CENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES				0!	MB NO. 0938-039	
STATEME	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA				CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	ЛLDING	00	COMPLETED		
		155226	B. W	ING _		09/07	7/2022	
NAME OF 1	PROVIDER OR SUPPLIER	}			ADDRESS, CITY, STATE, ZIP COD			
					N CAPITOL AVE			
NORTH	CAPITOL NURSING	G & REHABILITATION CENTER	T	INDIAI	NAPOLIS, IN 46202			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTIO		(X5)	
PREFIX	· ·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROL DEFICIENCY)	PRIATE	COMPLETION	
TAG F 0000	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	BENEEN		DATE	
1 0000								
Bldg. 00								
Ü	This visit was for the	ne Investigation of Complaint	F 0	000				
	IN00388926.							
	^	8926 - Substantiated.						
		encies related to the						
	allegations are cited	1 at F064.						
	Unrelated deficience	cies are cited.						
	Survey dates: Septe	ember 6 and 7, 2022						
	Facility number: 00	00131						
	Provider number: 1							
	AIM number: 1002	74910						
	Census Bed Type:							
	SNF/NF: 56							
	Total: 56							
	Census Payor Type	::						
	Medicaid: 51							
	Other: 5							
	Total: 56							
	Those deficiencies	reflect State Findings cited in						
	accordance with 41							
	decordance with 11	0 110 10.2 3.1.						
	Quality review com	npleted on September 9, 2022						
		-						
F 0656	483.21(b)(1)							
SS=D		nt Comprehensive Care Plan						
Bldg. 00	, , .	rehensive Care Plans						
	- ' ' ' '	e facility must develop and						
		prehensive person-centered						
		resident, consistent with						
	I the resident rights	s set forth at §483.10(c)(2)	- 1				İ	

