STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155329	A. BUILDING 00 B. WING	11/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROSEWALK VILLAGE	1302 N LESLEY AVE INDIANAPOLIS, IN 46219

(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 Complaints IN00393916 and IN00393992. Complaint IN00393916- Unsubstantiated due to lack of evidence. Complaint IN00393992 - Substantiated. Federal/state deficiencies related to the allegations are cited at F689. Survey dates: November 16, 2022 Facility number: 000222 Provider number: 155329 AIM number: 100274950 Census Bed Type: SNF/NF: 94 SNF: 5 Total: 99 Census Payor Type: Medicare: 5 Medicaid: 76 Other: 18 Total: 99 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on November 18, 2022	F 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after December 2nd, 2022.	
F 0689 SS=G Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Omar Johnson	Executive Director	11/29/2022

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
	155329	A. BUILDING 00 B. WING	11/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROSEWALK VILLAGE	1302 N LESLEY AVE INDIANAPOLIS, IN 46219

(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
	The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to ensure a resident (Resident B), who was deemed dependent on staff for bed mobility and transfers, did not experience increased pain and swelling after being transferred by a staff member and later identified with a fracture, and not ensuring the use of a gait belt during a transfer for 1 of 1 resident reviewed for injury of unknown origin. Findings include: The clinical record for Resident B was reviewed on 11/16/22 at 11:10 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, vascular dementia, congestive heart failure, age-related osteoporosis, cognitive communication deficit, and spinal stenosis. The Quarterly Minimum Data Set (MDS) assessment, dated 8/15/22, indicated Resident B was severely cognitively impaired, required extensive assistance of 2 staff person for bed mobility, transfers, and toilet use, along with extensive assistance with one staff person for locomotion on/off unit, dressing, and personal hygiene. There were no impairments to Resident B's upper and/or lower extremities, no falls since admission and/or previous assessment, and wheelchair was marked for mobility device.	F 0689	**What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** ·Resident B no longer resides at the facility. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** ·All residents deemed dependent on staff for bed mobility and transfers have the potential to be affected by the alleged deficient practice. ·CEN/designee to complete 1x skills validation titled Transfer to Wheelchair with licensed nursing staff by December 2nd, 2022. ·DNS/designee will conduct in-service with licensed nursing staff on proper wheelchair transfers including use of a gait belt by December 2nd, 2022. **What measures will be put into place or what systemic changes will be made to ensure that the deficient**	12/02/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155329	A. BUILDING 00 B. WING	11/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROSEWALK VILLAGE	1302 N LESLEY AVE INDIANAPOLIS, IN 46219

(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
	A care plan, revised 8/26/22, indicated Resident B was at risk for pathological fracture related to diagnosis of osteoporosis. An approach was listed for assistive devices as needed. A fall care plan, revised 8/26/22, indicated Resident B was at risk for falls and required assistance with transfers and bed mobility. An approach was listed for assistance with one staff for transfers. A progress note, dated 11/2/22 at 2:53 p.m., indicated Resident B was having increased pain with transfers and swelling to the right knee. A progress note, dated 11/2/22 at 9:02 p.m., indicated Resident B was sent to the emergency room due to abnormal finding on x-ray of right femur. An incident reported to the Indiana State Department of Health Survey Report System, dated 11/2/22 at 7:20 p.m., indicated the following, "...While rendering morning ADL [activities of daily living] care, resident noted to have edema to right leg and knee with complaints of leg and knee pain...Type of Injury...right hip with offset large oblique spiral fracture of the proximal femoral diaphysis...Follow up...IDT [interdisciplinary team] determined, while transferring resident from bed to wheelchair, resident turned without moving her feet, causing the spiral fracture. All staff to be educated related to transfers and providing ADL care to residents with osteoporosis...." An interview conducted with Nurse 2, on 11/16/22 at 12:05 p.m., indicated Resident B's level of assistance would depend on how she was feeling. If Resident B was resistive to ADL care, we would have 2 staff members assist with her ADL care.		**practice does not recur?** ·DNS/designee will conduct in-service with licensed nursing staff on proper transfers including use of a gait belt by December 2nd, 2022. ·Observational rounds will be completed by the Unit Manager/designee daily each shift to ensure wheelchair transfers are being made properly, including use of a gait belt **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·To ensure compliance the DNS/Designee will complete the Skills Validation: Transfer to Wheelchair tool for six months with audits being completed once weekly for one month, and then monthly for 5 months by a nurse manager or designee. The Skills Validation: Transfer to Wheelchair audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155329	A. BUILDING 00 B. WING	11/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROSEWALK VILLAGE	1302 N LESLEY AVE INDIANAPOLIS, IN 46219

(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
	An interview conducted with Certified Nursing Assistant (CNA) 3, on 11/16/22 at 12:10 p.m., indicated Resident B wasn't a morning person. CNA 3 was able to transfer Resident B with one person unless Resident B was being resistive with care and then she would need 2 staff members to assist her. Resident B would refuse ADL care such as being transferred, toileted, and dressed. There were good and bad days for Resident B. CNA 3 came into work on 11/2/22 at 7:30 a.m. and noted Resident B up in her wheelchair in her room. CNA 3 passed the breakfast tray to Resident B and the resident was crying and stating, "my hip". CNA 3 commented on how Resident B's right hip looked swollen, and she proceeded to tell the nurse about it. An interview conducted with CNA 4, on 11/16/22 at 12:28 p.m., indicated she arrived at work on 11/2/22 at 6:00 a.m. to work on the hallway where Resident B resided. There was a "get up" list and Resident B, along with 3 other residents, was on that list. She proceeded to provide ADL care to Resident B while she was lying in bed and got her dressed for the day. She took her arms and went underneath Resident B's arms and grabbed the back waist of Resident B's pants to lift her up and transfer her from her bed to her wheelchair. CNA 4 commented on how Resident B did not bear weight, but she was "light as a feather". CNA 4 also commented on how it was her first day working on the unit that Resident B resided on as well as the nurse working that morning. So, the 2 staff members were not familiar with the residents and how they transferred back there. She knew there were no residents who transferred with a mechanical lift. Resident B was nice and not resistive to care that morning. She didn't complain of any pain before, during, or after the transfer.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155329	A. BUILDING 00 B. WING	11/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROSEWALK VILLAGE	1302 N LESLEY AVE INDIANAPOLIS, IN 46219

(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
	CNA 4 indicated there was not a gait belt located in Resident B's room for use and such was not utilized during the transfer for Resident B while transferring her from the bed to the wheelchair. An interview conducted with Nurse 6, on 11/16/22 at 12:02 p.m., indicated they had determined that Resident B's feet stayed grounded during the transfer from her bed to wheelchair and along with her diagnosis of osteoporosis could be what caused the spiral fracture. A skills validation titled "TRANSFER TO WHEELCHAIR", dated 2/2010, was in the investigative file for the incident involving Resident B. The document indicated the following, "...Procedure Steps...11. Place gait belt around resident's waist...12. Grasp belt securely on both sides...13. With legs on the outside of the resident's legs, brace resident's lower legs to prevent slipping...14. Instruct resident on count of three to slowly rise to a stand...15. Help resident to pivot to front of wheelchair with back of resident's legs against wheelchair...19. Remove gait belt...." This Federal tag relates to Complaint IN00393992. 3.1-45(a)(1) 3.1-45(a)(2)			