MD were notified of the weight loss. Resident # 23 was placed on hospice care on 4-22-16. 2. No other residents were affected. Significant weight loss will be reported timely to the MD and Family if this occurs. 3. Weights will be reviewed by the clinical team timely and assure MD and family are notified. DON or designee will verify weight documentation is complete and verified on the monthly and weekly weight logs. Nurse consultant reviewed weight policy with clinical team on 4-15-16. Licensed nursing staff was in serviced on 5/9/16 regarding weight loss. Weight exception report will be run weekly by DON or designee. Residents with significant weight loss of 5% or greater will be reported to MD weekly. DON or designee will maintain weekly weight log for two months or until 90% compliance.	05/13/2016

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	04/18/2016

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
	to her and she refused indicating she only wanted her coffee. On 4/14/16 at 12:50 p.m., Resident #23 was observed to have a BBQ sandwich, macaroni and cheese, cole slaw and watermelon to eat for lunch. She ate her watermelon only and indicated she was finished eating. She did not have a Healthshake with her lunch. She indicated she would eat ice cream, if the staff would get it for her. She ate 25% of her meal. She pulled the front of her shirt up over her face to cover her face and her forehead. On 4/14/16 at 12:58 p.m., RN (Registered Nurse) #6 was observed coming over to the resident after she had pulled the front of her shirt over her face and the top of her forehead and asked her if she could get her something else to eat. The resident agreed to eat ice cream. RN #6 got chocolate ice cream for the resident, but she did not eat it. Resident #23's record was reviewed on 4/15/16 at 9:56 a.m. Diagnoses included, but were not limited to, diabetes mellitus type 2, hemiplegia and hemiparesis		4. DON or designee will report to the QA Committee monthly of any untimely weight notifications on an ongoing basis.	

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	04/18/2016

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
	following unspecified cerebrovascular disease affecting left non-dominant side, dysphagia, and major depressive disorder. The resident had Physician orders dated for the following dates: 4/4/16--Healthshake 120 cc two times a day (Discontinued 4/12/16) 4/14/16--Weekly weights x 4 4/12/16--Healthshake 120 cc (cubic centimeters) with meals (Start date 4/13/16) 4/28/15--Regular diet, soft texture, Regular/Thin consistency. No consumptions could be found documented as the resident consuming the Healthshake supplement with meals, which the Physician had ordered on 4/12/16. The Electronic Medication Administration Record dated April 2016, lacked an order for Healthshakes from 4/4/16 to 4/12/16. The resident's weights for the last 180 days were as follows: 10/2/15--126 pounds 11/11/15-126 pounds 12/11/15--121 pounds 1/4/16--125 pounds 2/5/16--130 pounds 3/3/16--128 pounds			

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	04/18/2016

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
	4/7/16--117 pounds 4/8/16--117 pounds The resident's meal intakes were reviewed from 2/29/16 to 4/14/16 and documented as follows: Breakfast--only 14 meals were documented that indicated the resident had eaten. The average food intake was 51-75% (percent) of those meals. Lunch--51-75% Dinner-51-75% The resident had a Care Plan dated 12/17/14 with revised date of 4/12/16, which addressed the problem she was at nutritional risk due to dysphagia, dementia, and diuretic, which might trigger a significant weight loss > (greater than) 5% in 30 days and >10% in 180 days. Interventions included, "...4/4/12--health shakes as ordered, 12/17/14--Diet as Ordered, Offer HS [bedtime] snacks... Monitor weight: Monthly, Notify MD of significant Weight Change...." A Quarterly Nutritional Risk Assessment dated 4/4/16 at 12:58 p.m., indicated "Score 9.0 High Risk BMI [Body Mass Index] 22.7 estimated nutrition needs at			

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	04/18/2016

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
	1450-1740 cal [calories] /day, protein at 58g [grams]/day and fluid at 1624-1740 ml [milliliters]/day. Meal intakes meets 26-75% of estimated needs. She is on a soft diet and consumes 0-75% of most meals. on Lasix-may see weight fluctuations... Physical and mental functioning indicated out of bed with assistance, motor agitation (tremors, wandering, limited feeding assistance, supervision while eating, chewing or swallowing problems, teeth in poor repair, ill-fitting dentures or refusal to wear dentures, edentulous, taste and sensory changes, unable to communicate needs... May suggest health shakes BID [two times a day] to help increase calories with noted po [by mouth] intakes slightly declining." A Dietary progress note dated 4/12/16, indicated "Resident's weight 4/8/16 116.6 lbs, which was down 8.9% x 30 days and 10.6% x 180 days, triggered a significant weight loss > [greater than] 5% x [times] 30 days and >10% x 180 days. Resident is on a soft diet due to dysphagia and consumes 25-100% most meals. She enjoys Danishes and cinnamon rolls.			

