

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00318196 and IN00317816.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00318986.</p> <p>Complaint IN00318196 - Substantiated. Federal/State deficiencies related to the allegations are cited at F602.</p> <p>Complaint IN00317816 - Substantiated. Federal/State deficiencies related to the allegations are cited at F584 and F921.</p> <p>Complaint IN00318986 - Substantiated. Federal/State deficiencies related to the allegations are cited at F623 and F661.</p> <p>Survey dates: February 4, 5, 6, 7, 10, and 11, 2020</p> <p>Facility number: 000131 Provider number: 155226 AIM number: 100274910</p> <p>Census Bed Type: SNF/NF: 101 Total: 101</p> <p>Census Payor Type: Medicare:6 Medicaid:72 Other:23 Total:101</p> <p>These deficiencies reflect State Findings cited in</p>	F 0000	We would like to request a desk review/ paper compliance, for substantial compliance with this plan of correction. Preparation and execution of this plan of correction does not constitute an admission of or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because the Federal and State Law requires it. Compliance has been and will be achieved no later than the last completion date identified in the plan of correction. Compliance will be maintained as provided in the plan of correction. Failure to dispute or challenge the alleged deficiencies below is not an admission that the alleged facts occurred as presented in the statements.	
------------------------	--	--------	--	--

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 0550 SS=D Bldg. 00	<p>accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on February 18, 2020</p> <p>483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.</p> <p>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.</p> <p>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.</p> <p>§483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents' dignity were maintained by not removing hospital arm bands after hospitalizations for 2 of 2 residents reviewed for dignity, and a staff person not sitting while assisting a resident to eat a meal for 1 of 4 residents randomly observed in the memory care dining room. (Resident QQ, RR, and SS)</p> <p>Findings include:</p> <p>1. The clinical record for Resident QQ was reviewed on 2/4/20 at 12:15 p.m. The resident's diagnosis included, but was not limited to, cerebral infarction (stroke). Resident was returned to facility from hospital stay on 1/22/20.</p> <p>The Annual MDS (Minimum Data Set) assessment, dated 10/16/19, indicated resident's cognition was severely impaired.</p> <p>During an observation of the resident on 2/4/20 at 12:06 p.m., she had a white hospital arm band on her right arm.</p> <p>An interview was conducted with the Director of Nursing Services (DNS) on 2/10/20 at 11:25 a.m. The DNS confirmed with a staff person providing care to Resident QQ, that the resident did have a hospital armband on her right arm. The DNS indicated the resident's hospital arm band should have been removed.</p>	F 0550	<p>It is the practice of this provider to provide each resident the right to be treated with dignity.</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident QQ and RR had arm bands removed immediately. Both residents were assessed and were found to have no adverse effects related to the deficient practice.</p> <p>Immediate corrective action was taken on 02.06.20 for resident SS, lunch meal was completed with LPN #2 sitting down. Resident SS was assessed and found to have no adverse effects related to the deficient practice.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?</p> <p>All residents who reside in facility and require assistance with eating have the potential to be affected by this deficient practice. All residents residing in facility were assessed for armbands. No other residents identified to affected by deficient practice.</p> <p>What measures will be put into</p>	03/12/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>2. The clinical record for Resident RR was reviewed on 2/4/20 at 11:04 a.m. The resident's diagnosis included, but was not limited to, hemiplegia. The resident's admission date was 1/10/20.</p> <p>The Annual MDS assessment, dated 1/17/20, indicated resident's cognition was severely impaired.</p> <p>During observations of Resident RR, on 2/4/20 at 11:04 a.m. and 2/7/20 at 11:34 a.m., the resident had hospital arm bands on his right and left arms.</p> <p>An observation was made of Resident RR with the DNS on 2/10/20 at 11:15 a.m. The resident had on his right arm a pink hospital arm band and white, pink, and yellow hospital arm bands on his left arm.</p> <p>An interview was conducted with the DNS on 2/10/20 11:20 a.m. She indicated the resident's hospital arm bands should have been removed.</p> <p>3. The clinical record for Resident SS was reviewed on 2/6/20 at 12:30 p.m. The resident's diagnosis included, but was not limited to, dementia without behavioral disturbance.</p> <p>The Quarterly MDS assessment, dated 12/3/19, indicated the resident's cognition was severely impaired.</p> <p>During an observation of a lunch meal in the Memory Care dining room on 2/6/20 at 12:25 a.m., License Practical Nurse (LPN) 2 assisted Resident SS to eat her lunch meal. The LPN was standing next to the resident's chair while she provided bites of food to the resident with a spoon.</p>		<p>place or what systemic changes will be made to ensure that the deficient practice does not recur? Education provided to Nursing Staff. All staff will be in-serviced on Resident's Rights and Dignity policies provided by DNS/designee on/by March 12, 2020. Licensed Nurses/designee will remove armbands from residents upon admission to facility. DNS/ Designee will complete the admission checklist audit tool and ensure that armbands were removed on next business day. Dining room Manager Observation Checklist will be completed and reviewed by IDT on next business day to ensure that meal service is completed with attention to dignity while dining. How will the corrective actions be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? DNS/ designee will complete the Annual POC QAPI (QA) tool weekly for 4 weeks, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The DNS/Designee will complete the Annual POC QA Tool for 4 weeks, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 0554 SS=D Bldg. 00	<p>An interview was conducted with the DNS on 2/6/20 at 1:33 p.m. She indicated LPN 2 should have been sitting while assisting Resident SS with her lunch meal.</p> <p>A Resident Rights policy was provided by DNS on 2/6/20 at 3:15 p.m. It indicated "...Policy...All staff members recognize the rights of residents at all times and residents assume their responsibilities to enable personal dignity, well being, and proper delivery of care..."</p> <p>3.1-32(a)</p> <p>483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, record review, and interview, the facility failed to ensure the clinical appropriateness of a resident to self administer a medication for 1 of 5 residents reviewed for medication administration. (Resident Z)</p> <p>Findings include:</p> <p>An observation was made on 2/6/20 at 11:25 a.m., of Licensed Practical Nurse (LPN) 6 administering medications to Resident Z. Upon entrance to the resident's room a bottle of Deep Sea Nasal spray was on top of the resident's bedside table.</p> <p>An observation was made on 2/6/20 at 11:40 a.m., with Assistant Director of Nursing Service (ADNS) of the resident's room. A bottle of Deep Sea Nasal spray was on top of the resident's bedside table.</p>	F 0554	<p>of these audits will be reviewed by the QAPI committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee.</p> <p>It is the practice of this provider to provide each resident the right to self-administer medications if the interdisciplinary team determined that it is clinically appropriate. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident Z was assessed and found to have no adverse effects related to deficient practice. MD/NP was notified, and no new orders obtained. IDT completed the Self-Administration Observation for Resident Z. How other residents having the potential to be affected by the same deficient practice will be</p>	03/12/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>During an interview and record review with ADNS on 2/6/20 at 11:40 a.m., ADNS indicated Resident Z's clinical record did not contain a self-administration assessment completed for the Deep Sea Nasal spray and therefore the medication should have not been left at bedside.</p> <p>The Self Administration of Medications policy received on 2/6/20 at 1:29 p.m., from ADNS indicated, "...If a resident desires to participate in self-administration, the Interdisciplinary Team will assess the competence of the resident to participate by completing the "Self-Administration of Medication Assessment" observation. A physician order will be obtained specifying the resident's ability to self-administer medications and, if necessary, listing which medications will be included in the self-administration plan. The licensed nurse will instruct the resident regarding proper administration of medication. Storage of self-administered medication will comply with state and federal regulations. All bedside medications will be maintained in a secured location in the resident's room. The resident will be assessed for continued self-administration of medications quarterly and with any significant change of condition. The resident's care plan will be updated to include self administration.".</p> <p>3.1-11</p>		<p>identified and what corrective actions will be taken? All residents who reside in facility and have orders for self-administering medications have the potential to be affected by the deficient practice. IDT completed an audit of residents who self-administer medications, no other residents identified to be affected by deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? All licensed staff will be educated on providing assessing and completing the self-administration observation for all residents that self-administer medications, provided by DNS/designee on or before March 12, 2020. IDT will complete daily audit tool to ensure that residents with new orders for self-administration of medications have the proper assessment/ observation completed. This will be on completed x 30 days; areas will thereafter be monitored through the QAPI process. How will the corrective actions be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The DNS/Designee will complete the Annual POC QA tool for 4 weeks, monthly times 6 and then quarterly to encompass all shifts</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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 0583 SS=D Bldg. 00	<p>483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records.</p> <p>§483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>§483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.</p> <p>§483.10(h)(3) The resident has a right to</p>		until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>secure and confidential personal and medical records.</p> <p>(i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.</p> <p>(ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.</p> <p>Based on observation and interview, the facility failed to protect personnel health information for 3 of 3 Residents reviewed for privacy (Resident JJ, KK, and ZZ)</p> <p>Findings include:</p> <p>1. During an random observation, on 02/05/2020 at 10:46 a.m., the 2nd floor nursing station was observed. A dry erase sign was noted to be hanging on a bulletin board at the nursing station. The sign was visible from the hallways around the nursing station. The sign was marked with black dry erase marker and read 209b- Resident JJ initials- LL (left lower) edema- Venous Doppler (type of test) - Awaiting ETA (Estimated Time Arrival), 203- Resident KK's initials- gross urine-UA (urinalysis) and C and S (Culture and Sensitivity), 211- Resident ZZ's initials- UTI (urinary tract infection)- ATB (antibiotic therapy)-continue antibiotics.</p> <p>a. The clinical record for Resident JJ was reviewed on 2/5/2020 at 10:56 a.m. The resident's diagnoses included, but were not limited to, acute and chronic respiratory failure.</p> <p>During an observation on 2/5/2020 at 10:56 a.m., Resident JJ's name was posted outside her door.</p>	F 0583	<p>It is the practice of this provider to provide each resident the right to have personal privacy and confidentiality of his or her personal and medical records maintained.</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Residents JJ, KK, ZZ were not affected by systemic change. Signage was immediately removed.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?</p> <p>All residents who reside in facility and had change of condition had the potential to be affected by this deficient practice. All residents residing in facility were assessed and No other residents were identified to affected by deficient practice.</p> <p>What measures will be put into</p>	03/12/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>b. The clinical record for Resident KK was reviewed on 2/5/2020 at 10:30 a.m. The resident's diagnosis included, but was not limited to, urinary tract infection.</p> <p>During an observation on 2/5/2020 at 10:30 a.m., Resident KK's name was posted outside his door.</p> <p>c. The clinical record for Resident ZZ was reviewed on 2/5/2020 at 11:20 a.m. The resident's diagnosis included, but was not limited to, urinary tract infection.</p> <p>During an observation on 2/5/2020 at 11:20 a.m., Resident ZZ's name was posted outside her door.