STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155294	A. BUILDING 00 B. WING	03/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FORUM AT THE CROSSING	8505 WOODFIELD CROSSING BLVD INDIANAPOLIS, IN 46240

(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 a Recertification and State Licensure Survey. Survey dates: February 25, 26, 27, 28, March 1, and 4, 2019. Facility number: 000119 Provider number: 155294 AIM Number: N/A Census Bed Type: SNF: 31 Residential 30 Total: 61 Census Payor Type: Medicare: 16 Other: 15 Total: 31 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review was completed on March 11, 2019.	F 0000	**This Plan of Correction constitutes The Forum at the Crossing's written allegation of compliance for the alleged deficiencies cited. Submission of the Plan of Correction is not a admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.** **The Forum at the Crossing respectfully requests a desk review for this Plan of Correction** **Alleged date of compliance is March 23, 2019.**	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's			

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

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	physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).			

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	Based interview and record review the facility failed to notify the physician of blood sugar values outside the call order parameters for 1 of 3 residents reviewed for notification of change. (Residents 80) Finding includes: The record for Resident 80 was reviewed on 03/04/2019 at 9:30 a.m. Diagnoses included, but were not limited to, Diabetes Mellitus. A current care plan indicated a problem of alteration in blood sugar levels with approaches that included, but were not limited to, provide blood sugar checks as ordered and notify healthcare practitioner as requested of the results, monitor and report any signs and symptoms of hypoglycemia (low blood sugar). Current physician's orders included, but were not limited to, "...Notify MD if blood glucose readings < 70 or > 250...." The Medication Administration Record (MAR) for 02/20/2019 indicated the resident's accucheck was 290 at 4:30 p.m., on 02/21/2019, was 378 at 11:30 a.m. and 288 at 4:30 p.m., and on 02/23/2019 was 277 at 4:30 p.m. On 03/04/2019 at 4:30 p.m., the Director of Nursing indicated there was no documentation of physician notification. A Policy titled "Blood Glucose Monitoring" was provide by the Director of Nursing on 03/14/2019 at 3:08 p.m., and deemed as current. The policy indicated: "...15. If the blood glucose level is out of established ranges ordered by the Health Care Practitioner:...b. Promptly notify the ordering	F 0580	**F580 Notify of Changes (Injury/Decline/Room, etc.) CFR(s):483.10(g)(14)(i)** **-** **(iv)(15)** **1.Corrective action for those residents affected: Blood sugars for resident #80 were reviewed with the Medical Director to insure the MD was aware of the resident's blood sugar history.** **2.Measures to identify and correct this problem for residents with the potential of being affected: Diabetics in the facility with call orders for blood sugars were checked for notification of the MD and any discrepancies were reported to the Medical Director.** **3.Systemic Change: Call orders will be added to the sliding scale order on the eMAR with a method to easily record the doctor notification.** **4.Monitoring: A quality improvement review will be conducted by the Director of Nurses or designee to insure that this new method of documenting physician notification compliance is followed. This review will be conducted weekly for 4 weeks, biweekly for 4 weeks, monthly for 2 months. The results of these reviews will be reported to the QAPI Committee.**	03/23/2019

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	Health Care Practitioner of results...16. In the progress/treatment records or Blood Glucose Monitoring Record document...c. Any physician notifications or treatment provided." 3.1-5(a)(2)		**5.Compliance Date: 3/23/2019**	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, record review and interview, the facility failed to ensure OTC (over the counter) medications were labeled appropriately with resident's name, drug name,	F 0761	**F761 Label/store drugs and biologicals CFR(s): 483.45(g)(h)(1)(2)** **1. Corrective action for those**	03/23/2019

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	strength, and directions for use for one random observation. (Resident 231) Finding includes: During an observation of the split hall medication administration pass, on 2/27/19 at 9:09 a.m., with QMA 1(qualified medical aid), two OTC medications, Vitamin B12 and Lactose Enzyme capsules were found unlabeled. During an interview at that time with QMA 1, she indicated the medications were not supplied from the facility's pharmacy but were brought in from home for Resident 231. During an interview with Unit Manager 1, on 2/27/19 at 9:12 a.m., she indicated medications brought from home should have a complete pharmacy label attached. A facility policy titled, "Medication Management Program Guidelines", provided by the Administrator on 3/1/19 at 9:15 a.m., indicated " ...The prescription label must include the following: Practitioner name, Resident name, Drug name, strength, Date dispensed and prescription number, directions for use, name and address of pharmacy dispensing the drug ...." 3.1-25 (j)		**residents affected: OTC medications for Resident #231 were labeled as required with the resident name and directions.** **2.Measures to identify and correct this problem for residents with the potential of being affected: Medication carts were audited and any OTC medications that were not labeled as required were labeled.** **3.Systemic Change: Resident labels will be printed for each resident and kept in the medication cart so that they are readily available as OTC medications are brought in by family members.** **4.Monitoring: A quality improvement review will be conducted by the Director of Nurses or designee to insure that this new method of labeling OTC medications is followed. This review will be conducted weekly for 4 weeks, biweekly for 4 weeks, monthly for 2 months. The results of these reviews will be reported to the QAPI Committee.** **5.Compliance Date: 3/23/2019**	
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and			

