STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>			COMPLETED	
		155298	B. WI	NG		05/22/2017	
			<u> </u>	CTREET	ADDRESS CITY STATE ZIR CODE		
NAME OF F	PROVIDER OR SUPPLIEF	R			ADDRESS, CITY, STATE, ZIP CODE		
PYRAMII	D POINT POST-AC	CUTE REHABILITATION CENTER			OWNSHIP LINE RD APOLIS, IN 46260		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	Ι	ID	PROVIDENCE N. AV OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	· C	DATE
F 0000							
Bldg. 00	Complaint IN00 Complaint IN00 Federal/State de allegations are c	230239 - Substantiated. fficiencies related to the sited at F157 and F329. May 21 & 22, 2017 : 000195 r: 155298 00267690	F 00	000	Plan of Correction Submitted f Pyramid Point Post Acute Rehabilitation Center IDR Request submitted in addition to POC 06/06/2017 Craig A. Hestand Executive Director	or	
	These deficienci cited in accordant 16.2-3.1.	ies reflect State findings nce with 410 IAC completed on May 24,					
F 0157 SS=G Bldg. 00	2017. 483.10(g)(14) NOTIFY OF CHA (INJURY/DECLIN						

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

TITLE (X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPL	ETED
		155298	B. WI	NG		05/22/	2017
				CTDEET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				OWNSHIP LINE RD		
		UTE REHABILITATION CENTER			APOLIS, IN 46260		
FTRAMIL	J POINT POST-AC	OTE REHABILITATION CENTER		INDIAN	APOLIS, IN 40200		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	(g)(14) Notification	n of Changes.					
	resident; consult we physician; and not her authority, the rewhen there is- (A) An accident intresults in injury and requiring physician. (B) A significant of physical, mental, or is, a deterioration psychosocial statuconditions or clinic. (C) A need to alter (that is, a need to form of treatment or consequences, or of treatment); or (D) A decision to the resident from the following status of the stat	mmediately inform the with the resident's cify, consistent with his or resident representative(s) volving the resident which do has the potential for intervention; mange in the resident's per psychosocial status (that in health, mental, or is in either life-threatening cal complications); or treatment significantly discontinue an existing due to adverse to commence a new form transfer or discharge the facility as specified in motification under (i) of this section, the e that all pertinent led in §483.15(c)(2) is gided upon request to the lest also promptly notify the esident representative, if					
	(A) A change in ro assignment as spe	om or roommate ecified in §483.10(e)(6); or					

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPL	ETED
		155298	B. WI	NG		05/22	/2017
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			OWNSHIP LINE RD		
PYRAMI	D POINT POST-AC	UTE REHABILITATION CENTER			IAPOLIS, IN 46260		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		esident rights under					
		aw or regulations as raph (e)(10) of this section.					
	(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). Based on record review and interview,						
			F 01	.57	This plan of correction constitutes the	!	06/09/2017
		d to ensure the physician			facility's written credible allegation of compliance. Preparation and/or exect	ution	
		potential change in			of this Plan of Correction does not		
		a resident receiving			constitute admission or agreement by provider of the truth of the facts allege		
		erapy was initially			the conclusion set forth on the Statem		
		ruising for 1 of 4			of Deficiencies. This plan of correction prepared and/or executed solely because		
		yed for physician			required by the provisions of the heal	th	
	notification of cl	2 2			and safety code section 1280 and 42 CFR 483.		
		observed with blotchy					
		right side between 6-6:30			Identifying Prefixes F-157 (G	<u>)</u>	
		uising was not reported to					
		til 6 hours later when the			Immediate corrective action for those Residents affected		
					the deficient practice;	Бу	
		served with a large			,		
		r right side (a solid			Resident B was transferred to	the	
		ed blood within the			acute hospital on 4/23/17 and		
	Í	sident was sent to the			received sub-sequent medical care and treatment.	I	
	_	d the next day. (Resident			Care and treatment.		
