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

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 00 B. WING	06/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALTENHEIM HEALTH & LIVING COMMUNITY	3525 E HANNA AVE INDIANAPOLIS, IN 46237

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00405626. This visit included a State Residential Licensure Survey. Complaint IN00405626 - Federal/State deficiencies related to the allegations were cited at F842. Survey dates: May 30, 31, June 1, 2, 5, 6, & 7, 2023 Facility number: 000103 Provider number: 155196 AIM number: 100290000 Census Bed Type: SNF/NF: 81 Residential: 65 Total: 146 Census Payor Type: Medicare: 14 Medicaid: 46 Other: 21 Total: 81 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed June 9, 2023.	F 0000	Please find enclosed the Plan of Correction to the complaint survey conducted May 30 – June 7, 2023. This letter is to inform you that the plan of correction attached is to serve as The Altenheim's credible allegation of compliance. We allege compliance on 06/21/2023. Submission of this plan of correction does not constitute an admission by The Altenheim or its management company that the allegations contained in the survey report is a true and accurate portrayal of nursing care and other services in this facility. Nor does this provision constitute an agreement or admission of the survey allegations. We respectfully request desk review.	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2)			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Chirag Patel	Executive Director	06/16/2023

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.

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	and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the			

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	comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on observation, interview, and record review, the facility failed to ensure physician orders for skin treatment services were accurately provided and recorded for 2 of 7 residents reviewed. (Resident 174, Resident 25) Findings include: 1. During an interview on 5/30/23 at 1:57 p.m., Resident 174 indicated he was admitted to the facility with a "sore spot" on his right outer ankle area and that staff treat the area every Tuesday and Thursday. On 6/2/23 at 10:00 a.m., Resident 174's clinical record was reviewed. Resident 174 was admitted to the facility on 4/11/23. The diagnoses included, but were not limited to, disorder of the skin and diabetes. The Admission MDS (Minimum Data Set) assessment, dated 4/18/23, indicated Resident 174 was cognitively intact and was receiving applications of ointment/medications for skin conditions. Resident 174's care plan included, but was not limited to, "Problem: Resident has skin breakdown to outer ankle; start date: 4/12/23; Goal: Area will resolve without complication; Target date: 7/30/23; Approach: pressure reducing/redistribution cushion in chair/wheelchair; pressure reducing/redistribution mattress on bed; Turn and reposition every 2 hours with avoidance of pressure to affected area; weekly skin checks by licensed nurse..."	F 0656	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident 174 and resident 25 wound orders were corrected on 06/05/2023. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? Residents with wound orders have the potential to be affected. Residents with wound orders have been audited to ensure all wound orders are correct. 3. What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur? Licensed nurses have been educated regarding transcription of wound orders. All wound orders will be reviewed in clinical stand up to ensure wound orders are correct. Education will be provided upon hire and periodically to licensed nurses. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur? DON or designee will audit all wound orders to ensure that	06/21/2023

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	Physician orders included, but were not limited to, "betadine (povidone-iodine) [OTC] solution; 10%; amt [amount]: apply a small amount topically 3x/week T [Tuesday], Th [Thursday], Sat [Saturday] for preventing bacterial infection. Apply to R [right] lateral ankle wound/scab. Start date: 4/12/23 - open ended [no end date]." The April 2023 Medication Administration Record (MAR) indicated Resident 174's right ankle was treated with betadine every Tuesday and Thursday from 4/13/23 thru 4/27/23. The May 2023 MAR indicated Resident 174's right ankle was treated with betadine every Tuesday and Thursday from 5/2/23 thru 5/30/23. The June 2023 MAR indicated Resident 174's right ankle was treated with betadine on Thursday, 6/1/23. On 6/2/23 at 11:42 a.m., Resident 174's right outer ankle area was observed. During an interview at that time, the Unit Manager indicated Resident 174 had a physician's order for betadine treatments to the healing right outer ankle area. Resident 174 was admitted with a traumatic injury as a result from a fall that affected the outer ankle area. During an interview on 6/5/23 at 1:36 p.m., the DNS (Director of Nursing Services) indicated Resident 174's physician's betadine treatment order for the right outer ankle area was supposed to be two times per week. The nursing staff should have consulted with the prescribing provider to determine the frequency for which the treatment was to be provided and then update the clinical record to ensure the record was clear and		wound orders are correct. Audits will occur daily x 30 days, weekly x 12 weeks, then monthly for 6 months. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting. Frequency and duration of reviews will be adjusted as needed if compliance is below 100%. Ongoing frequency and duration will be determined by the Quality Assurance Committee 5. Date of compliance: 6/21/23.	

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accurate.

2. During an interview on 5/31/23 at 9:04 a.m., Resident 25 indicated she had a "sore below her right knee and staff wrapped her lower leg every day."

On 6/5/23 at 8:34 a.m., Resident 25's clinical record was reviewed. The diagnoses included, but were not limited to, unspecified open wound on the lower leg; lower extremity arterial disease; and disorders of the skin and subcutaneous tissue.