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

and §483.10(c)(3), that includes measurable

(X6) DATE

TITLE

Any defiency statement 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 disclodays 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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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BI	JILDING	00	COMPL	ETED
		155226	B. WI	NG		09/07/	
				·			
NAME OF F	PROVIDER OR SUPPLIER	R			ADDRESS, CITY, STATE, ZIP COD		
					CAPITOL AVE		
NORTH (CAPITOL NURSING	G & REHABILITATION CENTER		INDIAN	APOLIS, IN 46202		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	Τ	ID	BROWDERIC BY AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	IE	DATE
	objectives and tim	neframes to meet a	1				
	1 -	I, nursing, and mental and					
		ds that are identified in the					
	comprehensive as						
	•	are plan must describe the					
	following -	are plan mast asserned and					
	_	nat are to be furnished to					
		the resident's highest					
	practicable physic	_					
		-being as required under					
	§483.24, §483.25	-					
	-	hat would otherwise be					
		183.24, §483.25 or §483.40					
		led due to the resident's					
		under §483.10, including					
		treatment under §483.10(c)					
	(6).	troutinont under 3 100.10(5)					
		ed services or specialized					
		rices the nursing facility will					
	provide as a resul						
		s. If a facility disagrees with					
		PASARR, it must indicate					
	_	e resident's medical record.					
		with the resident and the					
	resident's represe						
		s goals for admission and					
	desired outcomes	•					
		s preference and potential for					
		Facilities must document					
	_	ent's desire to return to the					
		ssessed and any referrals					
		gencies and/or other					
	1	es, for this purpose.					
		ins in the comprehensive					
		ropriate, in accordance with					
		set forth in paragraph (c) of					
	this section.	oot for an in paragraph (o) or					
		on, interview, and record	F 06	656	What corrective action(s) wil	ı	10/01/2022
		failed to develop and	1 00)50	be accomplished for those	•	10/01/2022
		rehensive person-centered care			residents found to have beer		
	implement a compi	chensive person-centered care			lesidents idund to nave been		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3			(X3) DATE	X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPL	LETED
		155226	B. W	ING		09/07/	/2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			CAPITOL AVE		
NORTH	CAPITOL NURSING	G & REHABILITATION CENTER			IAPOLIS, IN 46202		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		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		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		le objectives and timeframes to			affected by the deficient		
		reds for a resident who			practice?		
		cility with a urinary catheter,			Resident B immediately		
		ospice services after a			had a care plan put in place to		
	_	of 4 residents whose care			address fecal/fecal tube, urina	ary	
	plans were reviewe	d. (Resident B)			catheter and hospice.		
	Findings include:				How will you identify other		
					residents having the potenti	al	
		for Resident B was reviewed			to be affected by the same		
	_	p.m. Resident B's diagnoses			deficient practice and what		
		mited to, chronic obstructive			corrective action will be take	∍n?	
		NASH (nonalcoholic			· All residents with		
		iver damage and inflammation			fecal/rectal tubes, urinary		
	with fatty liver, typ	e II diabetes, and			catheters and are on hospice		
	schizophrenia.				the potential to be affected by	the	
					alleged deficient practice		
		Resident B was made on 9/7/22			· An audit will be comple	ted	
	_	dent B was noted to have a			by the Director of		
		be, urine collection bag, as well			Nursing/designee to ensure the	ıat	
		collection bag hanging			any resident with fecal tubes,		
	bedside.				urinary catheters, are being		
		1.0/0/02 + 11.00			addressed. Issues are being		
		ed 9/2/22 at 11:32 p.m.			addressed as identified. Audit	. Will	
		B returned from the hospital			be completed by Oct 1, 2022		
	_	ces and was a "DNR" (sic, do			DNS/Designee will	-	
		esident B had a urinary			inservice nursing staff and ID	I	
	catheter and a fecal	tube in place.			team on developing and		
	A review of Decid-	nt Ple ordere was samulated an			implementing care plans for	700	
		nt B's orders was completed on Resident B's orders did not			residents with condition chang	•	
	-	r a urinary catheter, fecal/rectal			including foley catheters, feca	d.	
	tube, or an order for	-			tubes and hospice care by		
	idue, of all order 10.	i nospice services.			October 1, 2022.	nto	
	Δ review of Deside	nt B's most current care plan			What measures will be put in	ito	
		indicated, it did not contain a			place or what systemic changes you will make to		
		urinary catheter, fecal/rectal			ensure that the deficient		
	tube, nor hospice se	-			practice does not recur?		
	idoe, noi nospice se	DI VICCS.			Practice does not recur? • DNS/Designee will		
	An interview with I	DON conducted on 9/7/22 @			_	т	
	I will interview with i	5011 conducted on 3/1/22 (w	1		inservice nursing staff and ID	İ	1

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	00	COMPLET	ΓED
		155226	B. W	ING		09/07/20	022
	PROVIDER OR SUPPLIER	S & REHABILITATION CENTER	•	2010 N	ADDRESS, CITY, STATE, ZIP COD CAPITOL AVE IAPOLIS, IN 46202		
(V4) ID	CUMMADV	CTATEMENT OF DEFICIENCIE	T	ID	T		(V5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	,	LISC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE '	DATE
1710		, a chart review for Resident B	1	1710	team on developing and		DATE
	•	0/6/22 and they should have			implementing care plans for		
	-	are plan for the new urinary			residents with condition change	ies.	
	-	I tube, and hospice services			including foley catheters, feca	· I	
		to the current care plan, but			tubes and hospice care by		
	stated that they "abs	solutely" needed to be			October 1, 2022.		
	included in the care	plan. DON also indicated, the			· IDT will review all new		
		imum data set) coordinator was			admissions/readmissions utiliz	zing	
		lly are responsible for			the IDT Admission/Readmissi	on	
	initiating and/or upo	dating care plans.			Review and Care Plan		
					Initiation/Update tool the next		
	3.1-35(a)				business day following all		
					admissions and readmissions		
					How the corrective action (s)		
					will be monitored to ensure t	ne	
					deficient practice will not		
					recur, i.e., what quality		
					assurance program will be p into place?	ut	
					·Care Plan Updating QAPI 1	-ool	
					will be utilized weekly x 4 wee		
					and monthly x 6 months, with	,	
					results reported to the Quality		
					Assurance and Performance		
					Improvement Committee over	seen	
					by the Executive Director. If n	10	
					trends identified after those 6		
					months, review will occur as		
					needed.		
					·If a threshold of 95% is not		
					achieved, an action plan will b		
					developed to ensure complian	ice	
F 0657	483.21(b)(2)(i)-(iii)						
SS=D	Care Plan Timing						
Bldg. 00	_	rehensive Care Plans					
J. 22		omprehensive care plan					
	must be-	,					
		in 7 days after completion					
	of the comprehens	· · · · · · · · · · · · · · · · · · ·	1				