</p> <p>During an interview on 2/5/2020 at 11:45 a.m., UM (Unit Manager) 21 indicated the sign was how the nursing staff communicated pertinent information about the residents and that it could be seen from the hallways.</p> <p>On 2/5/2020 at 2:19 p.m., the DNS (Director of Nursing Services) provided the Use and Disclosure of Protected Health Information policy indicated "...Purpose of Policy: To ensure that the use and disclosure of Protected Health Information [PHI] is consistent with applicable laws, regulations and health information standards...Definition...Protected Health Information [PHI] means any personally identifiable health information related to an individual that can be used to identify a patient, and was created, used, or disclosed in the course of providing a health care service, such as diagnosis or treatment. PHI can be present in any form including verbal communication, written documentation, or transmitted by electronic communication. This includes any information</p>		<p>place or what systemic changes will be made to ensure that the deficient practice does not recur? Sign was immediately removed and placed in confidential location. All Licensed Staff educated on HIPPA and proper use of "Report Board" will be completed on or before March 12,2020. DNS/ Designee will ensure that "report board remains in a confidential location at all times.</p> <p>How will the corrective actions be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The DNS/Designee will complete the Annual POC QA Tool for 4 weeks, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 0584 SS=D Bldg. 00	<p>about health status, provision of care, or health payment that can be linked to an individual..."</p> <p>3.1-3(o)</p> <p>483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>The facility must provide-</p> <p>§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.</p> <p>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;</p> <p>§483.10(i)(3) Clean bed and bath linens that are in good condition;</p> <p>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2) (iv);</p> <p>§483.10(i)(5) Adequate and comfortable</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>lighting levels in all areas;</p> <p>§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and</p> <p>§483.10(i)(7) For the maintenance of comfortable sound levels.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident was provided clean linen for 1 of 12 residents observed during an environmental tour. (Resident RR)</p> <p>Findings include:</p> <p>The clinical record for Resident RR was reviewed on 2/4/20 at 11:04 a.m. The resident's diagnosis included, but was not limited to, hemiplegia (paralysis on one side of the body).</p> <p>The Annual MDS (Minimum Data Set) assessment, dated 1/17/20, indicated the resident's cognition was severely impaired.</p> <p>An observation of Resident RR was made on 2/4/20 at 11:06 a.m. and 3:40 p.m. The resident was lying in bed with a yellow stain on his pillow case.</p> <p>An interview was conducted with Resident RR's family member on 2/4/20 at 3:45 p.m. The family member indicated the resident's pillow cases were always dirty.</p> <p>During an environmental tour with the Maintenance Supervisor and Housekeeping Supervisor on 2/11/20 at 9:25 a.m., Resident RR's room was observed. The resident was lying in bed with a pillow case that had a yellow stain, and the</p>	F 0584	<p>It is the practice of this provider to provide each resident the right a safe, clean, comfortable, and home-like environment.</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident RR had clean provided and was found to have no adverse effects related to the deficient practice identified.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?</p> <p>All residents who reside in facility have the potential to be affected by this deficient practice. Resident rooms inspected, and no other residents or rooms identified as being affected by this deficient practice. In-service staff on clean linen and safe environment by ED/ Designee by 3/12/20</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient</p>	03/12/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/11/2020
NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>comforter had red and yellow stains on it.</p> <p>An interview was conducted with the Housekeeping Supervisor on 2/11/20 at 9:50 a.m. She indicated she would let housekeeping know to keep an eye on his bedding. The housekeeping staff did not change dirty linens on the beds when resident's were in them. The nursing staff changed the bed linens if the resident's were in their beds and soiled.</p> <p>The laundry/linen policy was provided by the Director of Nursing Services on 2/10/20 at 2:58 p.m. It indicated "...The laundry staff shall handle, store, process, and transport linen appropriately to prevent the spread of infection, in resident-care areas and in the laundry facility. Purpose: To ensure the proper care of linen and laundry to prevent the spread of infection..."</p> <p>This Federal tag relates to complaint IN00317816.</p> <p>3.1-19(f)(5)</p>		<p>practice does not recur?</p> <p>Care companion to verify that linen is clean during rounds. Ensure that nursing staff receive home-like environment and changing linen in-service and how residents' rooms and linen cleanliness should be routinely checked for soilage and linen change documented on shower sheets. In-service staff on clean linen and safe environment by ED/ Designee by 3/12/20. Nursing Assistants will change and document linen changes on resident's shower sheet. This documentation will be audited the following business day.</p> <p>How will the corrective actions be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>DNS / designee will complete the Annual POC QAPI (QA) tool weekly for one month, bi-weekly for two months, and then monthly for six months. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/11/2020
NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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 0585 SS=D Bldg. 00	<p>483.10(j)(1)-(4) Grievances §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.</p> <p>§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.</p> <p>§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.</p> <p>§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;</p> <p>(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;</p> <p>(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;</p> <p>(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;</p> <p>(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
--------------------	--	---------------	---	----------------------

	<p>pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;</p> <p>(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and</p> <p>(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.</p> <p>Based on interview and record review, the facility failed to make a prompt effort to resolve a resident's grievance for 1 of 4 residents reviewed for dignity. (Resident D)</p> <p>Findings include:</p> <p>The clinical record for Resident D was reviewed on 2/5/20 at 10:00 a.m. The resident's diagnosis included, but was not limited to, heart failure. She was admitted to the facility on 1/24/20.</p> <p>The Admission MDS (Minimum Data Set) assessment, dated 1/20/20, indicated the resident's cognition was intact.</p> <p>An interview was conducted with Resident D on 2/5/20 at 10:21 a.m. She indicated the facility staff did not treat her with respect and dignity. Shortly</p>	F 0585	<p>It is the practice of this provider to provide each resident the right to be treated with dignity.</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident D received psychosocial follow-up and was found to have no adverse effects related to the alleged deficient practice identified.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?</p> <p>All residents who reside in facility have the potential to be affected</p>	03/12/2020
--	---	--------	--	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>after she got to the facility, she asked one of the CNAs (Certified Nursing Assistants) for an extra blanket and was told, if she pulled up the blanket she already had, then she wouldn't be cold, and she was not given an extra blanket. Resident D could not recall which CNA did not give her a blanket, but was able to describe her. The resident informed another one of the facility staff members about the situation, but couldn't recall which one. She was able to describe her.</p> <p>The ED (Executive Director) provided 3 grievances for Resident D on 2/7/20 at 1:22 p.m. One was in regards to laundry, and 2 were in regards to medication. None of them referenced a CNA and a blanket.</p> <p>An interview was conducted with the ED on 2/7/20 at 1:27 p.m. The ED was informed of Resident D's concern with the CNA and the blanket. The ED indicated she was unaware of this concern, and perhaps the Therapy Director was the one informed of Resident D's concern, as she fit the description given by Resident D.</p> <p>An interview was conducted with the TD (Therapy Director) on 2/7/20 at 1:34 p.m. She indicated she was Resident D's Customer Care Companion, and the resident did inform her of the CNA/blanket issue on 1/31/20. She asked Resident D if she informed anyone of her concern and was told no, so she (TD) filled out a grievance form on 1/31/20 and placed it in the CCC's (Customer Care Coordinator's) mailbox. The TD did not recall discussing the blanket in morning meeting, but she "definitely filled out the grievance for the blanket." She had not heard anything else about the blanket, since she filled out the grievance.</p>		<p>by this deficient practice. All residents made aware of the grievance policy during resident council meeting. Letter sent to families about the facility grievance policy. In-service staff on the facility grievance policy by 3/12/20.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? New and outstanding grievances to be discussed by the IDT team each business day. In-service staff on the grievance policy by ED/ Designee by 3/12/20. This audit will be completed x 30 days, areas thereafter will be monitored through the QAPI process.</p> <p>How will the corrective actions be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? ED / designee will complete the Annual POC (QA) tool weekly for one month, bi-weekly for two months, and then monthly for six months. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance. Deficiency in this practice will result in disciplinary action up to and including termination of the</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>Based on interview and record review, the facility failed to assure residents were free of misappropriation of funds for 1 of 2 residents reviewed for misappropriation. (Resident MM)</p> <p>Findings include:</p> <p>The clinical record for Resident MM was reviewed on 2/7/2020 at 1:17 p.m. The resident's diagnosis included, but was not limited to, fracture on left foot.</p> <p>The Admission MDS (Minimum Data Set) Assessment, dated 11/6/2019, indicated the resident's cognition was intact.</p> <p>During an interview on 2/7/2020 at 10:00 a.m., the ED (Executive Director) indicated Resident MM had an incident involving her debit card while she was a resident at the facility.</p> <p>On 2/7/2020 at 10:45 a.m., the ED provided the investigation file for the incident involving Resident MM's debit card.</p> <p>The investigation file included a brief investigation of the incident, dated 12/12/2019, which indicated Resident MM alleged that she gave her bank card to CNA (Certified Nursing Assistant) 20 and that CNA 20 had her bank card and had stolen her money. The immediate action taken was notification of the police and suspension of CNA 20 pending an investigation. The preventative measures taken was that in servicing was initiated on abuse, training, reporting, and prevention.</p> <p>The investigation file included an interview with Resident MM, which was conducted on 12/12/2019 at 4:30 p.m. The documentation of the</p>		<p>efforts to resolve Abuse, neglect, and misappropriation/ Exploitation.</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident MM is no longer a resident within the facility.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?</p> <p>All residents who reside in facility have the potential to be affected by this deficient practice. All interviewable residents interviewed. All concerns have been resolved. In-service staff on abuse and types of abuse by 03/12/20.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</p> <p>All current staff will be in-serviced on the facility abuse policy by 03/12/20. All new hires will receive abuse in-servicing in general orientation. New and outstanding grievances to include those related to misappropriation will be discussed by the IDT team each business day with follow up completed. This audit will be completed x 30 days, areas thereafter will be monitored through the QAPI process.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>interview indicated that Resident MM gave her debit card to CNA 20 so that she could go to the store for her and purchase a gift card for her granddaughter. She had also requested CNA 20 to get a money order for an attorney. She had given CNA 20 her debit card on either 11/30/2019 or 12/1/2019 to help her make the purchases, which CNA 20 had done. On 12/11/2019, a purchase was made at a grocery store, which she had not asked CNA 20 to do for her. CNA 20 had told her she did not have her card anymore.