STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155816	A. BUILDING 00 B. WING	02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ARLINGTON PLACE HEALTH CAMPUS	1635 N ARLINGTON AVE INDIANAPOLIS, IN 46218

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00387775, IN00375593, IN00388283, IN00375770, IN00376002 and IN00400238. Complaint IN00387775 - Unsubstantiated due to lack of evidence. Complaint IN00375593 - Unsubstantiated due to lack of evidence. Complaint IN00388283 - Unsubstantiated due to lack of evidence. Complaint IN00375770 - Unsubstantiated due to lack of evidence. Complaint IN00376002 - Substantiated. Federal/State deficiencies related to the allegations are cited at F557. Complaint IN00400238 - Substantiated. Federal/State deficiencies related to the allegations are cited at F557. Unrelated deficiencies are cited. Survey dates: February 1, 2, and 3, 2023 Facility number: 013005 Provider number: 155816 AIM number: 201256400 Census Bed Type: SNF/NF: 34 SNF: 23 Residential: 11 Total: 68	F 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the, February 3rd through February 6th, 2023, Complaint Survey (IN00375593, IN00375770, IN00376002, IN00387775, IN00388283) (IN00400238). Please accept this Plan of Correction as the provider's credible allegation of compliance as of February 18th, 2023. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Janet Worley		02/17/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Census Payor Type: Medicare: 23 Medicaid: 29 Other: 5 Total: 57 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 6, 2023			
F 0557 SS=D Bldg. 00	483.10(e)(2) Respect, Dignity/Right to have Prsnl Property §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. Based on interview and record review, the facility failed to ensure a resident's right to be treated with respect and dignity by 2 (CRCAs) Certified Resident Care Assistants arguing over a resident's care (Resident B) in front of the resident for 1 of 3 residents reviewed for dignity. Findings include: The clinical record for Resident B was reviewed on 2/2/23 at 1:20 p.m. The diagnoses included, but were not limited to, respiratory failure with hypoxia, history of tracheostomy (an incision in the windpipe made to relieve an obstruction to breathing) complication, and anxiety disorder.	F 0557	F 557 Respect, Dignity/Right to have Personal Property The facility failed to ensure a resident's right to be treated with respect and dignity by 2 (CRCAs) Certified Resident Care Assistants arguing over a resident's care (Resident B) in front of the resident for 1 of 3 residents reviewed for dignity. It is the practice of this provider to provide care/services for highest well-being in accordance with State and Federal law. 1: What corrective action(s) will be accomplished for those residents found to have affected by the	02/18/2023

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	A Quarterly (MDS) Minimum Data Set assessment, dated 1/1/23, indicated Resident B was cognitively intact. An interview conducted with Resident B, on 2/2/23 at 3:25 p.m., indicated when she was in another room previously there were 2 CRCAs that were in her room and made comments in front of her such as "you take too much time" or "I don't have time". They were referring to how long it took to care for Resident B. She requested to no longer have the 2 CRCAs (CRCA 3 and CRCA 4) care for her. There was another occasion with CRCA 4 coming into her room at 12:30 p.m. and commented "why are you still in bed"? CRCA 4 then went on to say, "I'm going to lunch" and didn't proceed to get Resident B up out of bed. An interview conducted with the Executive Director (ED), on 2/3/23 at 11:55 a.m., indicated Resident B told her the 2 CRCAs were arguing about her care in front of her. The ED spoke with Resident B, CRCA 3, and CRCA 4. Resident B commented on how she didn't like the 2 CRCAs and said their actions were not appropriate. The ED stated, "that's true, it wasn't appropriate". The situation could have been discussed outside of Resident B's room but not in front of them. CRCA 4 was legally deaf and speaks in a higher tone. Resident B had a particular time when she wanted to go to bed while on a previous hallway. Her preference apparently changed when she went onto the other hallway but the staff, CRCA 3 and CRCA 4, were discussing the changing of the time Resident B wanted to go to bed. The ED commented "that doesn't matter". If Resident B wanted to go to bed you assist them to bed upon request. The ED indicated she spoke with CRCA 3 and CRCA 4 in regard to customer service concerns, but nothing was put in writing.		deficient practice? Resident B psychosocial support provided, preferences reviewed and updated as applicable. 2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. DHS/designee initiated and completed investigation with reportable submission and follow-up, no other resident's with identified concerns. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The DHS/designee will conduct an in-service with facility staff on the Resident Rights Policy. As a measure of ongoing compliance, the DHS/designee will complete an audit of 5 resident interviews to ensure staff has maintained professional and courteous interactions during care episodes. Audit will be conducted five times weekly for 4 weeks, then three times weekly for 4 weeks, then twice weekly for 4 weeks, then twice monthly for 3 months, then monthly until continued compliance is maintained for 2 consecutive quarters (six months). The results of these audits will be reviewed by	