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155226	B. WI	NG		09/07/	2022
				STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEI	R			CAPITOL AVE		
NORTH	CAPITOL NURSING	3 & REHABILITATION CENTER			IAPOLIS, IN 46202		
11011111	-	- CARLETT CHOICE CENTER					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		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		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		n interdisciplinary team, that					
	includes but is no						
	(A) The attending						
		urse with responsibility for					
	the resident.	with recogniciality for the					
	resident.	with responsibility for the					
		food and nutrition services					
	staff.	TOOL AND NUMBER OF STREET					
	(E) To the extent	practicable the					
	1 ' '	e resident and the resident's					
		An explanation must be					
	. ,	dent's medical record if the					
		e resident and their resident					
		determined not practicable					
		ent of the resident's care					
	plan.						
	(F) Other appropr	iate staff or professionals in					
	disciplines as dete	ermined by the resident's					
	needs or as reque	ested by the resident.					
	(iii)Reviewed and	revised by the					
		eam after each assessment,					
	_	comprehensive and					
	quarterly review a						
		on, interview, and record	F 06	557	What corrective action(s) wil	I	10/01/2022
	_	failed to timely revise a			be accomplished for those		
		based the needs of the			residents found to have beer	ו	
	1	onse to current interventions			affected by the deficient		
		nad skin breakdown related to			practice?		
	,	ssociated skin damage) for 1 of			Resident B's care plan		
	5 residents reviewe	d for skin issues. (Resident B)			related to recurrence of MASE		
	Findings include:				was reinstated and updated pe		
	r manigs merade:				residents current plan of care. How will you identify other		
	The clinical record	for Resident B was reviewed			residents having the potentia	al	
		p.m. Resident B's diagnoses			to be affected by the same	ai	
		mited to, chronic obstructive			deficient practice and what		
		NASH (nonalcoholic			corrective action will be take	n?	
		iver damage and inflammation			· All residents with impair		
	with fatty liver, typ				skin integrity have the potentia		

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	T OF HEALTH AND HUN R MEDICARE & MEDIC						RM APPROVED IB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(V2) M	III TIDI E CO	ONSTRUCTION	(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER	lì í	UILDING	00	COMPLETED	
AND PLAN	OF CORRECTION	155226	B. W		<u>00 </u>		
		155220	D. W			09/07	12022
NAME OF I	PROVIDER OR SUPPLIER	•			ADDRESS, CITY, STATE, ZIP COD		
White of 1	ROVIDER OR SOLIEER			2010 N	CAPITOL AVE		
NORTH	CAPITOL NURSING	3 & REHABILITATION CENTER		INDIAN	IAPOLIS, IN 46202		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		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	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	schizophrenia.				be affected by alleged deficien	nt	
					practice.		
	_	rly MDS (minimum data set)			 An audit was completed 	d by	
		ated, Resident B did not have			DNS/Designee on all resident	S	
	_	tensive assistance of two			with areas of skin impairment	to	
	^	bility, was totally dependent			ensure the care plan timing a	nd	
		2 persons for transfers and			revision is accurate.		
		ed extensive assistance of one			 Regional Director of Cli 		
	person for personal	hygiene.	Services will inservice IDT Team				
					on timing and revisions to car	е	
		cant change MDS dated 8/9/22			plans by October 1, 2022		
	1	B did not have MASD, but did			What measures will be put in	nto	
	have a surgical wou	and a skin tear.			place or what systemic		
					changes you will make to		
		n assessment (a measurement			ensure that the deficient		
		ute to a either a higher			practice does not recur?		
	1	on of pressure, or lower tissue			 Regional Director of Cli 	nical	
	_	re) completed on 7/31/22			Services will inservice IDT Te	am	
	indicated, Resident	B was "at risk".			on timing and revisions to car	е	
					plans by October 1, 2022		
	1	ed 5/26/22 at 2:03 p.m.			· IDT will review all area	of	
		B had MASD to left and right			skin impairment weekly to ens		
		also indicated, the physician			care plans have been updated		
	was not notified.				interventions are implemented	d.	
					· IDT team will utilize Ski	n	
		dated 6/23/22 at 10:37 a.m.			Impairment checklist tool wee	kly	
		B had excoriation (erosion of			to ensure all areas are record	ed	
	1	buttock measuring 6 cm			and care planned accurately.		
		th, 1.5 cm in width, and 0.1 cm			How the corrective action (s	-	
	-	riation was not present on			will be monitored to ensure	the	
	admission.				deficient practice will not		
					recur, i.e., what quality		
		dated 6/23/22 at 10:26 a.m.	assurance program will be put				
		B had pink, excoriation to the			into place?		
	right posterior thigh	which was not present on			·Care Plan Updating QAPI	ГооІ	