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	04/18/2016

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
	Started health shakes 120 ml BID [two times a day] few days ago. On Lasix [a diuretic] may see weight fluctuations. Resident was unable to answer questions and kept stating she wanted out of here. She is able to say she drinks the shakes. May suggest health shakes with meals to provide 600 extra calories. estimated nutrition needs at 1325-1590 calories per day, protein 53 g [grams]/day, fluid at 1484-1590 ml [milliliter]/day...." A document titled "eInteract Change in Condition Evaluation V4.1," dated 4/13/16 at 12:40 p.m., indicated the Situation was the resident had abnormal vital signs (low/high BP, heart rate, respiratory rate, weight change) and weight loss the Background indicated the resident's primary diagnosis was hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side and other additional pertinent diagnosis were dementia and diabetes. The Assessment indicated the most recent weight was 116.6 by wheelchair on 4/8/16 at 1616 (4:16 p.m.), the mental evaluation indicated decreased level of			

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	04/18/2016

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
	consciousness (sleepy, lethargic), the specific decreased level of consciousness was gradual change in level of consciousness was not associated with other criteria for immediate notification, the functional status evaluation indication general weakness, the change in the general weakness was without fever, change in level of consciousness or other acute symptoms, there were no behavioral changes observed, Review and Notify indicated the primary care doctor was notified on 4/13/16 at 10:00 a.m. and he would assess the resident when he came in. The family was notified on 4/13/16 at 10:30 a.m. During an interview on 4/15/16 at 1:00 p.m., the Director of Nursing (DON) with the Regional Director of Clinical Operations (RDCO) in attendance. The DON indicated the Physician was notified of the weight loss on 4/13/16, when the SBAR (Situation, Background, Assessment and Review and Notify) was filled out because she wanted to wait for the Registered Dietician (RD) to assess the resident and determine what interventions put into place before she notified the Physician. She			

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	04/18/2016

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
	indicated the Healthshakes did not come up from the kitchen that morning for breakfast, so she called the kitchen and told the kitchen staff to send the Healthshakes up to the dining room and the Executive Director made sure the Resident #23 received her Healthshake. The DON indicated the Healthshake was a Physician's order, but was suppose to be sent up from the kitchen. The RDCO indicated if the Healthshake was written as an order, then it should be written on the EMAR (electronic Medication Administration Record), then signed off the EMAR as being administered. A current policy titled "Weight Management," dated August 2014, provided by the Regional Director of Clinical Operations on 4/15/16 at 3:50 p.m., indicated "...PURPOSE: Residents identified to be at risk for weight variance, will have routine assessment and care plan interventions implemented accordance with Advance Directives. The objective of this process is to assess, and manage weight variances to determine appropriate referrals and/or interventions to achieve the best possible clinical outcomes.			

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	04/18/2016

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
	PROCEDURE:.. 6. Weekly weight monitoring may be appropriate for: New admission for one month, Significant unplanned weight loss/gain, clinical conditions which may require more frequent monitoring... 8. Dietary Services Manager/designee will complete weight review and determine significant changes. 9. Physician and responsible party will be notified of significant weight variances...." 3.1-46(a)(1)			
F 0328 SS=D Bldg. 00	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. Based on observation, interview and	F 0328	F328 1. RN # 8 was in-serviced on	05/13/2016