	B)				Plan / Process to identify oth	her	
					residents potentially affecte	ed	
	Findings include	:			by the same deficient praction		
					and corrective action(s) to b	е	
		of an injury of unknown			taken;		
	origin dated 4/23	3/17 was reviewed on			Each week, the DON will revie	ew	
	5/21/17 at 7 p.m	., The investigation			daily 24-hour communication		
	indicated:				incident reports to establish a		
					coordinate clinical compliance		
	a. LPN 2 indica	ated she assisted an			with timely physician notification and services to address any	on	
	I		1		and services to address ally		1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		ILDING	00	COMPL	
		155298	B. WI	NG		05/22/	2017
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
		LITE DELIABILITATION CENTED			OWNSHIP LINE RD		
		UTE REHABILITATION CENTER		INDIAN	APOLIS, IN 46260		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	``	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
TAG		vith toileting Resident B		IAG	urgent medical needs as		DATE
		and" 6 a.m. Resident B			indicated.		
	indicated she nee						
	bathroom. The resident was transferred				Each week, the Medical Recor Department will conduct a	as	
		N 2 indicated while in			Change-of-condition audit to		
		e observed "splotchy			identify residents potentially		
		ght hip." The LPN			affected by untimely physician		
	_	ea to be several smaller			response; Audit disparities will referred back to the nursing	be	
	bruises near each				department for prompt resolution	on	
					of any concerns.		
	b. During a telep	ohone interview with the			Facility measures and		
		n 4/27/17 by the DON,			systemic changes to ensure		
	the CNA indicate	•			the deficient practice does no	ot	
	"bruising/discolo	oration"at the time she			recur;		
		vith toileting the resident.					
		e area was not raised and			Licensed staff will receive in-service training on or before		
	was not solid.				6/8/17 by the DON, or Designe		
					on:		
	During an interv	iew with LPN 2 on			Promptly recognizing &		
	5/22/17 at 11 a.n	n., she indicated when			timely managing change of condition;		
	she came into wo	ork on 4/23/17 around 6			Promptly notifying Physic	ian	
	a.m., she heard	Resident B and she went			of any changes in condition.		
	•	e resident indicated she			Recognizing potential sign	ns	
	needed to use the	e bathroom. She			of bleeding associated with anticoagulant therapy, includin	a	
	indicated herself	and CNA 3 took the			physician notification as indica		
	resident to the ba	athroom. The resident			to address new or worsening		
	indicated at that	time it was too painful to			bruising/bleeding.		
		The LPN indicated the			Facility plan to monitor		
	•	e bruising on her right			corrective actions & sustain		
		of small bruises. She			compliance; Integrate QA		
	indicated the resi	ident was complaining of			Process;		
		ated she had vomiting			The DON will be responsible for	nr	
		The resident did not			identifying and reporting patter		
		. LPN 2 indicated she			of non-compliance with providi		

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DF CORRECTION IDENTIFICATION NUMBER: 155298	(X2) MULTIPLE CC A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 05/22/2017
	ROVIDER OR SUPPLIER D POINT POST-ACUTE REHABILITATION CENTER	8530 To	ADDRESS, CITY, STATE, ZIP CODE DWNSHIP LINE RD APOLIS, 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 APPROPRIA' DEFICIENCY)	DATE
	completed a change in condition assessment for the nurse on duty related to the resident's nausea and vomiting and put a call into the physician related to the nausea and vomiting. During the interview, LPN 2 indicated she was not the Resident's primary nurse and was not aware the resident was on anticoagulation therapy. She indicated she did not report the bruising to the nurse in charge of the resident or notify the physician of the bruising. She indicated, had she been aware the resident was on anticoagulation therapy, she would have notified the physician and the nurse in charge. She indicated bruising was a concern when a resident was on a "blood thinner." The record for resident B was reviewed on 5/21/17 at 6:30 p.m. Current diagnoses included, but were not limited to, Atrial fibrillation and pneumonia. Physician orders dated 4/21/17 indicated orders for: Enoxaparin (lovenox: anticoagulant) 80 mg (milligrams/0.8 ml (milliliter), inject 80 mg subcutaneous every 12 hours until INR (international normalized ratio: test used to monitor individuals on anticoagulation therapy) is greater than 2 for prevention of blood clots.		