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	comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be			

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	the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, interview and record review the facility failed to maintain infection control practices for isolation (Resident 20 and 21), linen handling (Resident 179) and storage of equipment (Resident 19) for 4 of 4 residents observed for infection control practices. Findings include: 1. The record for Resident 20 was reviewed on 02/28/19 at 11:47 a.m. Diagnoses included, but were not limited to, Vancomycin Resistant Enterococcus (VRE- a bacterial that is resistant to the antibiotic Vancomycin), Cerebral	F 0880	**F880 Infection Prevention & Control CFR(s):483.80(a)(1)(2)(4)€(f)** **1.Corrective action for those residents affected: An informational sign was placed on the PPE holder on the door of Resident #20. Therapists #31 and 34 were given education on Infection Control Practices. CNA #35 was provided education about wearing PPE outside of residents' rooms. CNA #36 was provided**	03/23/2019

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	Cryptococcosis (an infection of the tissue covering the brain) and chronic kidney disease. A current physician's order, indicated " ...Contact Isolation precautions d/t (due to) VRE urine every shift for infection ...." A current care plan, indicated " ...keep resident on contact isolation ...." During an observation, on 02/25/19 at 11:17 a.m., contact isolation personal protective equipment was observed hanging in an organizer on Resident 20's door. The PPE included gloves, gowns and masks. There was no informational sign "to see the nurse before entering the room." During this observation Therapist 31 was in Resident 20's room, sitting in a chair, working with Resident 20, without isolation clothing or gloves. Therapist 31 had the yellow isolation gown folded on the floor under her feet. Therapist 31 exited the room and did not wash her hands. She then walked from Unit 400 to Unit 500 and entered another resident's room at 11:28 a.m. Therapist 31 did not wash or sanitizer her hands before entering the room. In an interview, on 02/25/18 at 11:19 a.m., Therapist 31 indicated she did not know why Resident 20 was on contact isolation. In an interview, on 02/25/19 at 11:30 a.m., Registered Nurse 32 indicated Resident 20 was on contact isolation and isolation precautions should be used when staff are working with the resident. During an observation, on 02/27/19 at 11:26 a.m., the Rehabilitation Director was in Resident 20's room. She did not utilize any protective equipment while in the resident's environment. While the Rehabilitation Director was in the room, she moved the bedside table from the front of		**education about the proper method to transport linen throughout the hall. The nebulizer mask for Resident #19 was placed in the appropriate plastic bag** **2.Measures to identify and correct this problem for residents with the potential of being affected: Residents with isolation precautions had informational signs hung on the PPE organizer on the door. Therapy and nursing staff were observed for appropriate use of PPE during the delivery of care. Residents receiving nebulizer treatments were checked for proper storage of the nebulizer mask.** **3.Systemic Change: Education will be provided for nursing and therapy staff about the Infection Control and Prevention Policies and Procedures.** **4.Monitoring: A quality improvement review will be conducted by the Director of Nurses or designee to insure that Infection Control Policies and Procedures are being followed. This review will be conducted weekly for 4 weeks, biweekly for 4 weeks, monthly for 2 months. The results of these reviews will be reported to the QAPI Committee.** **5.Compliance Date: 3/23/2019**	