The Annual MDS (Minimum Data Set) assessment, dated 4/13/23, indicated Resident 25 was cognitively intact and was receiving applications of ointment/medications for skin conditions.

Resident 25's care plan included, but was not limited to, "Problem: Resident has s/s [signs and symptoms] of infection to right lower leg; start date: 5/19/23; Goal: Infection will resolve without complications; Target date: 6/2/23; Approach: administer antibiotics as ordered; monitor for any adverse side effects and notify MD [Medical Doctor] if any occur...treatment as ordered..."

The Physician's progress note, dated 5/25/23 at 7:15 p.m., indicated "...right lower leg: clean wound with wound cleaner or NS [normal saline]; apply 0.1 gentamicin cream [antibiotic used to stop the growth of certain bacterial infections]; cover with ABD [abdominal treatment pads] and secure with kerlix. Change daily and prn [as needed]."

The MAR indicated Physician orders included, but were not limited to, "gentamicin cream; 0.1%; amt: dime size amount to wound; topical;

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frequency: once - one time; special instructions: cleanse areas with wound cleaner then apply to wound beds on rt [right] lower extremity, apply ABD and kerlix daily and prn; diagnosis: unspecified skin changes; date created: 5/26/23; verified date: 5/26/23."

The 5/5/23 to 6/5/23 MAR document lacked any verification that the gentamicin cream was applied to Resident 25's lower extremity.

During an interview on 6/5/23 at 2:50 p.m., the DNS (Director of Nursing Services) indicated on 5/25/23 Resident 25's physician placed a new order for gentamicin cream to be applied to the resident's lower right extremity daily. The order was data entered into the electronic clinical record as a "one-time application rather than daily as prescribed by the physician." The DNS indicated the medication was applied daily to Resident 25's lower extremity even though the clinical record failed to reflect the medication administration. The clinical record should have accurately reflected the physician's order.

During an interview on 6/6/23 at 9:20 a.m., Qualified Medication Aide 3 indicated if a medication or treatment order discrepancy was noted, the nurse would be notified. The nurse would then seek clarification from the physician. The medication or treatment would not be administered until the discrepancy was clarified.

During an interview on 6/6/23 at 9:35 a.m., Licensed Practical Nurse 2 indicated physician's orders were to be reviewed and reconciled prior to providing a treatment. If a discrepancy was noted, the physician would be contacted to clarify the order prior to providing the treatment. If the treatment was given, the MAR would be

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	completed by the licensed staff indicating the treatment had been performed. On 6/2/23 at 2:10 p.m., the DNS provided a copy of the Protocol for Following Physician Orders policy, dated 4/3/2017, and indicated it was the current policy in use by the facility. A review of the policy indicated, "Policy statement: it is the goal of CarDon to provide care to our facility residents that will promote support for the optimal quality of life for the residents. Policy: it is the policy of CarDon and associates that we will provide the appropriate physician prescribed care to residents in our communities. The facility patient care, therapy and pharmacy services will reflect the orders and plan of care of the prescribing physician. Procedure: all licensed staff will verify and follow physician orders as written..." On 6/2/23 at 3:05 p.m., the DNS provided a copy of the Care Plans - Comprehensive policy, dated October 2009, and indicated it was the current policy in use by the facility. A review of policy indicated, "...an individualized comprehensive care plan that...meets the resident's medical, nursing...is developed for each resident...care plans are revised as information about the resident and the resident's condition change..." 3.1-35(g)(2)			
F 0842 SS=E Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the			

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	agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.			

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	§483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.			
	Based on record review and interview, the facility failed to inventory and document resident belongings upon admission and discharge for 4 of 4 residents reviewed. (Resident B, Resident C, Resident D, Resident E) Findings include: 1. On 5/30/23 at 12:30 p.m., Resident B's clinical record was reviewed. Resident B admitted to the facility on 11/9/22 and discharged on 2/8/23. An inventory sheet was not completed in Resident B's clinical record. 2. On 6/2/23 at 11:30 a.m., Resident C's clinical record was reviewed. Resident C admitted to the facility on 3/31/22 and discharged on 4/2/23. An	F 0842	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident B, C, D, and E have inventory sheets completed. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s)will be taken? Residents without inventory sheets have the potential to be affected. Resident inventory sheets have been audited to ensure they are complete	06/21/2023