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	04/18/2016

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
	record review, the facility failed to use the proper procedure to administer water and medications for 1 of 1 residents observed for medication administration through a G-tube (feeding tube) (Resident #18). Finding includes: On 4/13/16 at 3:53 p.m., RN (Registered Nurse) #8 was observed administering Resident #18's G-tube medications. RN #8 checked for residual, then checked for placement with air. She flushed the G-tube with 10 ml (milliliters) of water by pushing the water through the G-tube with the plunger of the piston syringe. She administered the Acetaminophen (a non-narcotic pain medication) through the G-tube by pushing it through with the plunger of the piston syringe. She flushed the G-tube with 10 ml water by pushing the water through the G-tube with the plunger of the piston syringe. RN #8 administered the Clonazepam (an anti-anxiety medication) by pushing the medication through the G-tube with the plunger of the piston syringe. She flushed the G-tube with 50 ml of water by pushing the water through with the plunger of the piston syringe. Resident #18's record was reviewed on 4/14/16 at 10:46 a.m. Diagnoses		4-13-16 on G-tube medication administration. 2. No other residents were affected. Nurses will be in-serviced on G-tube medication administration. 3. Nurses will be in-serviced on 5-10-16 on G-tube medication administration. Nurses will be checked off on G-tube medication administration by the clinical team. Then random weekly observation of G-tube medication administration by the DON or designee. 4. Any new nurse will be checked off G-tube medication administration prior to starting resident care. Don or designee will report any findings to the QA Committee monthly ongoing.	

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	04/18/2016

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
	included, but were not limited to, encounter for attention to Gastrostomy (G-tube), dysphagia and muscle weakness. The resident's Electronic Medication Administration Record dated April 2016, included, but was not limited to, the following orders: 4/30/15--Medication Administration Flush: Flush with a minimum of 30 ml water before giving medications, flush with at least 5 ml between medications and flush with a minimum of 30 ml after all medications have been given. 5/15/15--Acetaminophen 160/ml solution Give 20 ml (640 mg) by G-tube two times a day related to chronic pain. 3/25/16--Clonazepam 0.5 mg by G-tube two times a day for abnormal movements. During an interview on 4/13/16 at 4:03 p.m., RN #8 indicated she "always" flushed G-tubes and administered medications by pushing the fluids through the G-tube with the plunger of the piston syringe. She indicated this was the technique she was taught. She indicated she did not remember getting an orientation to the facility policy on G-tube administration or flushing of the G-tube.			

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	04/18/2016

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
	During an interview on 4/15/16 at 1:15 p.m., the Director of Nursing with the Regional Director of Clinical Operations in attendance indicated RN #8 should have administered the water and medications through the G-tube by gravity, not pushing them through with the plunger of the piston syringe. A current policy titled "Enteral Nutritional Therapy, (Tube Feeding)," undated, provided by the Regional Director of Clinical Operations on 4/14/16 at 10:00 a.m., indicated "...Procedure:...5. Holding the barrel of the syringe at or below the level of the stomach, pour prescribed amount of water into the syringe...." A current policy titled "[Name of Company] Medication Administration Operating Standard Guideline" dated December 2012, provided by the Executive Director on 4/14/16 at 8:40 a.m., indicated "...Enteral feedings...Prior to administering med, stop the feeding and flush the tube with a minimum of 15 ml [milliliters] water...." 3.1-47(a)(2)			

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	04/18/2016

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 0332 SS=D Bldg. 00	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, interview and record review, the facility failed to keep the medication error rate at less than 5% for 3 of 9 residents observed during medication pass. Three (3) errors were observed during 33 opportunities for errors in medication administration. This resulted in a medication error rate of 9.09% (Residents #2, #9 and #16). Findings include: 1. On 4/13/16 at 11:15 a.m., LPN (Licensed Practical Nurse) #7 was observed administering a medication to Resident #2, which included Niferex 150 capsule (an Iron supplement medication), give one capsule by mouth three times a day with meals. The Electronic Medication Administration Record (EMAR), dated April 2016, included, but was not limited to, the following order: 8/26/15--Poly-Iron 150 mg (milligrams) capsule Give one capsule by mouth with meals at 12:00 p.m. and 5:00 p.m. During an interview on 4/13/16 at 11:27	F 0332	F332 1. Resident #2 will only take the niferex with her other medication and this has been care planned. Resident #9 was given peanut butter crackers at the time, resident # 16 received ensure with the medications. Resident's #9 & 16 medication times were changed. 2. No other residents were affected. Staff will be in-serviced on medication administration. 3. Nurses will be in-serviced on 5-10-16 on medication administration then checked off to assure compliance by the clinical team. DON or designee will do a random weekly medication observation until 90% or greater is achieved times three audits. 4. Any new nurse will be in-serviced on medication administration and be checked off prior to starting resident care. Don or Designee will report any findings to the QA Committee monthly ongoing.	05/13/2016