</p> <p>During an interview on 2/7/2020 at 2:50 p.m., the ED indicated that she had interviewed staff who had worked on the unit which Resident MM resided to determine if anyone had reported missing items or had grievances. She had instructed the Social Service Director to interview the residents who resided on the unit where CNA 20 worked. There were no other interviewable residents who had property missing. She had provided training that staff were not allowed to accept anything from residents and that the activity department was to be notified if residents needed items purchased for them. It was never okay for a staff member to accept a debit card from a resident. She indicated she was unsure if Resident MM had the debit card in her possession at the time she was interviewed and that Resident MM had not wanted assistance in locating the card, however, she had been assisted in canceling the debit card with the bank.</p> <p>During an interview on 2/10/2020 at 1:20 p.m., the CCC (Customer Care Coordinator) indicated that Resident MM did not have the debit card in her possession when she assisted her to cancel the card with her bank.</p> <p>On 2/4/2020 at 3:00 p.m., the ED provided the</p>		<p>How will the corrective actions be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>ED/Designee will complete the Annual POC QAPI (QA) tool weekly for one month, bi-weekly for two months, and then monthly for six months. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 0623 SS=D Bldg. 00	<p>Abuse Prohibition, Reporting, and Investigation policy indicated "...Policy: It is the policy of ... to provide each resident with the environment that is free of abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to verbal abuse, sexual abuse, physical abuse, mental abuse, corporal punishment, and involuntary seclusions... [company name] will provide guidelines to facility staff to prohibit and prevent abuse, neglect, exploitation of residents and misappropriation of resident property...Definitions/ Examples of Abuse: Willful used in the definition of abuse means the individual must have acted deliberately, not that the individual intended to inflict injury or harm...Exploitation- The unfair treatment or use of a resident or taking a selfish or unfair advantage of a resident for personal gain through manipulation, intimidation, threats, or coercion. Examples include...Accepting from a resident or attempting to gain from a resident personal items or money thru persuasion, coercion, or sonication..."</p> <p>This Federal Tag relates to complaint IN00318196.</p> <p>3.1-28(a)</p> <p>483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must-</p> <p>(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>Long-Term Care Ombudsman.</p> <p>(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and</p> <p>(iii) Include in the notice the items described in paragraph (c)(5) of this section.</p> <p>§483.15(c)(4) Timing of the notice.</p> <p>(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.</p> <p>(ii) Notice must be made as soon as practicable before transfer or discharge when-</p> <p>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;</p> <p>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;</p> <p>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;</p> <p>(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or</p> <p>(E) A resident has not resided in the facility for 30 days.</p> <p>§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:</p> <p>(i) The reason for transfer or discharge;</p> <p>(ii) The effective date of transfer or discharge;</p> <p>(iii) The location to which the resident is</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>transferred or discharged;</p> <p>(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;</p> <p>(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;</p> <p>(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and</p> <p>(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.</p> <p>§483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.</p> <p>§483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).</p> <p>Based on record review and interview, the facility failed to complete the State Transfer and Discharge notice form for 1 of 2 residents reviewed for discharge. (Resident Y)</p> <p>Finding includes:</p> <p>The record for Resident Y was reviewed on 2/7/20 at 3:03 p.m. Diagnoses included, but were not limited to, left shoulder dislocation, left humerus fracture, hypertension, acute kidney failure, and muscle weakness.</p> <p>The Nurse Practitioner progress note, dated 11/13/19, indicated "Patient seen today for discharge planning for pt.[sic, patient] transition[ing] from SNF[sic, skilled nursing facility]. PCP[sic, primary care provider] f/u[sic, follow up] appointment to be scheduled. Pt.[sic, patient] referred home with PT/OT/SN[sic, physical therapy, occupational therapy and skilled nursing] for safe transition to home. He takes effort to travel. Resident verbalizes understanding of all discharge instructions. Pt. [sic] discharge initiated by facility due to violation of policy as per nursing he was found in his room snorting crushed Wellbutrin through a straw. Prescription is from outside provider [physician's name] whose staff has been notified of said abuse. Pt.[sic] will not be prescribed Wellbutrin or controlled medications by this provider with</p>	F 0623	<p>It is the practice of this provider to provide each resident the right to be treated with dignity.</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident Y is no longer a resident in the facility.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?</p> <p>All residents who reside in facility have the potential to be affected by this deficient practice. A list of all resident transfers and discharges since 1/1/20 has been compiled and sent to the Ombudsman by 3/12/20.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</p> <p>Licensed nurses and Social Service Department will be educated on Discharge Policy to include discharge paperwork</p>	03/12/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 0644 SS=D	<p>concern for acute abuse."</p> <p>The resident's clinical record lacked documentation to indicate the State Transfer and Discharge form was completed nor was a copy of the notice to discharge sent to the Office of the State Long-Term Care Ombudsman.</p> <p>An interview with the Director of Nursing Service (DNS) on 2/10/20 at 10:33 a.m., indicated the State Transfer or Discharge notice was not completed nor was a copy sent to the Ombudsman because she thought it was a resident initiated discharge.</p> <p>This Federal tag relates to complaint IN00318986</p> <p>3.1-12(a)(5)</p> <p>483.20(e)(1)(2) Coordination of PASARR and Assessments</p>		<p>completion on or by March 12, 2020 by ED/Designee. All facility-initiated discharges and transfers will be submitted to the Ombudsman monthly. Social Services will ensure residents with pending discharges will be reviewed at the morning meeting prior to the day of discharge/transfer and ensure all the proper services/paperwork have been arranged and documented as the order from the physician was written, as well as what medication should be sent with the resident.</p> <p>How will the corrective actions be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>Social Service/ designee will complete the Annual POC QAPI (QA) tool weekly for one month, bi-weekly for two months, and then monthly for six months. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
Bldg. 00	<p>§483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes:</p> <p>§483.20(e)(1) Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.</p> <p>§483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.</p> <p>Based on interview and record review, the facility failed to refer a resident with a newly evident or possible serious mental disorder for review for 2 of 3 residents reviewed for PASRR (Pre Admission Screening Resident Review.) (Residents F and X)</p> <p>Findings include:</p> <p>1. The clinical record for Resident F was reviewed on 2/5/20 at 11:02 a.m. The resident's diagnosis included, but was not limited to, psychotic disorder. He was admitted to the facility on 12/5/16.</p> <p>The 12/5/16 Notice of PASRR Level I Screen Outcome for Resident F read, "Level I Outcome: No Level II Required -- No SMI [Serious Mental Illness]/ID [Intellectual Disability]/RC [Related Condition] Rationale: The Level I screen indicates</p>	F 0644	<p>It is the practice of this provider to provide each resident the right to prescreening and resident review (PASARR) program, as practicable to avoid duplicative testing and effort.</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident F and X diagnosis and medication reviewed, and Level 1 updated in ASCEND.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents who reside in facility</p>	03/12/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/11/2020
NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>that a PASRR disability is not present because of the following reason: There is no evidence of a PASRR condition of an intellectual/developmental disability or a serious behavioral health condition. If changes occur or new information refutes these findings, a new screen must be submitted." The notice indicated the only mental health medication he was on at the time of the assessment was Depakote.</p> <p>The physician's orders for Resident F indicated he began taking Zyprexa (antipsychotic medication) on 12/16/16, and was currently receiving Zyprexa for psychotic disorder with delusions.</p> <p>Resident F's face sheet indicated a diagnosis of psychotic disorder, effective 12/24/18.</p> <p>An interview was conducted with the FSSD (Floating Social Services Director) on 2/7/19 at 2:39 p.m. She indicated there were no subsequent screens for Resident F after his 12/5/16 Level I. A new Level I should have been completed after a new mental illness diagnosis or the addition of any medication that would be of concern, so Resident F should have had a new Level I completed.</p> <p>The Level I and Level II Update Quickguide was provided by the DNS (Director of Nursing Services) on 2/7/20 at 3:09 p.m. It indicated "Level I's...Need to be reviewed with each MDS [Minimum Data Set assessment] (minimum of annually) to make sure the information is current. Looking at dx [diagnoses,] current psych [psychotropic] medications, and inpatient psych stays. If there are changes to Level I: 1. Update new Level I in ASCEND 2. ASCEND will indicate if a Level II is needed and notify Level II agency 3. If NOT a Level II the (sic) print Level I off and</p>		<p>have the potential to be affected by this deficient practice. SSD/Designee will complete a facility audit of all residents with diagnosis of serious mental illness or an intellectual/developmental disability or currently on psychotropic medications to ensure that Level I accurately reflect the resident status.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>ED/Designee will provide in-service/education to Social Service department on policy for PASSR Screening. SSD/ Designee will complete weekly audit for all new/re admitted residents to ensure that Level I screening has been completed and accurately reflects mental health diagnosis and psychotropic medications.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur?</p> <p>Medical Records / designee will complete the Annual POC (QA) tool weekly for one month, bi-weekly for two months, and then monthly for six months. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>place in the medical record 4. If IS a Level II then refer to below once Level II documentation is obtained...."</p> <p>2. The clinical record for Resident X was reviewed on 2/7/20 at 9:35 a.m. The resident's diagnoses include, but were not limited to, major depressive disorder, cerebral infarction, psychotic disorder with delusions due to know physiological condition, aphasia, and dysphagia.</p> <p>The Quarterly Minimum Data Assessment, dated 1/27/20, indicated the resident's cognition was severely impaired.</p> <p>A Level I PASRR was completed on 7/27/19 at another facility prior to Resident X's admission. On the PASRR Level I, under the Diagnosis, Mental Health Diagnosis section, it indicated, "No mental health diagnosis is known or suspected." The outcome rationale stated, "The Level I screen indicates that a PASRR disability is not present because of the following reason: There is no evidence of a PASRR condition of an intellectual/developmental disability or a serious behavioral health condition. If changes occur or new information refutes these findings, a new screen must be submitted."</p> <p>An interview was conducted on 2/7/20 at 10:59 a.m., with FSSD (Floating Social Service Director). FSSD indicated prior to admission, the PASRR Level I screen should be checked against the resident's diagnoses. If the mental health diagnosis was indicated on the Level I and the determination of that Level I was still no Level II was needed, then that would be the determination. In this situation, however, the resident's Level I evaluation did not have the Mental Health diagnosis listed on it so a Level II evaluation should have completed for the resident.</p>		ensure compliance. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 0655 SS=D Bldg. 00	<p>3.1-16(d)(1)</p> <p>483.21(a)(1)-(3) Baseline Care Plan §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-</p> <ul style="list-style-type: none"> (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- <ul style="list-style-type: none"> (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. <p>§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-</p> <ul style="list-style-type: none"> (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). <p>§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	<p>includes but is not limited to:</p> <ul style="list-style-type: none"> (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. <p>Based on interview and record review, the facility failed to timely develop baseline care plans which included goals based on admission orders for 1 of 1 resident reviewed for care plans and 1 of 1 resident reviewed for edema. (Resident HH and JJ)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. The clinical record for Resident HH was reviewed on 2/4/2020 at 3:10 p.m. The resident's diagnosis included, but was not limited to, diabetes. <p>The Admission MDS (Minimum Data Set) Assessment, dated 1/31/2020, indicated the resident's cognition was intact and the resident had been admitted to the facility on 1/24/2020.</p> <p>During an interview on 2/4/2020 at 3:21 p.m., Resident HH indicated she would like the staff to tell her what her blood sugar results were and how much insulin she was receiving.</p> <p>The clinical record contained a care plan, with a problem start date of 1/27/2020, which indicated Resident HH was at risk for adverse effects of hyperglycemia (high blood sugar) or hypoglycemia (low blood sugar) related to the use of glucose lowering medication and the diagnosis</p>	F 0655	<p>It is the practice of this provider to ensure that each resident have a baseline care plan developed timely.</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident Care Plan has been completed, no adverse effects noted.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?</p> <p>All residents who admit to the facility have the potential to be affected by the deficient practice. IDT completed an audit of residents who admitted to the facility within the last 30 days, no other residents identified to be affected by deficient practice.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</p>	03/12/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>of diabetes.</p> <p>During an interview on 2/7/2020 at 11:09 a.m., the DNS (Director of Nursing Services) and MDSC (Minimum Data Set Coordinator) indicated there were no care plans developed prior to 1/27/2020 and that the baseline care plans should have been completed within 48 hours of admission.</p> <p>2. The clinical record for Resident JJ was reviewed on 2/5/2020 at 10:56 a.m. The resident's diagnoses included, but were not limited to, acute and chronic respiratory failure.</p> <p>The Admission MDS Assessment, dated 1/10/2020, indicated the resident's cognition was intact and the resident was admitted to the facility on 1/3/2020.</p> <p>During an interview on 2/5/2020 at 10:56 a.m., Resident JJ indicated that her left leg had been swollen for over a week. She was waiting for a scan to be done on it.</p> <p>The clinical record contained a physician's order, dated 1/3/2020, which indicated Resident JJ was to receive enoxaparin (an anticoagulant medication) 40 mg subcutaneously daily for DVT (Deep Vein Thrombosis) daily until 1/28/2020.</p> <p>The clinical record contained a care plan, dated 1/16/2020, which indicated Resident JJ was at risk for bleeding or bruising related to use of an antiplatelet medication.</p> <p>The clinical record lacked a care plan to address the resident's use of an anticoagulant medication from 1/3/2020 through 1/28/2020.</p> <p>During an interview on 2/11/2020 at 3:10 p.m., the</p>		<p>All licensed staff will be educated on completing the baseline careplan at time of admission, provided by DNS/designee on or before March 12, 2020. DNS/ Designee will complete and audit of residents admitting on Friday on the following day to ensure that compliance is met within policy guidelines.</p> <p>How will the corrective actions be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>The DNS/Designee will complete the Annual POC QA Tool for 4 weeks, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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 0661 SS=D Bldg. 00	<p>DNS (Director of Nursing Services) indicated the enoxaparin had been ordered upon admission for a DVT prophylaxis and there was no other care plan addressing it's use prior to 1/16/2020.</p> <p>On 2/7/2020 at 2:50 p.m., the DNS provided the IDT Baseline Care Plan Policy indicated " Policy: It is the policy of this facility that each resident will have an interdisciplinary baseline care plan developed within 48 hours of admission. The baseline care plan will be developed in collaboration with the resident, family and / or representative and direct care staff to incorporate findings based on the admission assessment, observations, interviews and resident preferences. The baseline care plan will include resident-centered goals and interventions relative to resident need and preferences to promote the residents highest level of functioning including medical, nursing, mental and psychosocial needs. Procedure...Baseline Care Plan will include, but not limited to the following: The resident's initial goals for care; the instructions needed to provide effective and person-centered care; the resident's immediate health and safety needs; Physician's orders...</p> <p>483.21(c)(2)(i)-(iv) Discharge Summary §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	<p>include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative.</p> <p>(iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).</p> <p>(iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.</p> <p>Based on record review and interview, the facility failed to ensure a resident's discharge summary included the reconciliation of post-discharge medications or a post-discharge plan of care addressing therapy and at home care needs for 1 of 2 residents reviewed for discharge. (Resident Y)</p> <p>Findings include:</p> <p>Resident Y's clinical record was reviewed on 2/7/20 at 3:03 p.m. The resident's diagnoses included, but not limited to, left shoulder dislocation, left humerus fracture, muscle weakness, and hypertension.</p> <p>A Physical Therapy plan of care, dated 11/8/19, from the Director of Nursing Service (DNS) indicated Resident Y was referred for physical therapy after suffering a left shoulder dislocation</p>	F 0661	<p>It is the practice of this provider to ensure that each resident's discharge summary include post-discharge reconciliation of medications. It is the practice of this provider to ensure that there is a post discharge plan of care that addresses therapy and at home services.</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident Y no longer resides in facility.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All</p>	03/12/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>and numeral head fracture on 10/22/19, due to a fall on to the left shoulder. The necessity for therapy was related to the need for bilateral lower extremity strengthening. "Without therapy patient will be at a risk for further functional decline and increased potential risk for falls." The skilled services focuses included, but not limited to, therapeutic exercise, neuromuscular re-education, gait training, and therapeutic activities. The frequency and duration was deemed 5 times a week for 12 weeks.</p> <p>An Occupational Therapy plan of care, dated 11/8/20, indicated the resident was referred for occupational therapy due to a decline in upper body functional use, balance, strength, and endurance with resulting decline in higher level ADL (activities of daily living)/mobility skills. The necessity for therapy was related to facilitate return independent function per prior level of function. "Without occupational therapy services, the resident is at risk for falls with potential injury and failure to return back to safe independent living". The skilled services focuses included, but not limited to, electrical stimulation, ultrasound, therapeutic exercises, self care training, and orthotic management. The frequency and duration was 5 times a week for 12 weeks.</p> <p>A physician's order, dated 11/13/19, indicated the resident "...may d/c[discharge] home w/ [with] home health services: SN/PT/OT[skilled nursing, physical therapy, occupational therapy]..."</p> <p>The Discharge Summary, dated 11/13/19, indicated the resident's recapitulation of stay as the admitting diagnoses was muscle weakness, left humerus fracture, and hypertension. Resident was alert and oriented with clear speech. The</p>		<p>residents discharging from the facility have the potential to be affected by the deficient practice. IDT completed an audit of residents who discharged from the facility within the last 30 days and identified that no other residents had been affected by deficient practice.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? All licensed staff will be educated on completing the discharge summary to include, medication reconciliation and completion of medication instructions, provided by DNS/designee on or before March 12, 2020. Social Service department will be educated on obtaining post-discharge services, provided by ED/Designee. IDT will discuss planned discharges on the business day prior to discharge date to include post-discharge services to ensure services obtained.</p> <p>How will the corrective actions be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The DNS/Designee will complete the Annual POC QA Tool for 4 weeks, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>resident was sent home with a 3 day supply of medications and all his belongings. Staff provided verbal education to the resident and his family member on medication administration. The discharge summary did not contain any entries in the following sections: Customary routine, continence, cognitive patterns, dental, communication, nutrition, vision, pressure ulcer/injury, mood and behavior patterns, activity pursuits, psychosocial well being, physical functioning and structural problems nor a list treatment discharge orders, referrals/appointments for physical therapy, occupational therapy or skilled nursing. The medication section did not list the time of last administration, when next dose was due or reason for use.</p> <p>An interview was conducted on 2/11/20 at 9:52 a.m., with the CCS (Consultant for Clinical Services) indicated the need for physical therapy, occupational therapy and skilled nursing should have been addressed on the discharge summary. If the resident had refused the services, then documentation of such refusal should have been documented in the clinical record even if only in nursing notes.</p> <p>An interview was conducted on 2/11/20 at 10:28 a.m., with CCS indicated the medication directions should contain in writing the frequency, reason for use, time of last admin, and when do next. Verbal education does not provide the needed information and should be documented in writing.</p> <p>An interview was conducted on 2/11/20 at 2:37 p.m., with the BOM(Business Office Manager). The BOM indicated the resident had Managed Medicaid and should have been discharged with all his medications instead of a 3 day supply since Managed Medicaid only will fill a prescription</p>		consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 0689 SS=D Bldg. 00	<p>once in a 30 day period.</p> <p>The Discharge Planning Policy received on 2/11/20 from CCS, indicated "....3. Appropriate referrals for home health care, obtaining medications, equipment, treatments will be made as indicated by the physician. 4. Education and teaching identified as needed (i.e. wound care, specialized diets, etc.) will be given to resident/representative or support person and documented in the medical record...6. For discharges with a physician's order to home; discharge instructions will be completed by the IDT [Interdisciplinary team] including medication list and follow up appointments as scheduled..."</p> <p>This Federal tag relates to complaint IN00318986</p> <p>3.1-36(a)(3)(b)</p> <p>483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and</p> <p>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident's assisted device of non-skid socks was in place for 1 of 1 resident reviewed for accident hazards. (Resident WW)</p> <p>Findings include:</p>	F 0689	It is the practice of this provider to ensure that the resident's assistive devices are in place. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident WW had	03/12/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>The clinical record for Resident WW was reviewed on 2/5/20 at 9:45 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease and insomnia.</p> <p>The at risk for falls care plan, revised 2/5/20, indicated the "Resident is at risk for falls related to impaired mobility, impaired cognition, medications that may increase her risk for falls and advanced age. Diagnoses include dementia and arthritis. Walks almost constantly until she is very tired." An intervention was to assess feet routinely to ensure non-skid socks/shoes were in place.</p> <p>During an observation, on 2/6/20 at 12:33 p.m., the resident was sitting in a chair in the activity area. She did not have on any shoes or non-skid socks. The resident was wearing a pair of regular blue socks.</p> <p>During an observation, on 2/6/20 at 12:41 p.m., the resident stood up from the chair in the activity area and walked down the hall with the MCF (Memory Care Facilitator.) The resident was not wearing any shoes or non-skid socks.</p> <p>During an observation, on 2/6/20 at 12:50 p.m., the resident walked back into the activity and dining area with LPN (Licensed Practical Nurse) 2. The resident was not wearing any shoes or non-skid socks.