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	Resident 20 to her side and then removed Resident 20 from the room and took her to the therapy department. The Rehabilitation Director did not wash or sanitizer her hands after contact with surfaces in the resident's environment after exiting the room. In an interview, on 02/27/19 11:46 a.m., the Rehabilitation Director indicated she believed the infection was contained and she did not need to use the provided PPE. During an observation, on 02/27/19 1:52 p.m., LPN 33 entered Resident 20's room and had physical contact with items in the room (a white Styrofoam cup and blue package on bedside table). LPN 33 did not apply PPE before entering the resident's environment. During an observation, on 02/28/19 at 09:20 a.m., Therapist 34 did not use PPE prior to entering Resident 20's room. On 02/28/19 at 09:24 a.m., Therapist 34 was observed exiting Resident 20's room wearing gloves. She proceeded to transport Resident 20, in a wheel chair, through the facility wearing the gloves she had put on while in an isolation precaution area. In an interview on, 02/28/19 09:27 a.m., Therapist 34 indicated she should have donned gloves prior to contact with the resident and she believed she could wear the gloves in the common hallways. In an interview with the Corporate Support Nurse on 02/28/19 at 09:25 am, she indicated gloves are not to be worn in hall. In an interview, on 02/25/19 12:33 p.m., the Director of Nursing indicated the facility uses the Center for Disease Control (CDC) guidelines for isolation precautions. 2. The record for Resident 21 was reviewed on			

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	02/27/19 at 08:45 a.m. Diagnoses included, but were not limited to, pleural effusion (fluid in the lungs). During a dining observation, on 02/27/19 at 8:40 a.m., CNA 35 was in the dining room, with an isolation mask on, pulled down and tucked under her chin. At that time, CNA 35 indicated she had been working with Resident 21 who was coughing a lot and did not cover her mouth and she wore the mask when she had contact with the resident. CNA 35 indicated she should not have worn mask into the dining area. 3. The record for Resident 179 was reviewed on 03/03/19 at 1:43 p.m. Diagnoses included, but were not limited to, malignant neoplasm (a cancerous tumor), anemia (lack of normal red blood cells or hemoglobin) in neoplastic disease and malignant neoplasm of the bone. During a random observation of the 400 hall, on 03/04/19 at 9:20 a.m., CNA 36 was observed transporting clean linen pressed against her uniform. She then entered the room of Resident 179 and proceeded to use the linen to make the bed. At the time CNA 36 indicated she should not have the carried clean linen pressed against her body. 4. The record for Resident 19 was reviewed on 02/28/19 at 02:11 p.m. Diagnoses included, but were not limited to, cough and chronic obstructive pulmonary disease (COPD- progressive lung disease). During an observation, on 02/25/19 at 10:59 a.m., the nebulizer mask for Resident 19 was found hanging, by the head band straps, of the			

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	resident's nebulizer machine (a device used to deliver medication to the lungs). The mask was not covered or protected. During an interview on 02/25/19 at 11:04 am. RN 32 indicated nebulizer masks were to be stored in a plastic bag. "Transmission-Based Precautions" was reviewed, on 03/04/2019, from the Centers of Disease Control (CDC) website. The CDC indicated, "Contact Precautions... Use personal protective equipment (PPE) appropriately, including gloves and gown. Wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment. Donning PPE upon room entry and properly discarding before exiting the patient room is done to contain pathogens ...." A facility document provided by the Executive Director, on 02/27/19 at 3:18 p.m., titled "5.0 PROCEDURE" indicated, " ...Hand washing is preformed ...Before and after each resident contact ...After contact with soiled or contaminated articles ...After contact with an object ...where there is a concentration of microorganisms ...Before applying and after removal of ...gloves ...." A facility document provided by the Executive Director, on 02/27/19 at 3:18 p.m., titled, "Personal Protective Equipment Guidelines" indicated, " ...Remove PPE after it becomes contaminated and before leaving the work area ...." A facility document provided by the Executive Director, on 02/27/19 at 3:18 p.m., titled, "HAND WASHING" indicated, " ...The use of gloves			

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	DOES NOT eliminate the need to wash hands ...." A facility document provided by the Executive Director, on 03/04/19 at 10:13 a.m., titled "35.0 STORAGE, COLLECTION AND TRANSPORTATION OF LINENS" indicated, " ...Clean linen is handled in such a way as to minimize contamination from contact or airborne means ...Handle linen as little as possible ...Use a ...sheet to cover cart when delivering clean linen to the patient rooms ...." A facility document provided by the Executive Director, on 03/04/19 at 10:13 a.m., titled "Nebulizer Therapy" indicated, "Clean the nebulizer once " ...place in a plastic storage bag ...." 3.1-18(a)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: February 25, 26, 27, 28, March 1, and 4, 2019 Facility number: 000191 Residential Census: 30 Forum at the Crossing was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quaility Review was completed on March 11, 2019.	R 0000	**This Plan of Correction constitutes The Forum at the Crossing's written allegation of compliance for the alleged deficiencies cited. Submission of the Plan of Correction is not a admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.** **The Forum at the Crossing respectfully requests a desk review for this Plan of Correction** **Alleged date of compliance is**	

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			March 23, 2019.	