STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155683	A. BUILDING 00 B. WING	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
B & B CHRISTIAN HEALTHCARE CENTER	3208 N SHERMAN DR INDIANAPOLIS, IN 46218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00258089. Complaint IN0028089- Substantiated. Federal/State deficiencies are cited at F624. Survey dates: March 28 and 29, 2018 Facility number: 011032 Provider number: 155683 AIM number: 200262860 Census bed type: NF: 12 SNF/NF: 9 Total: 21 Census payor type: Medicaid: 21 Total: 21 This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 5, 2018	F 0000		
F 0624 SS=D Bldg. 00	483.15(c)(7) Preparation for Safe/Orderly Transfer/Dschrg §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. Based on record review and interview, the facility	F 0624	What: The Administrator	04/28/2018

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155683	A. BUILDING 00 B. WING	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
B & B CHRISTIAN HEALTHCARE CENTER	3208 N SHERMAN DR INDIANAPOLIS, IN 46218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	failed to ensure policies and procedures were followed to ensure a safe and orderly transfer to the facility by not doing a preadmission assessment to determine if the resident was appropriate for the facility. (Resident B.) 1 of 3 residents reviewed for transfer procedures. Findings include: The record of Resident B was reviewed on 3/28/18 at 9:30 A.M. Diagnoses included, but were not limited to, vascular dementia with behavioral disturbance, anxiety disorder, schizophrenia, intermittent explosive disorder, diabetes mellitus, chronic obstructive pulmonary disease, gastro-esophageal reflux disease, and cognitive communication deficit. A quarterly Minimum Data Set Assessment completed 2/14/18 at Resident B's discharging facility indicated he had a Basic Interview for Mental Status (BIMS) score of 15, indicated he had no cognitive deficits. Resident B's record indicated he was admitted from another long term care facility. The record contained no documentation of any assessment being done prior to the resident being transported by the receiving facility's Marketing Director and being assigned a bed. The Administrator was interviewed on 3/28/18 at 10:30 A.M. He indicted that the Marketing Director had gone to the discharging facility on 3/23/18 and met with Resident B. The Marketing Director agreed to accept Resident B to their facility. On 3/26/18 the Marketing Director returned to the discharging facility, signed paperwork, and transported Resident B to their facility, where he was assigned a bed. Resident		immediately had a meeting with the SSD, the Marketing Person and the Director of Nursing. The policy was revised with the assistance of the team. Resident B was the focus and was at this time assessed and admitted properly. How: No other residents were affected. The Revised Policy will ensure that no new resident will experience this problem. What: The New Revised Policy will be placed at the nursing station with a signature sheet for all team members involved in the admission process to sign, showing they have completed their part of the new admission. How: The new procedure will be monitored by the Administrator and the Director of Nursing. They will each sign off on all new admissions. This monitoring will be continuous henceforth. Completed 4/28/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155683	A. BUILDING 00 B. WING	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
B & B CHRISTIAN HEALTHCARE CENTER	3208 N SHERMAN DR INDIANAPOLIS, IN 46218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	B's record contained no assessment at the time of entry to the facility. The Administrator indicated the Marketing Director had not communicated these actions to himself, the Director of Nursing, or the Social Services Director, and the Marketing Director did not have authority to make admission decisions, or transport residents to the facility. The Social Services Director was interviewed 3/28/18 at 11:00 A.M. She indicated she typically did pre-admission assessments. She indicated she had not done any assessments on Resident B, and she was not aware he was in the facility until she noticed him in the hall way. The Marketing Director was interviewed on 3/28/18 at 1:15 P.M. He indicated that on 3/23/18 he received a call from the discharging facility, indicating they had a resident who desired to transfer. The Marketing Director went to the facility and met with Resident B, who indicated he wished to transfer. On 3/26/18, the Marketing Director returned to the discharging facility, signed paperwork, and transported Resident B to the facility, where he assigned him a bed. He indicated he had not communicated these actions to any other management at his facility. He indicated he has since become aware that all residents require a pre-admission assessment before they can be deemed appropriate for admission to the facility. He indicated he now realized he had overstepped his authority by accepting and transporting a resident to the facility who had not had a pre-admission assessment. Resident B was interviewed on 3/28/18 at 11:15 A.M. He appeared alert, oriented, and was cooperative. He indicated he was not aware of any irregularities in the transfer process, and that he			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155683	A. BUILDING 00 B. WING	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
B & B CHRISTIAN HEALTHCARE CENTER	3208 N SHERMAN DR INDIANAPOLIS, IN 46218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	was happy to be in the new facility. He indicated his goal was to return to the community with family, but that he understood that he would need to stay in the facility while treatment programs were worked out, and arrangements could be made. He indicated his mood was good, and he felt his needs were well met. An undated facility policy titled "Pre-Admission Assessment Policy" received from the Director of Nursing on 3/29/18 at 8:45 A.M., indicated: "Purpose: To establish guidelines and responsibilities to assure the facility only admits residents whose medical and psychosocial needs can be met by the facility or available community resources. Responsibility: Administrator, Director of Nursing, or Admissions Director or Social Services Director. Policy: It is the policy of (name of the facility) to conduct a pre-admission assessment for each prospective resident. The assessment shall be used to determine whether the facility can meet the medical and psychosocial needs of the prospective resident and shall be used in planning for the care of those individuals who are admitted." This Federal tag relates to Complaint IN00258089. 16.2-5-2(a)			