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	04/18/2016

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
	a.m., LPN #7 indicated she "always" gave the Niferex (Poly-Iron) at this time to the resident because the medication "popped" up on the computer at 11:00 a.m., to be given to the resident. She indicated she did not realize the medication needed to be given with meals. She indicated lunch would be served around 12:00 p.m. 2. On 4/13/16 at 3:15 p.m., RN (Registered Nurse) #8 was observed administering medications to Resident #9, which included Metroprolol Tart (a blood pressure medication) 100 mg, give one tablet by mouth twice a day with food. The EMAR dated April 2016, included, but was not limited to, the following order: 5/15/15--Metroprolol Tart 100 mg tablet, give one tablet by mouth two times a day with food. During an interview on 4/13/16 at 3:18 p.m., RN #8 indicated she could give this medication between 2:00-6:00 p.m. She indicated the EMAR did not indicate she had to give the medication with food. She indicated the medication label indicated the medication needed to be given with food. She indicated dinner would be served closer to 6:00 p.m. She gave the resident a package of 6 peanut			

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	04/18/2016

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
	butter crackers and instructed him to eat them after it was brought to her attention the medication needed to be given with food. 3. On 4/13/16 at 4:09 p.m., LPN #9 was observed administering medications to Resident #16, which included Tamsulosin Hydrochloride (HCL) (a medication used to help with urinary retention) 0.4 mg, give one tablet by mouth in the evening after dinner. The EMAR dated April 2016, included, but was not limited to, the following order: 8/26/15--Tamsulosin HCL 0.4 mg capsule, give one tablet by mouth in the evening after dinner. During an interview on 4/13/16 at 4:21 p.m., LPN #9 indicated she "always" gave this resident his Tamsulosin HCL at this time instead of after dinner because he "always" took an Ensure with his medications. She indicated Ensure was considered a meal supplement. The Nursing 2014 Drug Handbook, 34th edition, copy right 2014, Tamsulosin Hydrochloride administration by mouth indicated give the drug 30 minutes after the same meal each day.			

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	04/18/2016

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
	A current policy titled "[Name of company] Medication Administration Operating Standard Guideline," dated December 2012, provided by the Executive Director on 4/14/16 at 8:40 a.m., indicated "Practice: Medications will be given in a manner which will prevent error related to the prescribing, dispensing and administration, or monitoring of a drug. Procedure:...Administer medications using the 5 R's: Right resident, Right medication, Right dosage, Right time, and Right route...Ensure that AC [before meals] and PC [after meals] medications are given at the proper times surrounding meals...." A current policy titled "6.0 General Dose Preparation and Medication Administration," dated 12/1/07 with a revised of date 1/1/13, provided by the Executive Director on 4/14/16 at 8:40 a.m., indicated "...Procedure:..4.1 Facility staff should: 4.1.1 Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident as set for in Appendex 17: Facility Medication Administration Times Schedule...5.8 Follow manufacturer medication administration guidelines (e.g., rotating transdermal			

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	04/18/2016

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
	patch sites, providing medication with fluids or food, shaking medications prior to pouring); and,...." 3.1-25(b)(9)			
F 0371 SS=F 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 Based on observation, interview and record review, the facility failed to maintain a clean and sanitary kitchen. This deficient practice had the potential to affect 31 of 33 residents who receive food from the kitchen. Findings include: On 04/11/2016 at 9:36 a.m., the initial kitchen tour began. Dietary aide #13 and Dietary aide #14 were present. 1. Observed in walk-in freezer were the following: a. Open box of Japanese	F 0371	F371 1. Items not dated were discarded. 2. No residents were affected. Staff will be in-serviced on labeling and dating food items and handling of dishes. 3. Staff was in-serviced on 5-3-16 on dating, labeling and handling dishes per policy. ED will monitor for dating and labeling and proper dish handling 3 times a week and the RD will do a weekly sanitation round. 4. Finding from rounds will be reported to the QA Committee monthly ongoing.	05/13/2016