</p> <p>During an observation, on 2/6/20 at 3:37 p.m., the resident walked down the hallway in the same regular blue socks without non-skid socks or shoes. The resident continued to walk up and down the hall.</p> <p>An interview was conducted with the MCF on</p>		<p>non-skid footwear placed immediately, MD/NP made aware of deficient practice. No new orders or changes in plan of care. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents with fall interventions are at risk for deficient practice. DNS/Designee will complete and audit of the falls for the last 30 days to ensure that each intervention is in place. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? DNS/Designee will in-service all staff on Fall Policy on or before March 12,2020. DNS/ Designee will complete daily audit tool and meet with direct care staff Monday through Friday to review resident profiles, discuss updates including observation of new intervention(s) of residents sustaining recent falls. This will be completed x 30 days; areas will thereafter be monitored through the fall management QA tool. Updated resident care profiles will be provided to weekend staff through communication binder. How will the corrective actions be maintained to ensure the deficient practice will not recur, i.e., what quality</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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 0693 SS=D Bldg. 00	<p>2/6/20 at 3:42 p.m. She indicated Resident WW was not wearing non-skid socks, but she should be. The MCF had put the regular blue socks on the resident that morning between 7:00 a.m. and 8:00 a.m. There were no non-skid socks in the resident's drawer. The MCG meant to look for some, but had not had a chance to look for them.</p> <p>The Fall Management Program policy was provided by the DNS (Director of Nursing Services) on 2/6/20 at 4:06 p.m. It indicated "Facilities must implement comprehensive, resident-centered fall prevention plans for each resident at risk for falls or with a history of falls."</p> <p>3.1-45(a)(2)</p> <p>483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-</p> <p>§483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and</p> <p>§483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to</p>		<p>assurance program will be put into place? The DNS/Designee will complete the Annual POC QA Tool for 4 weeks, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.</p> <p>Based on observation, interview, and record review, the facility failed to administer a tube feeding as ordered for 1 of 2 residents reviewed for tube feeding (Resident FF)</p> <p>Findings include:</p> <p>The clinical record for Resident FF was reviewed on 2/4/2020 at 11:21 a.m. The resident's diagnosis included, but was not limited to, dysphagia (inability to swallow).</p> <p>On 2/4/2020 at 11:21 a.m., the resident was observed in her room. She was lying in bed with her eyes open. She had a tube feeding pump on a pole by her bed. The pump indicated the feeding was on hold. There were no staff present in the room.</p> <p>On 2/4/2020 at 2:13 pm., the resident was observed in her room. She was lying in bed with her eyes closed. She had a tube feeding pump on a pole by her bed. The pump indicated the feeding was on hold with run time error and was not infusing. There were not staff present in the room.</p> <p>The clinical record contained a physician's order, dated 1/16/2020, which indicated Resident FF was to receive Jevity 1.2 Cal (lactose-reduced food with fiber) through her gastric tube at 65 ml (militer) an hour with 100 ml water flushes every 4 hours.</p> <p>The clinical record did not contain any information about why to tube feeding was on hold or a physician's order to hold the tube</p>	F 0693	<p>It is the practice of this provider to ensure that each resident has tube feeding administered as ordered.</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident FF had placed immediately, MD/NP made aware of deficient practice. No new orders or changes in plan of care.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents that require feeding are at risk for deficient practice. DNS/Designee completed an audit of all residents that required enternal feeding during survey to ensure that feeding was being administered as ordered. No other residents were found to be affected by deficient practice.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? All licensed staff will be educated on following Physician orders for enternal tube feeding, provided by DNS/designee on or before March 12, 2020. IDT will complete daily</p>	03/12/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 0697 SS=D Bldg. 00	<p>feeding on 2/4/2020.</p> <p>During an interview on 2/6/2020 at 3:10 p.m., the DNS (Director of Nursing Services) indicated she was unsure why the tube feeding had not been running as ordered.</p> <p>3.1-44(a)(2)</p> <p>483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on interview and record review, the facility failed to address a resident's pain timely for 1 of 1</p>	F 0697	<p>audit tool to ensure that residents external feedings are being administered as ordered. This will be on completed x 30 days on random shifts; areas will thereafter be monitored through the external nutrition QA tool.</p> <p>How will the corrective actions be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The DNS/Designee will complete the Annual POC QA Tool for 4 weeks, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee.</p> <p>It is the practice of this provider to ensure that each resident has pain</p>	03/12/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	<p>residents reviewed for pain. (Resident VV)</p> <p>Findings include:</p> <p>The clinical record for Resident VV was reviewed on 2/4/20 at 11:15 p.m. The resident's diagnosis included, but was not limited to, orthopedic aftercare following surgical amputation. The resident's admission date was 1/30/20.</p> <p>The hospital discharge summary, dated 1/30/20, indicated the resident was to received 15 milligrams of oxycodone every 4 hours as needed for severe pain, and 5-325 milligrams of oxycodone every 4 hours as needed for moderate pain. The discharge summary noted the prescriptions were printed.</p> <p>The 15 milligrams of oxycodone and 5-325 milligrams of percocet were discontinued on 1/31/20.</p> <p>A physician's order, dated 1/31/20, indicated the resident was to receive 10-325 milligrams of percocet every 4 hours for moderate pain.</p> <p>The January 2020 Medication Administration Record (MAR) indicated the resident received 10-325 milligrams of percocet on 1/31/20 at 11:31 a.m. and 7:11 p.m.</p> <p>During an interview on 2/4/20 at 11:26 a.m., the resident indicated there had been a long delay in getting his pain medication when he first arrived. The day he was transferred his written prescriptions from the hospital were wrapped up in his clothes which caused a mix up with the delivery of his pain medication to the facility. He had to go without pain medication the first afternoon he arrived into the next morning. He</p>		<p>addressed timely.</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident VV was assessed by DNS/Designee, pain medication was in place and being utilized at this time. Resident was had no further concerns/adverse effects related to pain medication. MD/NP notified of deficient practice, no new orders or changes to plan of care.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All resident's admitting to facility with pain are at potential risk for deficient practice. DNS/ Designee completed an audit of recently admitted resident for the potential of unmet pain needs. No other residents were identified.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? All licensed staff will be educated on the pain management policy provided by DNS/designee on or before March 12, 2020. DNS/Designee will complete daily audit tool to ensure that residents admitted to facility has pain management needs addressed. This will be on completed x 30</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	<p>was in throbbing pain all night at a pain scale of 9 out of 10. The staff had called the doctor to get new prescriptions, but still there was a long delay to getting anything to help with the pain.</p> <p>A nursing progress note, dated 1/31/20 3:42 a.m., indicated "...resident [VV] is alert and oriented x [times] 3. able to make want and needs known. c/o [complaints of] pain to rt [right] toe. phone call placed to pharmacy. spoke with pharmacist concerning pain medication. stated "needed script". Phone call placed to MD. awaiting returning call at this time. resident made aware. resident is resting comfortably in bed. no noted distress. will continue to monitor..."</p> <p>During an interview with the Director of Nursing Services (DNS) on 2/7/20 at 9:44 a.m., she indicated there had been a problem with the resident's pain medication on the first day he arrived. The hard copy scripts were misplaced by the resident, and the staff had to contact the doctor to get new scripts. The staff should have addressed the resident's pain that night. They could have pulled pain medication from the EDK (Emergency Drug Kit).</p> <p>A pain management policy was provided by the DNS on 2/7/20 at 10:26 a.m. It indicated "...Policy: It is the policy of [name of corporation] to provide the necessary care and services to attain or maintain the highest practicable physical, mental an psychosocial well being. Including pain management. Procedures:...3. Interviewable Resident - Pain medications will be prescribed and given based upon intensity of the pain as follows: mild, moderate, severe, very severe, horrible...5. The physician will be notified unrelieved or worsening pain...11. The licensed nurse will monitor the efficacy of the analgesia and keep the</p>		<p>days; areas will thereafter be monitored through the Pain management QA tool.</p> <p>How will the corrective actions be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The DNS/Designee will complete the Annual POC QA Tool for 4 weeks, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 0698 SS=D Bldg. 00	<p>physician informed of any indicators of drug or dosage change as it relates to the resident's pain management..."</p> <p>3.1-37(a)</p> <p>483.25(l) Dialysis §483.25(l) Dialysis.</p> <p>The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.</p> <p>Based on interview and record review, the facility failed to ensure a resident was transported to dialysis timely for 1 of 1 residents reviewed for dialysis. (Resident PP)</p> <p>Findings include:</p> <p>The clinical record for Resident PP was reviewed on 2/5/20 at 10:15 a.m. The resident's diagnosis included, but was not limited to, end stage renal disease.</p> <p>A physician's order, dated 9/14/19, indicated the resident was to go to dialysis on Mondays, Wednesdays, and Fridays.</p> <p>A physician's order, dated 9/14/19, indicated the resident was to be transported to the dialysis center with the address and phone number. The resident was to be picked up at 6:50 a.m.</p> <p>A dialysis communication form for the resident, dated 2/3/20, indicated the resident was "...late for tx [treatment], runs as long as possible. pt chair time starts @ [at] 7:35 a.m. - pt needs to be here by</p>	F 0698	<p>It is the practice of this provider to ensure that each resident that requires transportation to dialysis be transported timely.</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? At time of survey, resident PP's was assessed, and dialysis scheduled reviewed to include chair time, and transport set. Arrangements in place at this time to ensure that there are no further concerns related to transportation.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents who require transportation to dialysis have the potential to be affected by deficient practice. DNS/ Designee</p>	03/12/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>7:15 a.m..."</p> <p>A dialysis communication form for the resident, dated 2/10/20, indicated the resident "...arrived late to tx, unable to run full tx time - please arrive by 7:15 [a.m.] for 7:30 [a.m.] chair time..."</p> <p>During an interview with License Practical Nurse (LPN) 4, on 2/11/20 at 12:16 a.m., she indicated the bus driver that normally took the resident to her dialysis appointments was no longer there. Everyone was helping out to transport the resident to the appointments. The staff person that took the resident on 2/3/20 and 2/10/20 was unable to find the dialysis center and caused the resident to be late.</p> <p>During an interview with the Assisted Director of Nursing Services (ADNS) on 2/11/20 at 12:20 p.m., she indicated she was aware the resident was late getting to dialysis. The resident was about 30 minutes late.</p> <p>A Dialysis Care policy was provided by the Director of Nursing Services (DNS) on 2/11/20 at 4:38 p.m. It indicated "...Policy: It is the policy of [name of corporation] to ensure that residents requiring dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care, and the residents' goals and preferences. The facility will assure that each resident receives care and services for the provision of hemodialysis and/or peritoneal dialysis consistent with professional standards of practice including...Facility must assist resident to ensure that arrangements are provided to secure transportation to and from dialysis appointments.</p> <p>3.1-37(a)</p>		<p>completed audit of all residents that require transport to dialysis to include chair time, and transport arrangements. No further residents identified to be affected by deficient practice.