

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155336	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/06/2019
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NAME OF PROVIDER OR SUPPLIER DECATUR TOWNSHIP CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4851 TINCHER RD INDIANAPOLIS, IN 46221
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaints IN00286294 and IN00285464.</p> <p>This visit in conjunction with the Recertification and State Licensure Survey that included the Investigation of Complaints IN00285087, IN00283972, IN00283769, IN00283578, IN00281688, and IN00283117.</p> <p>Complaint IN00286294 - Unsubstantiated, due to lack of evidence.</p> <p>Complaint IN00285464 - Substantiated. Federal/State deficiencies related to the allegations are cited at F656 and 691.</p> <p>Complaint IN00285087 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00283972 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00283769 - Substantiated. Federal/State deficiencies related to the allegations are cited at F695 and F698.</p> <p>Complaint IN00283578 - Substantiated. Federal/State deficiencies related to the allegations are cited at F561 and 698.</p> <p>Complaint IN00281688 - Substantiated. Federal/State deficiencies related to the allegations are cited at F698.</p> <p>Complaint IN00283117 - Substantiated. No</p>	F 0000	<p>Decatur Township Center submits this response and Plan of Correction (POC) as part of the requirements under state and federal law. The POC is submitted in accordance with specific regulatory requirements. It shall not be construed as admission of any alleged deficiency cited or any liability. The provider submits this POC with the intention that it is inadmissible by any third party in any civil or criminal action proceedings against the provider or its employee, agents, officers, or directors.</p> <p>The provider reserves the right to challenge the cited findings if at any time the provider determines that the disputed findings are relied upon in a manner adverse to the interests of the provider either by the governmental agencies or third party. Any changes to provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the federal rules of evidence and should be inadmissible in any proceeding on that basis. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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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F 0656 SS=D Bldg. 00	<p>deficiencies related to the allegations are cited.</p> <p>Survey Dates: January 30, 31, February 1, 2, 3, 4, 5 and 6, 2019</p> <p>Facility number: 000229 Provider number: 155336 AIM number: 100266850</p> <p>Census Bed Type: SNF/NF: 60 Total: 60</p> <p>Census Payor Type: Medicare: 9 Medicaid: 33 Other: 18 Total: 60</p> <p>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed on February 13, 2019.</p> <p>483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest</p>		<p>Credible Allegation and requests paper compliance review in lieu of a Post Survey Review on or after March 8, 2019.</p>	

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	<p>practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and</p> <p>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c) (6).</p> <p>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>Based on record review and interview, the facility failed to develop a colostomy plan of care for a totally dependent resident with a colostomy for 1 of 2 residents reviewed for colostomy care (Resident E) and facility failed to implement a plan of care for 1 of 1 resident assessed as being nutritionally at risk (Resident 211).</p> <p>Findings include:</p> <p>1.) On 02/04/19 at 10:36 a.m., the closed clinical</p>	F 0656	<p>How will corrective action be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident E passed away prior to survey. Resident 211 staff was educated on implementing ADL care per care plan and documenting it on the ADL Flow Record.</p> <p>How will the facility identify other</p>	03/08/2019

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	<p>record of Resident E was reviewed. Diagnoses included, but were not limited to, paraplegia.</p> <p>Resident E was admitted on 10/18/18 and passed away on 12/29/18.</p> <p>An admission Minimum Data Set (MDS) assessment, dated 10/25/18, indicated Resident E required full staff performance (total dependence) for colostomy care.</p> <p>The clinical record lacked a care plan for colostomy care.</p> <p>During in interview, on 2/5/19 at 8:48 a.m., the Interim Director Of Nursing, indicated she was not sure why a care plan was not developed for Resident E.</p> <p>On 2/5/19 at 8:35 a.m., the Interim Director Of Nursing provided a policy titled Standards of Clinical Gerontological Nursing Care, undated, and indicated it was the current policy being used by the facility. A review of the policy indicated, "...The gerontological nurse develops a plan of care that prescribes interventions to attain expected outcomes."</p> <p>2.) The clinical record of Resident 211 was reviewed on 2/4/19 at 10:40 a.m. Diagnosis included, but were not limited to: anorexia and severe protein calorie malnutrition.</p> <p>January and February of 2019 Physician orders included, but were not limited to, house supplement three times a day; regular diet; dronabinol capsule 10 mg (milligram) twice a day (an appetite stimulant).</p> <p>Resident 211 was admitted to the facility on</p>		<p>residents having the potential to be affected by the same deficient practice?</p> <p>Audit of ADL documentation for all residents. Audited all resident with an ostomy have appropriate orders and care plans in place.</p> <p>What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur?</p> <p>All Staff education completed, including agency on implementing ADL care per the care plans and documenting them on the ADL Flow Record. Education of MDS nurse including ostomy care plans on comprehensive care plans for all residents with an ostomy.</p> <p>How will the facility monitor its corrective actions to ensure the deficient practice will not recur? CNE or designee will complete audits of ADL documentation will be done 5 days per week for 4 weeks Audit all admissions care plans to ensure appropriate orders and care plans are created for all resident diagnosis requiring specialized care plans including but not limited to ADL care, and ostomy care. Results from audits will be presented to QAPI members monthly for determination of further monitoring needs.</p>	