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	04/18/2016

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
	vegetable blend was not dated and inner bag was not closed. b. Open uncontained bag of breadsticks were not dated and sat on freezer shelf. c. Two packages of tortilla shells sat on freezer shelf, undated. d. Open undated box of taquitos sat undated and uncontained on freezer shelf. e. Open box of green beans were left on freezer shelf, undated. f. Open box of French fries sat on freezer shelf undated. g. Open box of hot dogs were not dated. h. Open box of zucchini squash were not dated. i. Open box of pie crusts were not dated. j. Open box of pulled chicken meat and pulled chicken breasts were undated. k. Open box of pork sausage links with meat not contained within the box or inner bag was undated. l. Open box of egg noodles were not dated. m. Open box of sliced hot dog rolls were not dated n. Angel food cake wrapped in plastic wrap with large ice crystals inside plastic was undated and unlabeled			

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	04/18/2016

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
	o. Open box of hamburger patties were undated. p. Open box of onion rings were undated q. Open box of tater barrels open were undated. At that time, Dietary aide #13 indicated every box in the freezer should be dated. 2. Walk in pantry observations: a. An open box of partially full sugar was undated. b.One box of undated sliced apples was stored on floor in middle of the pantry with a box of undated mandarin orange slices stacked on top and an open, undated box of canned sweet potatoes stacked on top with an open, undated box of canned chunk tuna stacked on top c. One box of foam cups stored on the floor. d. Stored in a clear, plastic container on second shelf was seven bags of partially used, open and undated dry mixes. e. One open 25# bag of Jasmine rice was undated and not contained. f. A box of open, undated, dry dessert mixes was uncontained, with dry mix in the bottom of the			

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	04/18/2016

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
	box and a bag of chocolate pudding mix ripped open and sitting in the open box. g. A bag of long grain rice was open and undated and not contained and sat on bottom shelf. h. Open bag of uncontained 25# bag of powdered sugar was undated and sat on lower shelf. i. Dirt and debris observed behind storage racks. The debris was gray and black in color and contained food particles. j. Gray and black dirt and debris in moderate amounts on top of chocolate brownie mixes, chocolate and white cake mixes and ridged lasagna boxes sitting on top shelf. k. One open box of long grain rice was undated. l. Gray and black debris on top of open and closed tea boxes sitting on top shelf. m. Box of open, undated oatmeal cream pies. n. Box of open, peanut butter crackers were not dated. o. Box of open, fudge rounds were not dated. On 04/11/2016 at 11:50 a.m., food service began. 3. Observations included:			

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	04/18/2016

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
	Dietary aide #13 removed dishes from an oven and placed them in the dish storage unit. She utilized a suction apparatus to retrieve the warm plates to plate the food. During meal service she used the suction cup and removed 4 plates that were visibly soiled with dried on orange/red food substances. She removed the dirty dishes using the suction cup apparatus and sat them to the rear of the service line. She again utilized the same suction cup apparatus to remove 4 clean plates from the dish storage unit and began plating the food onto the plates. During an interview at that time, she indicated she should not have used the same suction cup and gave the suction cup to the Registered Dietician (RD) to wash and sanitize. No additional cup was available and the meal service was halted until the cup had been washed, sanitized and air dried. Dietary aide #13 began the meal service again once the suction cup had been returned by the RD. She removed 2 clean and 2 visibly soiled plates using the suction cup. She again started to plate the food and recognized the			

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	04/18/2016

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

dishes were dirty. Meal service was stopped again to allow the RD to clean and sanitize the suction cup apparatus. A total of 18 plates were visibly soiled with dry food particles and needed to be removed from meal service.

On 04/11/2016 at 12:10 p.m., Dietary aide #14 indicated to the RD and to Dietary aide #13 the dirty dishes were from the evening before.

On 4/13/16 at 2:35 p.m., the Dietary Manager indicated he had no policy for dish handling and dish washing.

On 4/13/16 at 2:35 p.m., an undated document titled, " Weekly deep cleaning list "was provided by the Dietary Manager. He indicated at that time, the cleaning list was put into place on 04/11/16. He indicated he had only been the Manager for 2 weeks.