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? ED/ Designee to complete education/ disciplinary action with the Activity director related to transportation policy & procedures. ED/ Designee will complete weekly audit of transportation calendar to ensure that all dialysis residents that require facility transportation have adequate transportation arrangements in place. This will be completed weekly x 30 days; areas thereafter will be monitored through the QAPI process.</p> <p>How will the corrective actions be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The DNS/Designee will complete the Annual POC QA Tool for 4 weeks, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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 0755 SS=D Bldg. 00	<p>483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-</p> <p>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and</p> <p>§483.45(b)(3) Determines that drug records are in order and that an account of all</p>		<p>developed to ensure compliance. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>controlled drugs is maintained and periodically reconciled.</p> <p>Based on interview and record review, the facility failed to ensure availability of medications for 1 of 5 residents reviewed for pharmacy services. (Resident F)</p> <p>Findings include:</p> <p>The clinical record for Resident F was reviewed on 2/5/20 at 11:02 a.m. The resident's diagnosis included, but was not limited to, edema.</p> <p>The at risk for fluid imbalance care plan, revised 1/10/20, indicated an intervention was to administer medications as ordered.</p> <p>The current physician's order for Resident F, dated 11/17/18, indicated to administer lasix (diuretic medication) 40 mg daily.</p> <p>The January, 2020 and February, 2020 MARs (medication administration records) indicated the lasix was not given on 1/18/20, 2/3/20, and 2/4/20.</p> <p>An interview was conducted with the DNS (Director of Nursing Services) on 2/11/20 at 1:26 p.m. She indicated the lasix was not administered on 1/18/20, 2/3/20, and 2/4/20 due to unavailability from the pharmacy. She spoke with the ADNS (Assistant Director of Nursing Services) who informed her it was on order from the pharmacy on those dates.</p> <p>The Medication Shortages/Unavailable Medications policy was provided by the DNS on 2/11/20 at 2:55 p.m. It indicated "Upon discovery that Facility has an inadequate supply of a medication to administer to a resident, Facility staff should immediately initiate action to obtain</p>	F 0755	<p>It is the practice of this provider to ensure the availability of medications for each resident. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident F had NP/MD notification of deficient practice. No new orders or changes. No adverse effects noted.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents receiving medication, including Lasix have the potential to be affected by deficient practice.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? DNS/Designee will provide in-service/education to all QMA/ Licensed Staff on the medication administration policy to include proper procedure for obtaining unavailable medications. DNS/Designee will review the EMAR compliance audit daily on each business day to ensure that medications are available and given per order.</p> <p>How will the corrective actions be maintained to ensure the</p>	03/12/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 0757 SS=D Bldg. 00	<p>the medication from Pharmacy."</p> <p>3.1-25(a)</p> <p>483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-</p> <p>§483.45(d)(1) In excessive dose (including duplicate drug therapy); or</p> <p>§483.45(d)(2) For excessive duration; or</p> <p>§483.45(d)(3) Without adequate monitoring; or</p> <p>§483.45(d)(4) Without adequate indications for its use; or</p> <p>§483.45(d)(5) In the presence of adverse</p>		<p>deficient practice will not recur, i.e., what quality assurance program will be put into place? The DNS/Designee will complete the Annual POC QA Tool for 4 weeks, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	<p>consequences which indicate the dose should be reduced or discontinued; or</p> <p>§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.</p> <p>Based on interview and record review, the facility administered a resident's medication in excessive dosage by not holding it, as ordered, for 1 of 5 residents reviewed for unnecessary medications. (Resident F)</p> <p>Findings include:</p> <p>The clinical record for Resident F was reviewed on 2/5/20 at 11:02 a.m. The resident's diagnosis included, but was not limited to, hypertension.</p> <p>The ineffective tissue perfusion care plan, revised 1/10/20, indicated one of the the goals was for Resident F to maintain adequate tissue perfusion as evidenced by blood pressure within normal limits. An intervention was to administer his medications as ordered.</p> <p>The February, 2020 physician's orders indicated the resident was prescribed metoprolol 37.5 mg twice daily and to hold for a systolic blood pressure less than 120 or heart rate less than 60.</p> <p>The January, 2020 and February, 2020 MARs (medication administration records) indicated the metoprolol was administered on the following days with the following systolic blood pressures:</p> <p>1/01/20 - 104 1/06/20 - 110 1/07/20 - 118 1/10/20 - 118 1/30/20 - 114</p>	F 0757	<p>It is the practice of this provider to ensure the resident's medications are administered as ordered, to include the holding of medications per order.</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident F had NP/MD notification of deficient practice. No new orders or changes. 1:1 education provided to staff.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents with care plans or orders that require blood pressure monitoring have the potential to be affected by deficient practice. DNS/Designee will complete a facility audit of all residents with physician orders to monitor blood pressure and hold medication to ensure that physician orders are required. Those no longer requiring monitoring will have parameters discontinued. If residents are found to be affected by deficient practice MD/NP will be made aware and plan pf care updated accordingly.</p>	03/12/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 0758 SS=D Bldg. 00	<p>1/31/20 - 115 2/03/20 - 112 2/08/20 - 118</p> <p>An interview was conducted with the DNS (Director of Nursing Services) on 2/11/20 at 11:30 a.m. She indicated the metoprolol should not have been administered when the resident's systolic blood pressure was under 120.</p> <p>The Medication Pass procedure was provided by the DNS on 2/11/20 at 1:26 p.m. It indicated, "Perform the 5 rights of medication. Right Resident. Right Medication. Right Dose. Right Route. Right Time."</p> <p>3.1-48(a)(1)</p> <p>483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use</p>		<p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? DNS/Designee will complete education for all licensed staff on following physician orders. DNS/Designee will complete weekly audit x 4 weeks for residents with blood pressure hold orders to ensure that compliance is met. Areas will thereafter be monitored through QAPI process.</p> <p>How will the corrective actions be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? DNS/ designee will complete the Annual POC QAPI tool weekly times 4 weeks, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	<p>§483.45(e) Psychotropic Drugs.</p> <p>§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:</p> <p>(i) Anti-psychotic;</p> <p>(ii) Anti-depressant;</p> <p>(iii) Anti-anxiety; and</p> <p>(iv) Hypnotic</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that---</p> <p>§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;</p> <p>§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;</p> <p>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and</p> <p>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>the PRN order.</p> <p>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.</p> <p>Based on interview and record review, the facility failed to document behaviors to support a failed gradual dose reduction for 1 of 5 residents reviewed for unnecessary medications (Resident NN)</p> <p>Findings include:</p> <p>The clinical record for Resident NN was reviewed on 2/11/2020 at 9:12 a.m. The resident's diagnosis included, but was not limited to, dementia with behavior disturbance.</p> <p>The physician's order, dated 1/31/2020, indicated the resident was to receive Seroquel (anti-psychotic medication) 250 mg (milligrams) once a day.</p> <p>A hand written physician's order, dated 2/7/2020, indicated to discontinue the current Seroquel Order and to increase Seroquel to 275 mg each day for psychosis, due to a failed GDR (Gradual Dose Reduction)</p> <p>During an interview on 2/11/2020 at 9:45 a.m., CNA (Certified Nursing Assistant) 22 indicated she had not seen any changes in the resident's behaviors in the past few weeks.</p> <p>During an interview on 2/11/2020 at 9:52 a.m., QMA (Qualified Medication Aide) 23 indicated she frequently worked on the unit and had not</p>	F 0758	<p>It is the practice of this provider to provide each resident the right to be free of the use of unnecessary medication.</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident MN to receive a new observation period for GDR of Seroquel.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents who reside in facility have the potential to be affected by this deficient practice. All residents who triggered for failed GDR within the past 30 days will be reviewed for completion of supportive documentation.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur: DNS/Designee will provide education related to Behavior Management and tracking policy. All residents who trigger for failed GDR or increase of psychotropic</p>	03/12/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>noticed any changed in the resident's behavior. He had acted the same since she had met him.</p> <p>On 2/11/2020 at 11:10 a.m., the ED (Executive Director) provide the psychiatric progress notes for Resident NN.</p> <p>A psychiatric progress note, dated 1/13/2019, indicated the resident received Seroquel for psychosis with no symptoms present and that his dose was going to be reduced from 275 mg each morning to 250 mg each morning for a gradual dose reduction. His sleep, appetite, and cognition were stable and his energy was good.</p> <p>A psychiatric progress note, dated 2/7/2020, indicated that staff had reported verbally that patient was having an increase in sexually aggressive remarks since his Seroquel had been reduced, and that he had had the same behavior in the past which created difficulties. The gradual dose reduction of Seroquel was considered failed due to concerns of him escalating with sexual aggression.</p> <p>The behavior monitoring logs for January 2020 and February 2020 were reviewed. The January behavior log for Resident NN's inappropriate behavior with females, indicated he had multiple incidents on 1/17/2020 during the day shift and multiple incidents on 1/21/2020 during the day shift. All of the other entries on the behavior log for January 2020 indicated the behavior had not been exhibited. The February behavior log for the resident's inappropriate behavior with females had no incidents recorded from 2/1/2020 through 2/10/2020.</p> <p>The progress notes for February 2020 were reviewed. There were no notes present indicating</p>		<p>medication will have review to include SSD/SSA/ DNS/Designee and Psychiatric NP prior to initiation of medication change.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Social Service Director / designee will complete the Annual POC (QA) tool weekly for one month, bi-weekly for two months, and then monthly for six months. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 0761 SS=D Bldg. 00	<p>sexual aggression or the resident's inappropriate behavior with females.</p> <p>During an interview on 02/11/2020 at 12:28 p.m., the ADNS (Assistant Director of Nursing Services) indicated that if staff noted a change or increase in behaviors they should have been documented.</p> <p>On 2/11/2020 at 4:30 p.m., the DNS (Director of Nursing Services) provided the Behavior Management Policy indicated, "Policy: It is the policy of [name of company] to provide behavior interventions for residents with problematic or distressing behaviors. Interventions provided are both individualized and non-pharmacological and part of a supportive physical and psychosocial environment that is directed toward preventing, relieving and/or accommodating a residents distressed behavior. Procedure...2 When a behavior occurs, the staff communicates to the nurse what behavior occurred. The nurse record the behavior on the monitoring form, if the resident is being monitored for the behavior, including what interventions were attempted during the episode and whether or not they were effective..."</p> <p>3.1-48 (b) (2)</p> <p>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.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	<p>§483.45(h) Storage of Drugs and Biologicals</p> <p>§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.</p> <p>§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.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a multi-dose bottle of eye medication was used prior to the expiration date, controlled medications were double locked in a medication cart, discontinued medications were removed from the medication cart, improper storage of medication, food stored in medication refrigerator, and the proper labeling of medications stored in 1 of 6 medication rooms and 2 of 9 medication carts throughout the facility.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. An observation of the 3rd floor Vent unit medication cart on 2/11/20 at 12:12 p.m., with LPN (Licensed Practical Nurse) 7 indicated the narcotic medication drawer's lid was able to be lifted up, without being unlocked, giving access to the controlled medications inside the drawer. 2. An observation of the 2nd floor medication cart 	F 0761	<p>It is the practice of this provider to ensure that medications are stored properly, controlled medications are doubled locked, discontinued medications are removed from cart, no food items are stored in medication refrigerator, and medications are properly labeled.</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Vent medication cart narcotic drawer was addressed to ensure medications are being properly stored. Resident V's discontinued medication was removed from the cart. Resident U's thickened water was discarded and replaced to meet</p>	03/12/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/11/2020
NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>on 2/11/20 at 1:10 p.m., with LPN 8 indicated, an opened bottle of docusate for Resident V was inside the medication cart.</p> <p>A record review conducted on 2/11/20 at 1:11 p.m., for the resident indicated a physician's order, dated 11/15/19, was to discontinue the docusate.</p> <p>An interview conducted on 2/11/10 at 1:13 p.m., with LPN 7 indicated the docusate should have been removed from the medication cart and destroyed.</p> <p>3. Observation of the 2nd floor medication cart on 2/11/20 at 1:10 p.m., with LPN 8 indicated, an opened bottle of Hydrolyte thickened water with an open date of 2/3/20. The bottle was not labeled with a resident's name.</p> <p>An interview with LPN 8, at that same time and date as the observation, indicated the thickened water belonged to Resident U.</p> <p>The directions on the Hydrolyte thickened water indicated, "Storage and handling: store in cold dry place. When ready to serve, chill, break seal, re-tighten cap, and shake well. Refrigerate unused portion, discard if not used within 10 days of opening".</p> <p>4. An observation of the medication room on the 2nd floor with LPN 9 on 2/11/20 at 1:29 p.m., indicated the following:</p> <p>-Inside the medication refrigerator freezer were two frozen bottles of ice water and one bottle of frozen coke</p> <p>-Inside the medication refrigerator was an opened bottle of Latanprost 0.005% for Resident T labeled with an opened date of 11/13/19.</p>		<p>proper storage requirements. The food items and expired medications were removed from the 2nd floor medication refrigerator.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All resident's that reside in facility and receive medications have the potential to be affected by deficient practice.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? DNS/Designee will complete education for all licensed staff on medication storage policy. DNS/Designee will complete audit of med rooms and medication cart to ensure that compliance is met on Monday/Wednesday/ Friday.</p> <p>How will the corrective actions be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? DNS/ designee will complete the Annual POC QA tool weekly times 4 weeks, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	<p>An interview with the facility's pharmacy conducted on 2/11/20 at 2:27 p.m., indicated once a bottle of Latanprost has been opened and used for the first time the product should be used by or discarded after 28 days or 6 weeks depending on the manufacturer of the product.</p> <p>The Storage and Expiration of Medications, Biologicals, Syringes and Needles policy provided on 2/11/12 by the Director of Nursing Services (DNS) indicated, "...3. General Storage Procedures: 3.1 Facility should store Schedule II controlled substances and other medication deemed by Facility to be at risk for abuse or diversion in a separate compartment within the food medication carts and should have a different key or access device...3.6 Facility should ensure that food is not to be stored in the refrigerator, freezer, or general storage areas where medications and biologicals are stored...4. Facility should ensure that medications and biologicals: 4.1 Have an Expiration date on the label; 4.2 Have not been retained longer than recommended by manufacturer or supplier guidelines; or, 4.3 Have not been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the pharmacy or supplier...6. Facility should destroy and reorder medications and biologicals with soiled, illegible, worn, makeshift, incomplete, damaged or missing labels... 11. Facility should ensure that medications and biologicals are stored at their appropriate temperatures according to the United States Pharmacopeia guidelines for temperature ranges...16. Facility should destroy or return all discontinued, outdated/expired, or deteriorated medications or biologicals in accordance with Pharmacy return/destruction guidelines and other Applicable Law, and in accordance with Policy 8.2</p>		<p>QAPI committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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 0791 SS=D Bldg. 00	<p>(Disposal/Destruction of Expired or Discontinued Medication)..."</p> <p>3.1-25</p> <p>483.55(b)(1)-(5) Routine/Emergency Dental Svcs in NFs §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care.</p> <p>§483.55(b) Nursing Facilities. The facility-</p> <p>§483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services;</p> <p>§483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations;</p> <p>§483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay;</p> <p>§483.55(b)(4) Must have a policy identifying those circumstances when the loss or</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and</p> <p>§483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan.</p> <p>Based on interview and record review, the facility failed to address a dental recommendation timely for 1 of 1 residents reviewed for dental services. (Resident TT)</p> <p>Findings include:</p> <p>The clinical record for Resident TT was reviewed on 2/4/20 at 3:15 p.m. The resident's diagnosis included, but was not limited to, major depressive disorder.</p> <p>The Quarterly MDS (Minimum Data Set) assessment, dated 11/15/19, indicated the resident's cognition was intact.</p> <p>A care plan, dated 12/28/17, for Resident TT indicated the "Resident has most of her natural teeth and needs set up assist with oral care...Approach...obtain dental consult.."</p> <p>A physician's order, dated 6/7/18, indicated the resident was to receive dental services.</p> <p>An interview was conducted with Resident TT on 2/4/20 at 3:10 p.m. She indicated she currently was having trouble with her left top and bottom teeth. They have been hurting for awhile and she was suppose to have them removed.</p>	F 0791	<p>It is the practice of this provider to provide dental services to include timely follow up of recommendations.</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? At time of survey Resident TT had appointment scheduled for recommended follow up at the end of month. Follow up completed per orders. MD/MP aware of deficient practice with no new orders or change in plan of care.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents that require dental services have the potential to be affected by the deficient practice. SSD/designee will review presence and choice for desired Dental Service and ensure all residents who have the desire have received consult and follow</p>	03/12/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>A dental consult for Resident TT, dated 8/20/19, was provided by the Floating Social Services Director on 2/7/20 at 4:00 p.m. It indicated "...Pt [patient] was seen bedside. Pt reports pain on her left side, both upper and lowers. #10 is a root tip, broken off at gum line. Pt has decay on #7, #11, #12. Non restorable, DDS [dentist] reported #20 possible cracked. DDS recommends extractions of #10, #12, and #20, also would like her to have a pana x-ray. Referral has been submitted. Pt agrees..."</p> <p>An interview was conducted with the Floating Social Services Director on 2/7/20 at 4:05 p.m. She indicate she could not verify a pana x-ray was obtained or recommendations in August was addressed.</p> <p>A dentistry consult, dated 1/15/20, was provided by the Assistant Director of Nursing (ADNS) on 2/11/20 at 12:24 p.m. It indicated "...Anticipated Dental Care: multiple extractions. When indicated, prophylactic antibiotic medication will be administered according to the most recent recommendations..."</p> <p>An interview was conducted with the the Director of Nursing Services (DNS) and Assistant Director of Nursing Services (ADNS) on 2/11/20 at 12:26 p.m. The DNS indicated the delay in treatment for the resident was insurance coverage. The ADNS indicated the resident was seen on 1/15/20 and placed on antibiotics for a couple of weeks. The resident was scheduled at the end of February for extractions.</p> <p>There was no documentation provided to indicate the dental recommendation was addressed prior to 1/15/20 or insurance had denied coverage.</p>		<p>up of recommendations. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? ED/designee will conduct in-service with Social Service and Nursing staff on deficient practice and appropriate procedure for recommendations of providing Dental needs by March 12,2020. SSD/designee will review dental service documentation on the next business day following all dental service visits. How will the corrective actions be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? SSD/ designee will complete the Annual POC QA tool weekly times 4 weeks, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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 0804 SS=D Bldg. 00	<p>A dental services policy was provided by the DNS on 2/11/20 at 12:24 p.m. It indicated "...Policy. The facility obtains needed dental services, including routine and emergency dental services, assists in providing these services and makes prompt referrals for dental services as needed...Dental Services 1. The facility will obtain contracted outside dental services to meet the routine and emergency dental needs of each resident..."</p> <p>3.1-24(a)(1)</p> <p>483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides-</p> <p>§483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;</p> <p>§483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to serve food at a safe and appetizing temperature for 2 of 4 residents reviewed for food value. (Resident D and W)</p> <p>Findings include:</p> <p>1. An interview was conducted with Resident D on 2/5/20 at 10:29 a.m. She indicated she ate meals in her room on the 4th floor of the facility, and the food was served cold most of the time. On 2/6/20 at 3:28 p.m., she indicated she would have liked</p>	F 0804	<p>It is the practice of this provider to provide each resident the right to food and drinks that is palatable, attractive, and at a safe and appetizing temperature. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident D and W meal service preferences updated by Dietary manager/designee.</p>	03/12/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
--------------------	--	---------------	---	----------------------

	<p>for the rib sandwich and cheesy potatoes to be hotter.</p> <p>The clinical record for Resident D was reviewed on 2/5/20 at 10:00 a.m. The resident's diagnosis included, but was not limited to, heart failure. The Admission MDS (Minimum Data Set) assessment, dated 1/30/20, indicated the resident's cognition was intact.</p> <p>An observation of the 4th floor lunch tray delivery was made on 2/6/20 at 1:07 p.m. The rolling food cart was delivered to the 4th floor by the RD (Registered Dietician) on 2/6/20 at 1:07 p.m. The facility staff began delivering the trays to residents on 2/6/20 at 1:11 p.m. On 2/6/20 at 1:19 p.m., the RD tested the food temperatures from a test tray retrieved from the rolling food cart during tray delivery. The rib sandwich was 125.2 degrees Fahrenheit. The cheesy potatoes were 124 degrees Fahrenheit. The coleslaw was 58 degrees Fahrenheit.</p> <p>An interview was conducted with the RD on 2/6/20 at 1:19 p.m., immediately after she tested the food temperatures. She indicated hot foods were supposed to exceed 160 degrees Fahrenheit, and cold foods were supposed to be below 41 degrees Fahrenheit. The RD was unaware the food trays were being served at out of range temperatures.</p> <p>The above test tray was tasted on 2/6/20 at 1:25 p.m. The rib sandwich was not hot to taste, and the cheesy potatoes were cool to taste.</p> <p>2. During an interview on 2/5/20 at 10:56 a.m., with Resident W she indicated the food on her room trays were lukewarm by the time she was served her meals.</p> <p>On 2/6/20 at 12:20 p.m., during the lunch service</p>		<p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents who reside in facility have the potential to be affected by this deficient practice. Dietary staff to be in-serviced, topics will include steps to assure all equipment is operating properly to maintain acceptable food temperatures throughout meal service.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Culinary Manager/Registered Dietician will complete the Short Sanitation tool daily. Dietary staff to be in-serviced, topics will include steps to assure all equipment is operating properly to maintain acceptable food temperatures throughout meal service.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur? Dietary Manager / designee will complete the Food and Nutrition Test Tray QAPI (QA) tool weekly for one month, bi-weekly for two months, and then monthly for six months. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If the</p>	
