PRINTED: 01/12/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP COD 7525 ROSEGATE DRIVE INDIANAPOLIS, IN 46237 (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION RO000 Bidg. 00 This visit was for the Investigation of Complaint IN00396258. Complaint IN00396258 - Substantiated. State deficiencies related to the allegations are cited at R0052. Survey dates: December 15 and 16, 2022 Facility number: 012936 Residential Census: 69 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed December 22, 2022. AND STATE ADDRESS, CITY, STATE, ZIP COD 7525 ROSEGATE DRIVE INDIANAPOLIS, IN 46237 PREFIX TAG RO000 RESIDENTIAL CARE V, L.L.C. INDIANAPOLIS, IN 46237 PREFIX TAG RESIDENTIAL CARE V, L.L.C. BY PREFIX TAG RESIDENTIAL CARE V, L.L.C. INDIANAPOLIS, IN 46237 RACHICORRECTION INDIANAPOLIS, IN 46237 INDIANAPOLIS, IN 46237 RACHICORRECTION INDIANAPOLIS, IN 46237 RACHICORRECTION INDIANAPOLIS, IN 46237 INDIANAPOLIS, IN 46237 RACHICORRECTION INDIANAPOLIS, IN 46237 INDIANAPOLIS, IN 46237 INDIANAPOLIS, IN 46237 RACHICORRECTION INDIANAPOLIS, IN 46237 INDIANAPOLIS, IN 46237 RACHICORRECTION INDIANAPOLIS, IN 46237 RACHICORRECTION INDIANAPOLIS, IN 46237 RACHICORRECTION INDIANAPOLIS, IN 46237 INDIANAPOLIS, IN 46237 RACHICORRECTION INDIANAPOLIS, IN 46237 RACHICORRECTION INDIANAPOLIS, IN 46237 INDIANAPOLIS, IN 46237 RACHICORRECTION INDIANAPOLIS, IN 46237 RACHICORR	l f '			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY	
NAME OF PROVIDER OR SUPPLIER RESIDENTIAL CARE V, L.L.C. (X4) ID (X5) INDIANAPOLIS, IN 46237 ID (X6) INDIANAPOLIS, IN 46237 ID (X6) INDIANAPOLIS, IN 46237 ID (X6) INDIANAPOLIS, IN 46237 ID (X5) ORDER TATION SHOULD BE (X6) ORDER TO SHO	AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING <u>00</u>					
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(completed if applicable). Physicians will be notified if needed. What measures will be put into place or what systemic changes has the facility will make to ensure that the deficient practice dose not recur: The Director of Nursing/designee will in-service all licensed nurses on the revised Fall Management Program policy, falls with head		IN00396258. Complaint IN0039 deficiencies related R0052. Survey dates: Dece Facility number: 00 Residential Census This State Residential accordance with 41	6258 - Substantiated. State It to the allegations are cited at ember 15 and 16, 2022 12936 1269 1261 tial Finding is cited in 10 IAC 16.2-5.	R 00	000	accomplished for those residents found to have been affected by the deficient practice: The resident found to be affect by the deficient practice was unable to return to the commutation. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: The Director of Nursing will revite charts of residents who ha falls in October, November, and December of 2022 to ensure the physician was notified and neurological assessments inition (completed if applicable). Physicians will be notified if needed. What measures will be put in place or what systemic changes has the facility will make to ensure that the deficient practice dose not recur: The Director of Nursing/design will in-service all licensed nursion the revised Fall Management.	nity. e of e view d he ated to	

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

TITLE

(X6) DATE

Ann Jee Kirstein Executive Director 01/06/2023

Any definency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin

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.

State Form Event ID: LJ4E11 Facility ID: 012936 If continuation sheet Page 1 of 5

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

PRINTED: 01/12/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING B. WING						
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 7525 ROSEGATE DRIVE					
RESIDEN	NTIAL CARE V, L.L.	C.		IAPOLIS, IN 46237				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE				
				trauma and the effects of anticoagulant/antiplatelet medications, neurological assessments and documental notification of MD, shift to shift report procedure, and ensurin communication to all nursing smembers of falls and interven The Director of Nursing/design will complete a Skills compete on Post Fall Procedure with allicensed nurses. A fall procedicheck list has been developed implemented for the charge nurses. A fall check list has be developed and implemented for Director of Nursing to ensure nurse is following fall manage procedures. A fall risk/fall prevention will be assessed upadmission, readmission, with change of condition, and semi-annually using a formalizable fall risk assessment tool. How the corrective action with the monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place. A QA tool has been developed resident falls. This tool will be completed by the Director of Nursing or designee weekly x weeks, bi-monthly x4 weeks, the monthly until 2 consecutive months of compliance is maintained. Compliance will be defined at a threshold of 95%	g staff tions. nee ncy I ure I and een or the the ment con ted II e e: d for 4 hen			

State Form Event ID: LJ4E11 Facility ID: 012936 If continuation sheet Page 2 of 5