proper care, assessment, and timely management of change condition to the QA committee each month for the next 3 mor for trend identification, action planning, and additional monitoring needs as indicated. The Medical Records Superviswill be responsible for identifyi patterns of non-compliance wi prompt physician notification, areporting issues to the QA committee each month for the next 3 months for trend identification, action planning, additional monitoring needs as indicated. Pyramid Point Post Acute Rehabilitation would like to submit a formal request for an IDR of F-157 (G), as we believe there is incomplete and inaccurate information in the 2567 which would demonstrate these tags should not have been cited. I would like to formally ask for a face-to-face meeting to review and discuss F-157	s in aths sor ang the and so service of the servic

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155298		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/22/2017	
	PROVIDER OR SUPPLIER D POINT POST-AC	UTE REHABILITATION CENTER	8530 T	ADDRESS, CITY, STATE, ZIP CODE OWNSHIP LINE RD IAPOLIS, IN 46260	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	,	oagulant) 2 mg Monday nd 3 mg on Saturday and l Fibrillation.		Completion Date(s): 06/09/2	017
	_	s and symptoms of hift for anticoagulant use.			
	Nursing docume	ntation indicated:			
		n., resident with change sea and vomiting and the			
	physician was no	otified. See SBAR			
		round, assessment, form). The "einteract			
	Change in Condi	ition Evaluation" form			
	completed by LF	PN 2 on 4/23/17 at 6:34			
	•	ne resident was having			
	nausea and vomi	ting. Section . "B.			
	,	neral information)"			
	indicated "4. Is				
	warfarin/coumac	lin?" This question			
		d as yes or no. "4c.			
		her anticoagulant?"			
		as not answered as yes or			
	no. "Section C	_			
	` ′	tin Evaluation16.			
		anges15. [check mark]			
	_	erved24. Other relevant			
		sident had emesis x			
		hysician] on called [sic]			
		rn call. Day nurse			
		v orders at this time"			
	_	ondition form did not			
	indicate the right	t side bruising that was			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155298		(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/22/2017		
	PROVIDER OR SUPPLIER D POINT POST-AC	UTE REHABILITATION CENTER	8530 T	ADDRESS, CITY, STATE, ZIP CODE OWNSHIP LINE RD IAPOLIS, IN 46260		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLE DAT	ETION
	this nurse and the accurately complevaluation of the communication to other nursing state 4/23/17 at 1:22 purising to hip and etiology. Reside hypotension. Or notified with new ER. Daughter with SBAR 911 Trans at 12:50 p.m., coindicated the resistransferred to the and new bruising coumadin. The rewas 72/52, had donausea, and vom "Assessment or Athink is going onPossible interm." The bruising was 4/23/17 between was not reported nurse in charge of not communicate potential alteration.	letted for a thorough resident and to the physician and ff. o.m., resident had new rea with no known and also presented with a call physician was a vorders to send to the reas made aware. An after form dated 4/23/17 ampleted by LPN 1 ident was being a hospital for hypotension g. The resident was on resident's blood pressure recreased consciousness, iting. Section A Appearance What do you a with the resident?				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPL	
		155298	B. WI	NG		05/22	/2017
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	-	
					OWNSHIP LINE RD		
PYRAMII	D POINT POST-AC	UTE REHABILITATION CENTER		INDIAN	APOLIS, IN 46260		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	`	pital) Emergency Room					
	` '	d 4/23/17 at 1:25 p.m.,					
		ident presented with low					
	-	f 90/45 and a right flank					
	(side) hematoma	ı.					
		ed 4/23/17 at 2:20 p.m.,					
	indicated a CT (•					
		in showed a large					
	muscular and sul	bcutaneous hematoma on					
	_	ht flank. There was a					
	"huge right flank	and right abdominal					
	hematoma with t	tenderness to					
	palpation"						
	An ER note date	4/23/17 at 2:24 p.m.,					
	indicated the res	ident had a right flank					
	hematoma with t	the upper part of the					
	hematoma in the	intramuscular area and					
	the lower part in	to the subcutaneous					
	tissues. The hen	natoma extended from					
	the right lower ri	ibs through the groin area					
	on the right. The	ere was no					
	enteroperitoneal	or intra-abdominal					
	hemorrhage.						