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admission. The area measured 3.1 cm in length,

light serosanguinous (pink tinged, containing

small amount of blood) drainage.

3.5 cm in width, and 0.1 cm in depth. The area had

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will be utilized weekly x 4 weeks,

and monthly x 6 months, with

results reported to the Quality

Assurance and Performance Improvement Committee overseen

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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
		155226	B. WI	NG		09/07/	/2022
				OTD FET	DDDEGG CHTV CT TT TD COT		
NAME OF P	PROVIDER OR SUPPLIEF	Ł			ADDRESS, CITY, STATE, ZIP COD		
	0.4 DITOL	0 0 DELLA DILLITA DI CONTROLLE			CAPITOL AVE		
NORTH (CAPITOL NURSINO	3 & REHABILITATION CENTER		INDIAN	APOLIS, IN 46202		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		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	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	A nursing note date	d 8/23/22 at 1:28 p.m.			by the Executive Director. If n	10	
	indicated, Resident	B's bilateral buttocks and			trends identified after those 6		
	thighs were cleaned	and treated with "calmo and			months, review will occur as		
	collegen" (sic, a bar	rrier cream)(sic, collagen).			needed.		
					·If a threshold of 95% is not		
	An interview with I	LPN (Licensed Practical Nurse)			achieved, an action plan will b	e	
	3 was conducted on	9/7/22 at 2:58 p.m. LPN 3			developed to ensure complian		
	indicated, Resident	B was incontinent of urine and			•		
	bowel and was freq	uently soiled or "wet" because					
		lose which can cause					
	frequent, loose stoo	ls. She indicated, the urine					
	and bowel moveme	nt sometimes leaked through					
	to the bed. LPN 3 in	ndicated, she had worked on					
	8/22/22 and Reside	nt B was one of her residents.					
	She indicated, Resid	dent B's skin was very fragile					
	and she frequently	would have issues with					
		would go through cycles of					
		curring again". On 8/22/22,					
	_	esident B's bilateral buttocks					
	and bilateral posteri	for thighs. She indicated, both					
	1	e red and excoriated and she					
	had excoriation to t	he bilateral, posterior thighs					
		own the backside of both					
	thighs. LPN 3 was	not able to indicate when the					
	excoriation started						
	Resident B's hospita	al records for her					
	hospitalization date	d from 8/23/22 to 9/2/22 were					
	_	ocal hospital on 9/7/22 at 7:52					
		ecords contained a photo of					
	_	ks and bilateral, posterior					
	thighs dated 8/24/22	2 and labeled as "wound					
		ocks, posterior thighs legs.					
	_	nuded/erosion"; onset was					
		location was buttock/sacral					
	_	ere "extensive moisture/stool					
	_	d minimum amount of					
		inage. From the documented					
	-	bilateral buttocks were beefy					
	_	as of darker red tones and					