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	An interview conducted with the Director of Nursing (DON), on 2/3/23 at 2:40 p.m., indicated there was no policy in regard to dignity. It goes underneath resident rights. This Federal tag relates to Complaints IN00376002 and IN00400238. 3.1-3(a)(1) 3.1-3(t)		the QAPI committee overseen by the ED. 4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place? For quality assurance, The ED and/or Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns noted and will decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met. 5. Date of completion: 02/18/2023 ="" p="">	
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must			

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	provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.			
	Based on interview and record review, the facility failed to administer medications to two residents which were available in the facility's emergency drug kit (EDK) for 2 of 4 residents reviewed for discharge rights. (Resident L and D) Findings include: 1. The clinical record for Resident L was reviewed on 2/3/23 at 9:51 a.m. Resident L's diagnoses included, but not limited to, sepsis, pneumocytosis (an infection of the lungs), acute respiratory failure with hypoxia, and kidney transplant recipient. Resident L was admitted to the facility on 12/9/22. A physician's order dated 12/9/22 indicated,	F 0755	F 755 Pharmacy Srvcs/Procedures/Pharmacist/Records The facility failed to administer medications to two residents which were available in the facility's emergency drug kit (EDK) for 2 of 4 residents reviewed for discharge rights. It is the practice of this provider to provide care/services for highest well-being in accordance with State and Federal law. 1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?	02/18/2023

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	Resident L was to receive one 875 mg/125 mg(milligram) tablet of amoxicillin-pot clavulanate(sic, an antibiotic, Augmentin) twice a day orally. Resident L's December MAR (medication administration record) was reviewed on 2/3/23. The MAR indicated, Resident L had not received the morning dose of the amoxicillin-pot clavulanate on 12/10/22. Under the "reasons/comments section of the MAR, it indicated, the 12/10/22 morning dose was "Drug/Item Unavailable". An interview with DON (Director of Nursing) was conducted on 2/3/23 at 2:26 p.m. indicated, the amoxicillin-pot clavulanate 825 mg/125 mg tablet was available in the facility's EDK at the time and should have been administered to Resident L. 2. The clinical record for Resident D was reviewed on 2/3/23 at 2:00 p.m. The diagnoses included, but were not limited to, encephalopathy, pneumonia, anemia, heart failure, diabetes mellitus, and pulmonary hypertension. Resident D was admitted to the facility on 1/21/23 from the hospital. A care plan, dated 2/3/23, indicated Resident D had a potential for experiencing symptoms of fatigue, weakness, and confusion related to anemia. An approach was listed to administer medications as ordered. A physician order, dated 1/21/23, indicated the use for carvedilol (blood pressure medication) 3.125 milligrams (mg) twice daily. The electronic medication administration record (EMAR) for January 2023 indicated the carvedilol 3.125 mg was not administered for the evening dose on 1/21/23 due to "waiting on pharmacy fill".		Resident L no longer resides in facility. Resident D no longer resides in facility. 2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. DHS/designee to complete campus wide review with all residents to ensure that all resident medications are available for administration per order. No adverse effects noted. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The DHS/designee will conduct an in-service with nursing staff on appropriate methods to reorder medications, EDK use, and obtaining needed prescriptions if appropriate. As a measure of ongoing compliance, the DHS/designee will complete an audit of 5 residents to ensure medications are administered per order. Audit will be conducted three times weekly for 8 weeks, then twice weekly for 4 weeks, then weekly for 4 weeks, then twice per month for 2 months, then monthly until continued compliance is maintained for 2 consecutive quarters (six months). The results of these	

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	A physician order, dated 1/21/23, indicated the use for pantoprazole (medication that reduces the amount of acid your stomach makes) 40 mg twice daily. The EMAR for January of 2023 indicated the pantoprazole 40 mg was not administered for the evening dose on 1/21/23 due to "waiting on pharmacy fill". A physician order, dated 1/21/23, indicated the use for simvastatin (is a statin, a type of lipid-lowering medication) 20 mg at bedtime. The EMAR for January of 2023 indicated the simvastatin 20 mg was not administered for the evening dose on 1/21/23 due to "waiting on pharmacy fill". A physician order, dated 1/21/23, indicated the use for torsemide (diuretic medication used to treat fluid overload due to heart failure, kidney disease, and liver disease and high blood pressure) 20 mg twice daily. The EMAR for January of 2023 indicated the torsemide 20 mg was not administered for the evening dose on 1/21/23 due to "waiting on pharmacy fill". An interview conducted with the Director of Nursing (DON), on 2/3/23 at 2:25 p.m., indicated that carvedilol 3.125 mg, simvastatin 20 mg, pantoprazole 40 mg, and torsemide 20 mg were all available in the emergency drug kit. 3.1-25(a)		audits will be reviewed by the QAPI committee overseen by the ED. 4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place? For quality assurance, The ED and/or Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns noted and will decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met. 5. Date of completion: 02/18/2023.	