	-						
	The resident was	s admitted to the hospital					
	for acute blood l	oss with right flank					
		vas given intravenous					
		e the blood pressure and					
		ion therapy (medications					
	_	plood) was stopped. The					
	resident was give						
	_	st to help blood clot) and					
			1				İ

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l í	ULTIPLE CO. JILDING	NSTRUCTION 00	(X3) DATE COMPL		
11112 12111	or condition.	155298	B. WI		00	05/22/	
		111111111111111111111111111111111111111		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	R			OWNSHIP LINE RD		
PYRAMII	D POINT POST-AC	UTE REHABILITATION CENTER	?		APOLIS, IN 46260		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	,	ation given to reverse the					
	the ER.	adin (anticoagulant) in					
	the ER.						
	The hospital reco	ords for 4/24/17 at 8:36					
	_	he resident became					
		th low blood pressure.					
	A code blue was	called and the resident					
	died at 9:08 a.m.						
		5 policy titled "Covenant					
		Standard Managing					
		ition" was provided by					
		17 at 4:15 p.m., and					
		nt. The policy indicated:					
	1	appropriately assess,					
		ommunicate change of					
) to the primary care ovide treatment and					
		ess changes in accordance					
		dsIf the change in					
	_	ot require an immediate					
		following steps may be					
		lect and completed the					
	einteract Change	e in Change in Condition					
	Evaluation. 2. 1	Notify the physician and					
	responsible party						
		eted einteract Change in					
		ation may be printed and					
		o the physician4.					
		sment findings and					
		6. Report change of					
		DON, ED and other					
	members of the	IDT [interdisciplinary					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155298		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/22/2017		
	PROVIDER OR SUPPLIER	UTE REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ſΈ	(X5) COMPLETION DATE
	from the Executi May 22, 2017 at as current. The p "Purpose To m therapy so that th parameters are m and report abnor associated with a	10 policy titled Therapy" was received ive Director (ED) on 4:05 p.m., and deemed policy indicated: nonitor anticoagulant herapeutic drug naintained6. Recognize mal conditions anticoagulant unicate with physician					
F 0329 SS=G Bldg. 00	resident's drug reg unnecessary drug any drug when use (1) In excessive de drug therapy); or (2) For excessive (3) Without adequal	DRUGS Drugs-General. Each gimen must be free from s. An unnecessary drug is ed ose (including duplicate duration; or					

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPL	ETED
		155298	B. WI	NG		05/22/	/2017
				CTDEET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹		l	OWNSHIP LINE RD		
PVRAMI	D POINT POST-AC	UTE REHABILITATION CENTER			IAPOLIS, IN 46260		
		OTE REHABILITATION CENTER		INDIAN			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	(5) In the presenc						
		ich indicate the dose					
	should be reduced or discontinued; or (6) Any combinations of the reasons stated						
		(1) through (5) of this					
	section. Based on record review and interview,						
			F 03	329			06/09/2017
		d to ensure a resident			This plan of correction constitutes the	:	
	1	agulant therapy was			facility's written credible allegation of compliance. Preparation and/or exect	ution	
	1	bruising was initially			of this Plan of Correction does not		
					constitute admission or agreement by provider of the truth of the facts allege		
		e physician was notified		the conclusion set forth on the State			
	_	nge in treatment for 1 of			of Deficiencies. This plan of correction		
		ewed for anticoagulation			prepared and/or executed solely becarequired by the provisions of the heal		
	therapy. Reside	nt B was observed with			and safety code section 1280 and 42		
	blotchy bruising	on her right side			CFR 483.		