PRINTED: 01/12/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>		COMPLETED		
			B. WI	NG		12/16/	2022	
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF PROVIDER OR SUPPLIER					OSEGATE DRIVE			
RESIDENTIAL CARE V, L.L.C.					IAPOLIS, IN 46237			
					1			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION			
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE	
					greater.			
					By what date the systemic			
					changes will be completed:			
					January 15, 2023			
R 0052	410 IAC 16.2-5-1.	2(v)(1-6)						
	Residents' Rights							
Bldg. 00	(v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment;							
5								
	(5) neglect; and							
	(6) involuntary seclusion.							
	Based on interview and record review, the facility			052	What corrective action will be accomplished for those residents found to have been		01/15/2023	
	neglected to complete neurological assessments after an unwitnessed fall for 1 of 3 residents							
	reviewed for falls. (Resident B).		affected by the deficient				
					practice: The resident found to be affected			
	Finding includes:							
	On 12/15/22 at 2:30 p.m., Resident B's clinical record was reviewed. The diagnoses included, but were not limited to, chronic kidney disease stage				by the deficient practice was			
					unable to return to the community. The MD has been made aware of			
	3, COPD (chronic obstructive pulmonary disease), acute embolism, hyperlipidemia,				the situation.			
	polyosteoarthritis, and peripheral vascular				How the facility will identify other residents having the			
	disease. Resident B's physician orders included, but were not limited to, Eliquis (a blood thinner) 5 mg (milligrams) twice a day.				_			
					potential to be affected by the same deficient practice and	C		
					what corrective action will be	e.		
					taken:	-		
					The Director of Nursing will re	view		
					the charts of residents who ha			
	A progress note dated, 12/2/22 at 4:45 a.m., resident indicated she was rushing to bathroom and fell, slight bump to back of head, neurological checks within normal limits. A progress note dated, 12/2/22 at 9:02 a.m.,				falls in October, November, ar			
					December of 2022 to ensure t			
					physician was notified and			
					neurological assessments initi	ated		
					(completed if applicable).			
					Physicians will be notified if			

State Form Event ID: LJ4E11 Facility ID: 012936 If continuation sheet Page 3 of 5

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING 00		COMPLETED		
			B. WING 12/16/			2022	
				CTREET	ADDRESS SITE STATE SID COD		
NAME OF I	PROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD		
DEOIDE	ITIAL CAREVILL	2			OSEGATE DRIVE		
RESIDE	NTIAL CARE V, L.L.	.C.		INDIAN	IAPOLIS, IN 46237		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROWIDER'S DLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	indicated upon arriv	val resident was found lying on			needed.		
	•	breathing but not responding.					
		ent to the emergency room.			What measures will be put in	to	
		<i>E</i> ,			place or what systemic changes has the facility will make to ensure that the		
	On 12/15/22 at 2:50	p.m., DHS indicated Resident					
		-					
	B had an unwitnessed fall first on 12/2/22. On 12/15/22 at 2:50 p.m., the DHS provided the fall				deficient practice dose not		
					recur:		
	on 12/15/22 at 2:50 p.m., the DHS provided the fall management policy, revised on 12/2017, and				The Director of Nursing/design	100	
					will in-service all licensed nurs		
	indicated it was the current policy in use by the facility. The policy indicated if the a resident's fall was not witnessed then the nursing staff would initiate the completion of neurological checks for				on the revised Fall Manageme		
					Program policy, falls with head		
					trauma and the effects of	ı	
	the duration of 72 hours. On 12/16/22 at 10:03 a.m., the DHS provided a copy of Resident B's neurological assessment				anticoagulant/antiplatelet		
					medications, neurological	ion	
					assessments and documentat		
		A review of neurological			notification of MD, shift to shift		
					report procedure, and ensuring	-	
		icated neurological checks			communication to all nursing s		
	every 15 minutes for 1 hour were completed. The 7:00 a.m. and 7:30 a.m., neurological checks were incomplete. The DHS indicated the nurse was late that morning. The neurological checks at 8:30				members of falls and intervent		
					The Director of Nursing/design		
					will complete a Skills compete	-	
					on Post Fall Procedure with al		
a.m., indicated t		resident was unresponsive.			licensed nurses. A fall procedu		
	This State tag relates to Complaint IN00396258.				check list has been developed	and	
					implemented for the charge		
					nurses. A fall check list has be		
					developed and implemented for		
					Director of Nursing to ensure t		
					nurse is following fall manager	nent	
					procedures. A fall risk/fall		
					prevention will be assessed up	on	
					admission, readmission, with		
					change of condition, and		
					semi-annually using a formaliz	ed	
					fall risk assessment tool.		
					How the corrective action will	I	
					be monitored to ensure the		
					deficient practice will not		

State Form Event ID: LJ4E11 Facility ID: 012936 If continuation sheet Page 4 of 5

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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/16/2022		
NAME OF PROVIDER OR SUPPLIER RESIDENTIAL CARE V, L.L.C.			STREET ADDRESS, CITY, STATE, ZIP COD 7525 ROSEGATE DRIVE INDIANAPOLIS, IN 46237				
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERNCED TO THE APPROPRIATE DEFICIENCY)		TE	(X5) COMPLETION DATE
					recur, what quality assurance program will be put into place. A QA tool has been developed resident falls. This tool will be completed by the Director of Nursing or designee weekly x weeks, bi-monthly x4 weeks, toonthly until 2 consecutive months of compliance is maintained. Compliance will be defined at a threshold of 95% greater. By what date the systemic changes will be completed: January 15, 2023	e: d for 4 hen	

State Form Event ID: LJ4E11 Facility ID: 012936 If continuation sheet Page 5 of 5