On 4/13/16 at 3:35 p.m., a document titled, "FOOD SAFETY IN RECEIVING AND STORAGE" provided by the Dietary Manager, dated 2/09, indicated, "Receiving guidelines ...b ...check for large ice crystals, solid areas of ice, discolored or dried-out food, or misshapen items ...2. Expiration dates and us-by dates will be checked to assure

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	04/18/2016

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
	the dates are within acceptable parameters ...General Food storage guidelines ...2. Food will be stored in its original packaging as long as the packaging is clean, dry and intact. 3. Food that is repackaged will be placed in a leak-proof, non-absorbent, sanitary container with a tight fitting lid. The container will be labeled with the name of the contents and dated with the date it was transferred to the new container ...Dry storage guidelines. 1. Foods will be stored at least 6 " off the floor and 18 " from sprinkler heads ...2. Open packages will be resealed tightly to prevent contamination .... " On 4/13/16 at 3:15 p.m., a document titled " SAFE FOOD HANDLING " provided by the Dietary Manager, dated 2/09 indicated, " ...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 with hands ...8. Leftovers must be dated, labeled, covered, cooled rapidly and stored in refrigerator or freezer .... " 3.1-21(i)(2)(3)			
F 0431	483.60(b), (d), (e)			

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	04/18/2016

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	DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview and record review, the facility failed to properly label two medications after order changes for 1 of 1 resident observed for direction change labels	F 0431	F431 1. Resident #3 received the correct medications per the correct route. Label change sticker was added to the current labels. 2. No other residents were	05/13/2016

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	04/18/2016

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
	(Resident #3). Finding includes: During an observation on 4/13/16 at 2:00 p.m., RN (Registered Nurse) #6 prepared medications for Resident #3. The nurse placed the crushed medications into a plastic cup and added applesauce, which included a Hydrocodone-Acetaminophen (a narcotic pain medication) 10-325 mg (milligrams) and a Diazepam (an anti-anxiety medication) 2 mg. During this observation, the medication cards provided from the pharmacy contained the following directions "Hydro-Acet 10-325 mg Give 1 tablet PO [by mouth] q [every] 6 hours" and "Diazepam 2 mg Give 1 tablet PO QID [four times a day]." A reconciliation of the current Electronic Medication Administration Record dated April 2016, included, but was not limited to the following orders: 9/30/15--Diazepam 2 mg Give one tablet by mouth three times a day for muscle spasms. 3/29/16--Hydrocodone-Acetaminophen 10-325 mg Give one tablet by mouth four times a day for pain. The medications lacked a "change" of		affected. Nurses will be in-serviced on updating medication labels. 3. Nurses will be in-serviced on 5-10-16 on adding change of direction stickers to labels when orders are changed. Clinical team will do random audits weekly on medication order changes until 90%or greater is achieved times three audits. 4. Pharmacy will review medication carts month to assure labels and orders match on new orders. Any findings will be reported to the QA Committee monthly ongoing.	

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	04/18/2016

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
	order label to alert the nurse the orders had been changed. During an interview on 4/13/16 at 2:48 p.m., LPN (Licensed Practical Nurse) #3 indicated the newest order for the Hydrocodone-Acetaminophen was one tablet four times a day. She indicated the newest order for the Diazepam was for three times a day. She indicated when the nurses received the new orders they had not placed a "change" of label sticker on the medication labels. During an interview on 4/15/16 at 1:00 p.m., the Director of Nursing indicated the nurses should have placed a "change" of direction sticker on the medication cards to note the orders had been changed and called the pharmacy to ensure the orders had been changed on the medication cards. A current policy titled "4.5 Reordering, Changing, and Discontinuing Orders," dated 12/1/07 with a revision date 1/1/13, provided by the Executive Director on 4/14/16 at 8:40 a.m., indicated "...Procedure:..3. Change Orders: Any request to change an existing order should be treated by Facility as a new order, with a corresponding cancellation of the previous order...Facility staff cannot alter directions on any existing			

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	04/18/2016

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
	prescription once it has been dispensed to the resident...3.5 If Pharmacy receives a new order that changes the strength or dose of a medication previously ordered, and there is adequate supply on hand: 3.5.1 Pharmacy should discontinue the original order; 3.5.2 Facility Physician/Prescriber should write the new order with new directions and Facility should enter the new order on the appropriate medication Record Forms; and, 3.5.3 If permitted by Applicable Law, Facility should notify Pharmacy not to send the medication by attaching a "Change in Directions" sticker to the existing quantity of medications until Pharmacy permanently affixes the new label to the medication package or container...." 3.1-25(k)(5)			