	between 6-6:30	a.m., and the bruising			Identifying Prefix Tag F-329		
	was not reported	to charge nurse on			(G):		
	physician until 6	hours later when the					
		served with a large			Immediate corrective action	(s)	
		r right side (a solid			for those Residents affected	l by	
		ed blood within the			the deficient practice;		
	_	sident was sent to the			Desident Description of the	41	
	· · · · · · · · · · · · · · · · · · ·				Resident B was transferred to acute hospital on 4/23/17 and	tne	
	l ^	d the next day. (Resident			received sub-sequent medica	I	
	B)				care and treatment.	•	
	Findings include	2:			Plan / Process to identify oth	her	
					residents potentially affected		
	An investigation	of an injury of unknown			by the same deficient practic		
		3/17 was reviewed on			and corrective action(s) to b	е	
		., The investigation			taken;		
	indicated:	., 110 111 0015411011			An audit will be conducted wit	h all	
	muicaicu.				residents receiving anticoagul		
	I DV 4 ' 4'				therapy to evaluate and facility		
		ted she visualized the	1		compliance with implementing		
	right side and hi	p of Resident B on			adequate monitoring.		

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155298	B. WI	NG		05/22/	2017
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	ROVIDER OR SUFFLIER				OWNSHIP LINE RD		
PYRAMI	D POINT POST-AC	UTE REHABILITATION CENTER		INDIAN	APOLIS, IN 46260		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		re was no redness or			Facility measures and		
	_	d filled mass. LPN 1			systemic changes to ensure		
		und the "bruising/blood			the deficient practice does not		
		en she went into room on			recur;		
	,	noon) to get admission			The DON, or designee will		
	1 1 0	nd the resident stated she			in-service on or before 6/8/17		
	felt funny. The LPN attempted to get a blood pressure and was unsuccessful. Another nurse arrived and they provided incontinent care and observed the noted area. LPN 1 then initiated transfer the to				Licenses Nurses on the		
					importance of monitoring		
					abnormal bleeding or bruising		
					associated with anticoagulant therapy; and, prompt physicial		
					notification of new or worsenir		
	hospital.				changes of condition.		
	agency CNA 3 von 4/23/17 "arou indicated she ne bathroom. The to the toilet. LP the bathroom sh bruising to her r described the arc bruises near each c. During a tele agency CNA 3 of the CNA indicat "bruising/discole assisted LPN 2 von She indicated the was not solid.	ated she assisted an with toileting Resident B and" 6 a.m. Resident B eded to go to the resident was transferred N 2 indicated while in e observed "splotchy ight hip." The LPN ea to be several smaller th other. The phone interview with the phone			Facility plan to monitor corrective actions & sustain compliance; Integrate QA Process; The DON, or designee will revenew anticoagulant orders each week to evaluate compliance initiating adequate monitoring plans (MD orders, Care Plan, MAR) as indicated. Each week, the Medical Reconseponder will conduct a Change-of-condition audit to identify residents potentially affected by untimely physician notification; Audit disparities whereferred back to the nursing department for prompt resolutions.	riew h with and rds	
	_	m., she indicated when			of any concerns.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN			00	COMPL			
		155298	B. WI	NG		05/22/	2017
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
					DWNSHIP LINE RD		
PYRAMIL	D POINT POST-AC	UTE REHABILITATION CENTER		INDIAN	APOLIS, IN 46260		
(X4) ID		TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCI)		DATE
		ork on 4/23/17 around 6			Trends identified with new order	er	
		Resident B and she went			reviews and COC audits will be		
		e resident indicated she			referred to the Monthly Quality		
	needed to use the				Assurance Committee for		
		and CNA 3 took the			problem-analysis, action planning, and additional		
		athroom. The resident			monitoring needs as indicated.		
		time it was too painful to					
		The LPN indicated the					
		e bruising on her right					
		of small bruises. She			Pyramid Point Post		
		ident was complaining of			Acute Rehabilitation would like to		
		ated she had vomiting			submit a formal request for an IDR		
		The resident did not			of F-329 (G), as we believe there is		
	_	. LPN 2 indicated she			incomplete and inaccurate		
	completed a char				information in the 2567 which would demonstrate these tags		
		ne nurse on duty related			should not have been cited. I would		
		nausea and vomiting and			like to formally ask for a face-to-face		
	_	e physician related to the			meeting to review and discuss F-329.		