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

PRINTED: 10/03/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155226		l í	UILDING	nstruction 00	(X3) DATE COMPL 09/07/	ETED	
	PROVIDER OR SUPPLIER	R & REHABILITATION CENTER		2010 N	DDRESS, CITY, STATE, ZIP COD CAPITOL AVE APOLIS, IN 46202		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R 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
	continuous from the the gluteal folds and posterior thighs and length of both thigh lateral(towards the (where buttocks me color with sloughin as a red, irritated, ra						
	she was a risk for si limited to: being oc very limited ability history of skin brea interventions include and document skin	lan dated 12/19/17 indicated, kin breakdown due to, but not casionally moist, chair fast, to change body positions, a kdown and MASD. The ded, but not limited to, assess condition weekly and as by the physician of abnormal					
	include a care plan impaired skin integ having excoriation The current care pla incontinence check barrier cream as pro	lan was not updated/revised to related to Resident B having rity related to MASD despite noted on 5/26/22 and 6/23/22. an dated 8/24/22 indicated for s and perineal care with house eventative measure for pressure of MASD on right and left					
	on 9/6/22 at 11:54 to of care will be initial risk factors and con	nt Program policy was received from DON. It indicated, "A plan ated to include resident specific stributing factors with intions implemented."					
F 0684 SS=D	483.25 Quality of Care						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 09/07/2022 155226 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2010 N CAPITOL AVE NORTH CAPITOL NURSING & REHABILITATION CENTER INDIANAPOLIS. IN 46202 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Bldg. 00 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview, and record F 0684 What corrective action(s) will 10/01/2022 review, the facility failed to ensure a resident with be accomplished for those a urinary catheter, fecal/rectal tube, and receiving residents found to have been hospice services had physician's orders indicating affected by the deficient such and failed to implement the facility's Skin practice? Management Program for a resident with skin Resident B's orders for issues for 1 of 4 residents reviewed for physician's foley catheter, fecal/rectal tube, orders and 1 of 3 residents reviewed for wounds. and hospice services were (Resident B) immediately entered. Resident B's wound Findings include: management and care plan immediately updated to reflect 1. The clinical record for Resident B was reviewed resident's areas of skin on 9/6/22 at 12:24 p.m. Resident B's diagnoses impairment. included, but not limited to, chronic obstructive How will you identify other pulmonary disease, NASH (nonalcoholic residents having the potential steathophepatitis)(liver damage and inflammation to be affected by the same with fatty liver, type II diabetes, and deficient practice and what schizophrenia. corrective action will be taken? All residents with An observation of Resident B was made on 9/7/22 catheters, fecal/rectal tubes, @ 11:52 a.m. Resident B was noted to have a hospice, and impaired skin urinary drainage tube, urine collection bag, as well integrity have the potential to be as a fecal tube and fecal collection bag hanging affected by alleged deficient bedside. practice. An audit was completed by A nursing note dated 9/2/22 at 11:32 p.m. DNS/Designee on all residents indicated, Resident B returned from the hospital with catheters, fecal/rectal tubes. "on Hospice" services and was a "DNR" (sic, do hospice to ensure the orders are

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not resuscitate). Resident B had a urinary