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	inventory sheet was not completed in Resident C's clinical record. 3. On 6/2/23 at 11:45 a.m., Resident D's clinical record was reviewed. Resident D admitted to the facility on 3/23/23 and discharged on 3/26/23. An inventory sheet was not completed in Resident D's clinical record. 4. On 6/2/23 at 12:00 p.m., Resident E's clinical record was reviewed. Resident E admitted to the facility on 1/19/23 and discharged on 2/17/23. An inventory sheet was not completed in Resident E's clinical record. During an interview on 6/5/23 at 9:30 a.m., the DON indicated that she was unable to locate inventory sheets for the four residents. The DON stated that there was an observation in the electronic record to open on admission to inventory new residents' personal belongings and that a paper copy of inventoried items would also be acceptable but was unable to locate either for Resident B, Resident C, Resident D, or Resident E. On 6/5/23 at 1:30 p.m., the DON provided a copy of the facility policy titled "Personal Property", dated as revised for April 2013. The policy indicated that "...5. The resident's personal belongings and clothing shall be inventoried and documented upon admission and as such items are replenished." This Federal tag relates to Complaint IN00405626. 3.1-9(g)		3. What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur? Licensed nurses were educated regarding completion of inventory sheets upon admission. Admission inventory sheets will be reviewed during clinical stand up to ensure all inventory sheets are completed. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur? DON or designee will audit inventory sheets to ensure completion. Audits will occur daily x 30 days, weekly x 12 weeks, then monthly for 6 months. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting. Frequency and duration of reviews will be adjusted as needed if compliance is below 100%. Ongoing frequency and duration will be determined by the Quality Assurance Committee 5. Date of compliance: 6/21/23.	
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	This visit was for a State Residential Licensure Survey. This visit included the Recertificiation and State Licensure Survey and the Investigation of Complaint IN00405626. Complaint IN00405626 - Federal/State deficiencies related to the allegations were cited at F842. Survey dates: May 30, 31, June 1, 2, 5, 6, and 7, 2023 Facility number: 000103 Residential Census: 65 This State Residential Finding is cited in accordance with 410 IAC 16.2-5.	R 0000	Please find enclosed the Plan of Correction to the complaint survey conducted May 30 – June 7, 2023. This letter is to inform you that the plan of correction attached is to serve as The Altenheim's credible allegation of compliance. We allege compliance on 06/21/2023. Submission of this plan of correction does not constitute an admission by The Altenheim or its management company that the allegations contained in the survey report is a true and accurate portrayal of nursing care and other services in this facility. Nor does this provision constitute an agreement or admission of the survey allegations. We respectfully request desk review.	
R 0148 Bldg. 00	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and			

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	comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on observation and interview, the facility failed to ensure an environment free of hazards for 1 of 2 observations. Hazardous materials were not kept secure and access panels were not locked and closed. (Sprinkler Valve Panel, Control Valve Panel, Second Floor Storage Closet) Findings include: 1. On 6/6/23 from 11:15 a.m. to 11:30 a.m., during a facility tour for the closed dementia care hallway, with UM 1, a metal panel on the wall next to the laundry room, labeled "2200 Sprinkler Valve" was unlocked and ajar. Inside were various pipes, valves, and some electrical components. No staff were visible in the area. On 6/6/23 from 11:40 a.m. to 12:05 p.m., during a facility tour for the rest of the residential area, with the DON (Director of Nursing), the following was observed on the second-floor area adjacent to the locked dementia care hallway: 2. A metal panel on the wall near the elevator, labeled "2100 Control Valve" was unlocked and ajar. Inside were various pipes, valves, and some electrical components. No staff were visible in the area. 3. A storage closet with folding doors was located between Rooms 2113 and 2115. The folding door lacked any locking mechanism. Inside the storage closet the following items were observed: - one one-gallon can of Gardz Problem Surface Sealer. The label indicated "keep out of reach..."	R 0148	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Sprinkler Panel doors have been locked and paint, surface sealer and supplies were removed from closet immediately. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s)will be taken? All Sprinkler Valve doors will remain locked at all times. All storage closets will remain locked at all times. 3. What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur? Maintenance staff have been educated regarding securing the sprinkler panel doors and keeping storage closets locked at all times. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur? Maintenance Director, administrator or designee will audit all sprinkler panels and storage closets to ensure they are secured. Audits will occur daily x	06/21/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 00 B. WING	06/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	- one 8 oz jar of Fast and Fine Spackle. The label indicated "keep out of reach..." - three one-gallon buckets of Sherwin Williams paint, one with the lid not completely sealed. The label indicated "keep out of reach..." - four five-gallon buckets of paint labeled "Pro-Mar 220". The label indicated "keep out of reach..." No staff were visible in the area. During an interview on 6/6/23 at 11:20 a.m., UM 1 indicated that the 2200 control panel should have been closed and locked. During an interview on 6/6/23 at 11:53 a.m., the DON indicated that the 2100 control panel should have been closed and locked and that the items in the unlocked storage closet should have been in a locked area. On 6/7/23 at 8:40 a.m., the DON indicated the facility lacked a policy specific to hazardous materials being kept in a secured location or locked.		30 days, weekly x 12 weeks, then monthly for 6 months. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting. Frequency and duration of reviews will be adjusted as needed if compliance is below 100%. Ongoing frequency and duration will be determined by the Quality Assurance Committee 5. Date of compliance: 6/21/23.	