	nausea and vomi	-					
	·	2 indicated she was not					
	_	imary nurse and was not					
		nt was on anticoagulation					
		licated she did not report					
		ne nurse in charge of the					
	-	the physician of the					
	_	dicated, had she been					
		nt was on anticoagulation					
		ald have notified the					
		e nurse in charge. She					
		g was a concern when a					
	resident was on a	a "blood thinner."			Completion Date(s): 06/09/20	017	
		5/00/15 110.00					
	_	iew on 5/22/17 at 10:30					
	a.m., LPN I indi	cated she had completed					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298	(X2) MULTIPL A. BUILDIN B. WING		NSTRUCTION 00	(X3) DATE : COMPL 05/22/	ETED
NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER			853	0 TO	DDRESS, CITY, STATE, ZIP CODE DWNSHIP LINE RD APOLIS, IN 46260	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	in the evening ar concerns except shoulder and the and oriented. She facility on 4/22/1 admission. She daughter was viscomplain of som right hip. LPN 1 the area and ther 1 indicated the dresidents hips at resident declined 4/23/17, Sunday indicated she wa and was in the fawent to the resident was not and indicated she stool. The LPN nurse moved the to provide care a bruise and blood called the doctor 1 indicated she fibleeding. A (Name of Hos (ER) noted, date indicated the res	tial admission on 4/21/17 and there was no skin a bruise on the resident's resident was very alert the indicated she was in the 17, Saturday for another indicated the resident's titing and the resident did the pain at that time to her indicated she looked at the was no bruising. LPN aughter was rubbing the that time and the dipain medication. On the around noon LPN 1 the manager on duty ficility. She indicated she the ent's room to have her sion paper work. The interested in breakfast the had been incontinent of with the assist of another resident over to her side and observed the large filled mass She then the and the daughter. LPN telt the resident was pital) Emergency Room did 4/23/17 at 1:25 p.m., ident presented with low f 90/45 and a right flank					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298	(X2) MULTIPLE CC A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 05/22/2017	
NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER			8530 TO	ADDRESS, CITY, STATE, ZIP CODE OWNSHIP LINE RD APOLIS, IN 46260		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE (X5) COMPLETION DATE	ON
	indicated a CT (of tomography) scal muscular and sulthe resident's riging "huge right flank hematoma with the palpation" An ER note, date indicated the resident material tower part in tissues. The hematoma in the the lower part in tissues. The hematoma in the right lower right lower right hemorrhage. The resident was for acute blood lehematoma and we fluids to increase her anticoagulating used to thin the bresident was given milligrams (assist Kcentra (medicated).	n showed a large ocutaneous hematoma on the flank. There was a stand right abdominal tenderness to the ded 4/23/17 at 2:24 p.m., addent had a right flank the upper part of the intramuscular area and to the subcutaneous matoma extended from the bs through the groin area there was no or intra-abdominal to sadmitted to the hospital toss with right flank was given intravenous the blood pressure and on therapy (medications blood) was stopped. The				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155298		(X2) MULTIPLE CC A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 05/22/2017	
NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER			8530 T	ADDRESS, CITY, STATE, ZIP CODE DWNSHIP LINE RD APOLIS, IN 46260	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	unresponsive wi	th low blood pressure. called and the resident			
	on 5/21/17 at 6:3 diagnoses include	esident B was reviewed 80 p.m. Current led, but were not limited tion and pneumonia.			
	4/21/17, indicate	assessment, dated and the only skin concern the left shoulder 5 by 4.5 cm.			
	Physician orders orders for:	, dated 4/21/17, indicated			
	mg (milligrams/ 80 mg subcutant INR (internation used to monitor	therapy) is greater than 2			
	`	coagulant) 2 mg Monday and 3 mg on Saturday and al Fibrillation.			
	_	s and symptoms of hift for anticoagulant use.			