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in place as applicable.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155226		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/07/2022	
	PROVIDER OR SUPPLIER	G & REHABILITATION CENTER	2010 N	ADDRESS, CITY, STATE, ZIP COD CAPITOL AVE IAPOLIS, IN 46202	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	A review of Reside 9/6/22 at 1:27 p.m. contain an order for tube, or an order for tube, or an order for tube, or an order for tube, or an order for tube, or an order for tube, or an order for tube, or an order for tube, or an order for tube, or an order for tube, or an order for tube, or an order for tube, or an order for tube, or an order for tube, or an order for tube, or an order for ecognized that the catheter, a fecal/rec She indicated, the catheter, a fecal/rec She indicated, the catheter, a fecal/rec She indicated, the catheter, a fecal/rec She indicated that the persons for the hospital or the hospital or the assistance of bathing, and require person for personal Resident B's significated, Resident B's significated, Resident B's Brader of risks that contribing intensity and duration of the side of the catheter and a fecal side of the cath	tube in place. Int B's orders was completed on Resident B's orders did not a urinary catheter, fecal/rectal r hospice services. DON conducted on 9/7/22 @, a chart review for Resident B D/6/22 and they should have re were no orders for a urinary stal tube or hospice services. Orders may have been missed and come back to the facility in a holiday weekend. Interly MDS (minimum data set) ated, Resident B did not have stensive assistance of two bility, was totally dependent and extensive assistance of one hygiene. Icant change MDS dated 8/9/22 B did not have MASD, but did and and a skin tear. In assessment (a measurement bute to a either a higher on of pressure, or lower tissue are) completed on 7/31/22		An audit was completed DNS/Designee on all residents with impaired skin integrity to ensure orders and observation are in place as applicable. DNS/Designee will inservice all nursing staff on implementation of orders for for catheters, fecal/rectal tubes, a hospice by October 1, 2022 DNS/Designee will inservice all nursing staff on faskin management policy by October 1, 2022 What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur? DNS/Designee will inservice all nursing staff on implementation of orders for for catheters, fecal/rectal tubes, a hospice by October 1, 2022 DNS/Designee will inservice all nursing staff on implementation of orders for for catheters, fecal/rectal tubes, a hospice by October 1, 2022 DNS/Designee will inservice all nursing staff on faskin management policy by October 1, 2022 IDT team will utilize Skir Impairment checklist tool week to ensure all areas are recorded and care planned accurately. IDT will review all new	DATE DATE DATE DATE DATE DATE
	A nursing note date	ed 8/23/22 at 1:28 p.m.		admissions/readmissions utiliz the IDT Admission/Readmission	·
		B's bilateral buttocks and		Review and Care Plan	
		d and treated with "calmo and		Initiation/Update tool the next	
	_	rrier cream)(sic, collagen).		business day following all	
	lonegen (Sie, a oa.			admissions and readmissions.	

An interview with LPN (Licensed Practical Nurse)

How the corrective action (s)

CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155226		JILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/07/2022	
	PROVIDER OR SUPPLIER	3 & REHABILITATION CENTER		2010 N	ADDRESS, CITY, STATE, ZIP COD I CAPITOL AVE JAPOLIS, IN 46202		
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OF 3 was conducted on indicated, Resident bowel and was freq she was given lactu frequent, loose stoo and bowel moveme to the bed. LPN 3 in 8/22/22 and Reside. She indicated, Reside and she frequently was most of the bed. Wass (moisture as "It would go throug occurring again". Resident B's bilater posterior thighs. She buttocks were red a excoriation to the b the buttocks down t LPN 3 was not able excoriation started to A contracted wound indicated, "Wound wound is currently Without Exposed S an etiology of MAS GluteusWound #1 wound is currently Thickness wound w located on the Righ LegWound #8R s is currently classific Exposed Support St	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION 19/7/22 at 2:58 p.m. LPN 3 B was incontinent of urine and uently soiled or "wet" because lose which can cause ls. She indicated, the urine nt sometimes leaked through edicated, she had worked on nt B was one of her residents. It is sociated skin damage) saying, the cycles of healing and then on 8/22/22, she had observed all buttocks and bilateral ne indicated, both of her nd excoriated and she had illateral, posterior thighs from the backside of both thighs. It to indicate when the this time. If care note dated 7/22/22 #11 status is HealedThe classified as a Full Thickness upport Structures wound with ED and is located on the Left 12 status is HealedThe classified as a Partial with etiology of MASD and is				the ut API ns, uality seen no	(X5) COMPLETION DATE
	Upper LegOther of with Rash / Dermat Gluteus and thighs.	condition(s) Patient presents itis located on the Bilateral The skin appearance had no					

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appearance exhibited: Rash. Skin temperature was

noted as: No Abnormality. General Notes:

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	T OF HEALTH AND HU R MEDICARE & MEDIO					ORM APPROVED OMB NO. 0938-039
STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155226		(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION G <u>00</u>	(X3) DA'	TE SURVEY MPLETED 07/2022	
	PROVIDER OR SUPPLIE	R G & REHABILITATION CENTER	201	EET ADDRESS, CITY, STATE, ZIP 0 N CAPITOL AVE NANAPOLIS, IN 46202	COD	
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI	SHOULD BE	(X5) COMPLETION DATE
	Skin Event for the buttocks and bilate present as of 8/22/2 contracted wound of Resident B's weekl was received on 9/(Director of Nursing warm and dry; had extremity; had open extremity and bruissecond toe; and she and repositioning of issue on her buttoch Resident B's weekl 8/12/22 was received DON indicated, he to bilateral lower eas left lower extremity to left great toe and compliant with turn did not indicate as posterior thighs. Resident B's weekl 8/19/22, received of DON, indicated, he open areas to left left was compliant with turn of the second point with turn	y skin assessment dated 8/5/22 7/22 at 12:55 p.m. from DON ag). It indicated, her skin was edema on the left lower as skin areas on left lower as sees on left great toe and left as was compliant with turning are. It did not indicate a skin as or posterior thighs. y skin assessment dated and on 9/7/22 at 12:55 p.m. from as skin was warm and dry; edema astremities, had open areas listed anity staples to left thigh; bruises as second toe; and she was aning and repositioning care. It askin issue on her buttocks or y skin assessment dated an 9/7/22 at 12:55 p.m. from ar skin was warm and dry; had an turning and repositioning cate a skin issue on her				
	Resident B's hospit	tal records for her				

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hospitalization dated from 8/23/22 to 9/2/22 were received from the local hospital on 9/7/22 at 7:52 a.m. The hospital records contained a photo of

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STATEMENT OF DEFICIENCIES X1) PROVIDER		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	LDING	00	COMPL	ETED
		155226	B. WIN	IG		09/07/	/2022
		<u> </u>	' 1	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEI	R			CAPITOL AVE		
NORTH	CAPITOL NURSING	G & REHABILITATION CENTER			APOLIS, IN 46202		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ks and bilateral, posterior					
	~	2 and labeled as "wound					
	_	ocks, posterior thighs legs.					
		nuded/erosion"; onset was					
	l -	location was buttock/sacral					
	_	ere "extensive moisture/stool					
		d minimum amount of					
		inage. From the documented bilateral buttocks were beefy					
		as of darker red tones and					
		skin. The reddened area was					
		e top of both buttocks down to					
		d proceeded onto both					
	_	d stopped midway down the					
	ı .	ns. On the left posterior thigh					
		side) to the intergluteal cleft					
	· ·	eet), was an area maroon in					
	color with sloughin	g skin. The entire area appears					
	as a red, irritated, ra	ash.					
	A Skin Managemer	nt Program policy was received					
	_	from DON. It indicated,					
		and prevention3Minimize					
		re and keep skin clean,					
	_	ents requiring incontinence					
	care. Utilize barrie	er cream for incontinence care6.					
	Any skin alteration	s noted by direct care givers					
	during daily care as	nd/or shower days must be					
	reported to the licer	nsed nurse for further					
		ude but not limited to(sic)					
	_	, redness, skin tears, blisters,					
		ensed nurse is responsible for					
		lteration by the direct					
		nift reported. 7. Facility skin					
		e assessment) are conducted					
	· ·	ıll residents' current skin					
		nsure appropriate preventative					
	_	ceAll newly identified areas					
		l be documented on the New					
	Skin Event. 5. The	wound nurse/designee will be					

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155226	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 09/07/2022		
NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP COD 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)		E	(X5) COMPLETION DATE	
	notified of alterations in skin integrityb. The wound nurse/designee will complete further evaluation of the wounds identified and complete the appropriate skin evaluation of the wounds identified and complete the appropriate skin evaluation on the next business dayWound management entries will be completed for non-ulcers (bruises, skin tear, abrasion, rashes)A plan of care will be initiated to include resident specific risk factors and contributing factors with appropriate interventions implemented." This Federal tag relates to complaint #IN00388926.							

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