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	<p>1/23/19. Resident weight, on admission, was 93.5 pounds.</p> <p>The admission MDS (Minimum Data Set) assessment, dated 1/30/19, indicated Resident 211 was mildly cognitively impaired. Resident 211 was identified as being a nutritional risk. Resident was at risk for malnutrition.</p> <p>A care plan, dated 1/24/19 and current through 4/24/19, indicated Resident 211 required assistance with ADLs (activities of daily living), that included but were not limited to, eating. Interventions included, but were not limited to, monitor for decline in ADL function.</p> <p>A care plan, dated 1/28/19 and current through 4/24/19, indicated Resident 211 was considered a nutritional risk related to unintentional weight loss and poor intake. Interventions included, but were not limited to, monitor for changes in nutritional status, changes in intake, date initiated 1/28/19.</p> <p>Resident 211's, January 2019, ADL Record lacked documentation for food consumption for the following meals:</p> <p>Percent of breakfast consumed on 1/26/19; 1/27/19; and 1/29/19.</p> <p>Percent of lunch consumed on 1/24/19; 1/26/19; 1/27/19; and 1/29/19.</p> <p>Percent of dinner consumed on 1/25/19; 1/26/19; 1/27/19; 1/28/19; 1/29/19; 1/30/19; and 1/31/19.</p> <p>Bedtime snacks on 1/24/19; 1/25/19; 1/26/19; 1/27/19; 1/28/19; 1/29/19; 1/30/19; and 1/31/19.</p> <p>Resident 211's, February 2019, ADL Record lacked</p>			

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

PRINTED: 03/14/2019

FORM APPROVED

OMB NO. 0938-039

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	<p>documentation for food consumption for the following meals:</p> <p>Percent of breakfast consumed on 2/1/19 and 2/5/19;</p> <p>Percent of lunch consumed on 2/4/19 and 2/5/19;</p> <p>Percent of dinner consumed on 2/1/9; 2/2/19; 2/3/19; and 2/5/19;</p> <p>Bedtime snacks on 2/1/19; 2/2/19; 2/3/19; 2/4/19; and 2/5/19.</p> <p>During an interview, on 2/5/19 at 11:33 a.m., the Interim DON (Director of Nursing) indicated the facility ADL Report document was to be completed in its entirety and monitored by the nursing staff at the end of each shift.</p> <p>During an interview, on 2/6/19 at 12:25 p.m., the Interim DON indicated the facility lacked a specific policy for implementing care plan interventions. The facility nurses were to utilize the Standards of Clinical Gerontological Nursing Care practice for implementation of care plan interventions.</p> <p>On 2/5/19 at 2:05 p.m., the Interim DON provided a copy of the Activities of Daily Living (ADL) Documentation policy, dated 5/4/15, and indicated it was the current policy in use by the facility. A review of the document indicated "...ADL assistance will be documented on the ADL Flow Record...by the end of the shift..."</p> <p>On 2/6/19 at 12:15 p.m., the Interim DON provided an undated copy of the Standards of Clinical Gerontological Nursing Care policy and indicated it was the current policy in use by the facility. A review of the document indicated, "...the</p>			

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F 0691 SS=D Bldg. 00	<p>gerontological nurse implements the interventions identified in the plan of care..."</p> <p>This Federal tag relates to Complaint IN00285464.</p> <p>3.1-35(a) 3.1-35(g)(2)</p> <p>483.25(f) Colostomy, Urostomy, or Ileostomy Care §483.25(f) Colostomy, urostomy,, or ileostomy care.</p> <p>The facility must ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. Based on record review and interview, the facility failed to provide colostomy care for a totally dependent resident for 1 of 2 residents reviewed for colostomy care. (Resident E)</p> <p>Findings include:</p> <p>On 02/04/19 at 10:36 a.m., the closed clinical record of Resident E was reviewed. Diagnoses included, but were not limited to, paraplegia.</p> <p>Resident E was admitted on 10/18/18 and passed away on 12/29/18.</p> <p>An admission Minimum Data Set (MDS) assessment, dated 10/25/18, indicated Resident E required full staff performance (total dependence) for colostomy care.</p> <p>A recapitulation review of Physician's orders, dated February 2019, indicated colostomy care, three times a day and as needed.</p>	F 0691	<p>Problem: F691</p> <p>How will corrective action be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident E passes away prior to the survey.</p> <p>How will the facility identify other residents having the potential to be affected by the same deficient practice?</p> <p>All residents with an ostomy were audited for appropriate orders, care plan and documentation related to ostomy care.</p> <p>What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur?</p> <p>All staff, including agency educated on ostomy care and documentation MDS nurse</p>	03/08/2019

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	<p>The clinical record lacked a care plan for colostomy care.</p> <p>A Treatment Administration Record, dated December 2018, indicated a Physician's order with a start date of 10/19/18, colostomy care three times a day and as needed. The record lacked documentation of colostomy care having been completed on the following shifts:</p> <p>December 12, 2018, on second and third shift. December 13, 2018, on second shift. December 14, 2018, on first and second shift December 15, 2018, on third shift. December 16, 2018, on second and third shift. December 17, 2018, on second and third shift. December 18, 2018, on second and third shift. December 19, 2018, on second and third shift December 20, 2018, on second and third shift. December 21, 2018, on second and third shift. December 22 - 29, 2018, no documentation of colostomy care.</p> <p>During in interview, on 2/5/19 at 8:48 a.m., the Interim Director Of Nursing indicated she was not sure why the Colostomy Care was not signed off as completed.</p> <p>On 2/5/19 at 9:00 a.m., requested a copy of the facility's policy regarding colostomy care, from the Director Of Nursing.</p> <p>By survey exit, on February 06, 2019, a policy regarding colostomy care had not been provided.</p> <p>This Federal tag relates to Complaint IN00285464.</p> <p>3.1-47(a)(3)</p>		<p>education on completing ostomy care plan with comprehensive care plan.</p> <p>How will the facility monitor its corrective actions to ensure the deficient practice will not recur? All resident admitted with an ostomy will be audited to ensure appropriate orders, care plan, and documentation. Results from audits will be presented to QAPI members monthly for determination of further monitoring needs.</p>	