	The Medication	Administration record			

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 05/22/2017
NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER			8530 TO	ADDRESS, CITY, STATE, ZIP CODE DWNSHIP LINE RD APOLIS, IN 46260	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
		oxaparin 80 mg was uneous injection at 9 a.m.,			
	Nursing docume	ntation indicated:			
	4/23/17 6:34 a.m. in condition naus physician was not (situation, backg recommendation Change in Condicompleted by LF a.m., indicated the nausea and vomi Background (Geindicated "4. Is warfarin/coumac was not answere Resident is on of This question was no. "Section C (Evaluation)Sk Describe skin ch No changes obse	a., resident with change sea and vomiting and the otified. See SBAR round, assessment, form). The einteract stion Evaluation form PN 2 on 4/23/17 at 6:34 me resident was having ting. Section . "B. meral information)" at the resident on lin?" This question das yes or no. "4c. ther anticoagulant?"			
	[times] 1. md [p and waiting return notified. No new The change in co- indicate the right observed during this nurse and the	hysician] on called [sic] on call. Day nurse or orders at this time" ondition form did not a side bruising that was the care observation by			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		î ´	ILTIPLE CO ILDING	NSTRUCTION 00	(X3) DATE S COMPL		
		155298	B. WI	NG		05/22/	2017
	OVIDER OR SUPPLIER	JTE REHABILITATION CENTER		8530 TC	DDRESS, CITY, STATE, ZIP CODE DWNSHIP LINE RD APOLIS, IN 46260		
	(EACH DEFICIENCE REGULATORY OR evaluation of the	o the physician and]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE	(X5) COMPLETION DATE
	none on day shift Practitioner will: 4/23/17 at 1:22 p	e, emesis on 2 and 3 shift, on new orders. Nurse see on 4/24/17. .m., resident had new ea with no known					
:	etiology. Reside hypotension. On notified with new ER. Daughter wa	nt also presented with call physician was v orders to send to the as made aware. An fer form dated 4/23/17					
:	indicated the resi transferred to the and new bruising coumadin. The re	hospital for hypotension The resident was on esident's blood pressure					
1	nausea, and vom	Appearance What do you with the resident?					
:	4/23/17 between was not reported nurse in charge o not communicate potential alteration	first observed on 6 and 6:30 a.m., and immediately to the f the resident and was d to the physician for on in treatment when he ausea and vomiting that					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298	(X2) MULTIPLE CC A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 05/22/2017
NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER			8530 TO	ADDRESS, CITY, STATE, ZIP CODE DWNSHIP LINE RD APOLIS, IN 46260	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	from the Execution May 22, 2017 at as current. The parameters are in the for signs and syngeffects, including to,excessive by the Recognize and reconditions associated the parameters are in for signs and syngeffects, including to,excessive by the Recognize and reconditions associated the rapyCommon whenadverse didentified" An October 2015 Care Operating Strange of Condition the ED on 5/22/1 deemed as current "Objective: To a document, and condition (COC) provider. To proservices to addressive with patient needs condition does in 911 transfer the followed: 1. See einteract Change	Cherapy" was received ve Director (ED) on 4:05 p.m., and deemed policy indicated: conitor anticoagulant derapeutic drug diaintained5. Monitor diaptoms of adverse drug g, but not limited duising, petechiae6. deport abnormal diated with anticoagulant dunicate with physician			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00 COMPLETE		COMPLETED
	155298	B. WING		05/22/2017
		CTREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER		, , , ,	
	D DOINT DOOT A QUITE DELIABILITATION OFNITED		OWNSHIP LINE RD	
PYRAMII	D POINT POST-ACUTE REHABILITATION CENTER	INDIAN	IAPOLIS, IN 46260	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPE	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	responsible party of assessment			
	findingscompleted einteract Change in			
	Condition Evaluation may be printed and			
	, ,			
	faxedtextedto the physician4.			
	Document assessment findings and			
	communications6. Report change of			
	condition to the DON, ED and other			
	members of the IDT [interdisciplinary			
	1			
	team] per facility practices"			
	3.1-48(a)(3)			
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