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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 0807 SS=D Bldg. 00	<p>for the 3rd floor ventilation unit, a test tray was obtained. The RD tested the food temperatures from a test tray. The food temperature results were as followed:</p> <ul style="list-style-type: none"> -Rib sandwich tested at 96 degrees Fahrenheit -Potatoes tested at 120 degrees Fahrenheit -Coleslaw tested at 52 degrees Fahrenheit -Canned peaches tested at 56 degrees Fahrenheit <p>During an interview with RD on 2/6/20 at 12:23 p.m., she indicated the food temperatures for the test tray were not at the correct serving temperatures.</p> <p>The Food Temperatures policy was provided by the DNS (Director of Nursing Services) on 2/6/20 at 3:58 p.m. It read, "All hot and cold food items will be served to the resident at a temperature that is considered palatable at the time the resident receives the food."</p> <p>3.1-21(a)(2)</p> <p>483.60(d)(6) Drinks Avail to Meet Needs/Prefs/Hydration §483.60(d) Food and drink Each resident receives and the facility provides-</p> <p>§483.60(d)(6) Drinks, including water and other liquids consistent with resident needs and preferences and sufficient to maintain resident hydration.</p> <p>Based on observation, interview, and record review, the facility failed to serve a resident cranberry juice, as ordered, for 1 of 7 residents reviewed for drinks/hydration services. (Resident B)</p>	F 0807	<p>threshold of 95% is not achieved an action plan will be developed to ensure compliance. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee.</p> <p>It is the practice of this provider to provide each resident the right to food and drinks required to ensure hydration needs are met. What corrective action will be accomplished for those</p>	03/12/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>Findings include:</p> <p>The clinical record for Resident B was reviewed on 2/5/20 at 12:00 p.m. The resident's diagnosis included, but was not limited to, dementia.</p> <p>The February, 2020 physician's orders for Resident B indicated the resident was to receive prune juice with breakfast and cranberry juice with lunch, effective 1/29/20.</p> <p>The 1/28/20 history of urinary tract infection care plan indicated an intervention was to encourage fluids.</p> <p>An observation of the Memory Care Unit lunch service was made on 2/5/20 at 12:21 p.m. Resident B was sitting at a table in the dining room. She had a tomato, cottage cheese, chicken and dumplings, oranges, a muffin, ice cream, a red drink, and water in front of her. She did not have any cranberry juice. On 2/5/20 at 12:36 p.m., RN 3 cleared Resident B's plate and glasses from the table. The resident never received her cranberry juice.</p> <p>An interview was conducted with CNA (Certified Nursing Assistant) 7 on 2/5/20 at 12:35 p.m. She indicated the red drink being served to residents was a fruit punch made from a package.</p> <p>An observation of the Memory Care Unit lunch service was made on 2/6/20 at 12:25 p.m. Resident B was not served cranberry juice before, during, or after her meal. The facility staff cleared Resident B's dishes from the table on 2/6/20 at 1:05 p.m., at which time, Resident B left the dining room without ever receiving her cranberry juice.</p> <p>An interview was conducted with the Memory</p>		<p>residents found to have been affected by the deficient practice? Resident B special hydration items highlighted on tray card.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents who reside in facility have the potential to be affected by this deficient practice. Dietary staff to be in-serviced, topics will include steps to assure all meal tickets are read correctly and preferred items received on the meal tray.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? ED /designee will complete the meal observation tool daily. ED/Designee will in-service for the dietary staff on reading and ensuring the tray cards match for the meal being served to the resident, preferences and additional nutritional requirements highlighted on tray card by 03.12.20.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur? Dietary Manager / designee will complete the Annual POC (QA) tool weekly for one month, bi-weekly for two months,</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 0812 SS=E Bldg. 00	<p>Care Assistant 1 on 2/6/20 at 1:25 p.m. She indicated the dietary department sent everything up with the residents' trays. If cranberry juice was on the residents lunch ticket, then she should have received it. "It was probably missed."</p> <p>The resident's 2/6/20 lunch meal ticket was reviewed with the Memory Care Assistant 1 on 2/6/20 at 1:25 p.m. The lunch meal ticket indicated the resident was to receive 6 ounces of cranberry juice with lunch.</p> <p>3.1-46(b)</p> <p>483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must -</p> <p>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.</p> <p>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record</p>	F 0812	and then monthly for six months. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee. It is the practice of this provider to	03/12/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>review, the facility failed to ensure clean dishes were stored properly in the kitchen and food was held at the proper temperature on the steam table. This had the potential to affect 11 of 101 residents in the facility.</p> <p>Findings include:</p> <p>A tour of the kitchen was conducted with the DM (Dietary Manager) on 2/4/20 at 10:50 a.m. There were clean white plates stored upward, not inverted and not covered, in the metal plate dispenser near the dishwasher. The dispenser was not in use at this time. The clean silverware holder contained 15 pieces of silverware. Eleven of the pieces of silverware were stored with the mouthpiece side upward, not handle side upward. A rolling cart in front of the dishwasher held clean red plates and bowls stored upward, not inverted, and were uncovered. There was debris inside of the top red bowl. The DM picked up the top red bowl and rubbed away the debris with her fingers.</p> <p>An interview was conducted with the DM on 2/4/20 at 10:50 a.m. She indicated the red dishes were stored upward, because they were getting ready to use them for the Memory Care Unit of the facility, but at night, the dishes were stored inverted.</p> <p>Food temperatures from the steam table were taken by the DM on 2/6/19 at 12:10 p.m., as she was preparing food trays for lunch service. The pureed rib temperature was 128 degrees Fahrenheit. The DM removed the pureed rib from the steam table and placed it into the oven. The pureed coleslaw temperature was 46.4 degrees Fahrenheit. The pan of pureed coleslaw was resting directly on top of the regular coleslaw.</p>		<p>provide each resident the right to serve food in accordance with the professional standards for food service safety.</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? No resident identified to have been affected by this practice.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents who reside in facility have the potential to be affected by this deficient practice. ED/Designee will complete in-service with dietary staff topics will include steps to assure all equipment is operating properly to maintain acceptable food temperatures throughout meal service by 03.12.20.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Culinary Manager/Registered Dietician will complete the Short Sanitation tool daily. ED/Designee will complete in-service with dietary staff topics will include steps to assure all equipment is operating properly to maintain acceptable food temperatures throughout meal</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 0880 SS=D Bldg. 00	<p>The Cleaning Dishes and Dish Machine policy was provided by the DNS (Director of Nursing Services) on 2/6/20 at 3:58 p.m. It read, "Flatware will be run through the dish machine a second time, then transferred to a cylinder with mouthpiece down or other appropriate storage container."</p> <p>The Food Temperatures policy was provided by the DNS on 2/6/20 at 3:58 p.m. It read, "Hot foods that are potentially hazardous will leave the kitchen (or steam table) at or above 135 [symbol for "degrees"] F [Fahrenheit,] and cold foods at or below 41 [symbol for "degrees"] F [Fahrenheit.]"</p> <p>3.1-21(i)(3)</p> <p>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 comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</p> <p>§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:</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable</p>		<p>service by 03.12.20. How the corrective action(s) will be monitored to ensure the deficient practice will not recur? Dietary Manager / designee will complete the Annual POC (QA) tool weekly for one month, bi-weekly for two months, and then monthly for six months. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>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;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(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</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§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 perform hand hygiene and glove changes appropriately during tracheostomy care for 1 of 3 residents reviewed for Respiratory Care (Resident W).</p> <p>Findings include:</p> <p>The clinical record for Resident W was reviewed on 2/11/2020 at 10:50 a.m. The resident's diagnoses included, but were not limited to, cerebral palsy and chronic respiratory failure.</p> <p>On 2/11/2020 at 10:30 a.m., RT (Respiratory Therapist) 5 was observed providing tracheostomy care for Resident W. RT 5 performed hand hygiene prior to beginning care. He donned non-sterile gloves and removed the soiled gauze pad from the tracheostomy site and changed the soiled disposable inner cannula. He opened the tracheostomy cleansing kit and prepared the tray by adding sterile normal saline. He continued to wear his soiled non-sterile gloves while preparing the tray. He donned sterile gloves over his soiled non-sterile gloves and proceeded to cleanse the tracheostomy site. After cleansing the tracheostomy site, he removed the sterile gloves and continued to wear the original soiled</p>	F 0880	<p>It is the practice of this provider to ensure appropriate infection control techniques are followed. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident W had no adverse reactions.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents requiring trach care had the potential to be affected by the deficient practice. Licensed nurses and Respiratory Staff will be educated by the DNS/Designee on Infection Control policy including following facility policy regarding trach care by March 12, 2020.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</p>	03/12/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>non-sterile gloves to change the tracheostomy ties. He removed the soiled non-sterile gloves and donned a new pair of non-sterile gloves without performing hand hygiene and applied a new gauze pad to the tracheostomy site.</p> <p>During an interview on 2/11/2020 at 10:45 a.m., RT 5 indicated that he normally put the sterile gloves on over his non-sterile gloves while performing tracheostomy care and that he should have performed hand hygiene when changing his gloves.</p> <p>During an interview on 2/11/2020 at 10:47 a.m., the ADNS (Assistant Director of Nursing Services) indicated that sterile gloves should not be placed over soiled non-sterile gloves.</p> <p>On 2/11/2020 at 11:10 a.m., the DNS (Director of Nursing Services) provided the Tracheostomy Routine care, Cleaning, Changing Inner Cannula, and Change Tracheostomy Ties Policy. It indicated "Procedure steps...7. Open sterile water/saline, if not provided inside kit 8. Open commercial kit using aseptic technique. Empty contents onto drape 9. Aseptically put on sterile gloves and prepare field. Follow Universal precautions and use gown, glove, and mask if needed 10. Remove the inner cannula. If the inner cannula is disposable, remove and dispose of it...12. Remove the soiled trachea dressing from around the stoma and discard. 13. Clean the area around the stoma...Cleaning inner cannula...Re-insert the inner cannula following the curvature of the neck 2. Apply a clean trachea dressing...5. Discard all used supplies into appropriate waste container 6. Perform hand hygiene..."</p> <p>3.1-18(l)</p>		<p>Licensed nurses and Respiratory Staff will be educated by the DNS/Designee on Infection Control policy including following facility policy regarding trach care by March 12, 2020. DNS/Designee will complete daily random audits to include all shifts to ensure that residents receiving trach care are being completed per policy to include hand hygiene. This will be completed on varying shifts x 30 days; areas will thereafter be monitored through the QAPI process.</p> <p>How will the corrective actions be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? DNS/ designee will complete the Annual POC QA tool weekly times 4 weeks, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 0921 SS=D Bldg. 00	<p>483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview and record review, the facility failed to maintain the facility in good repair for 6 of 12 residents rooms observed during an environmental tour. (Resident LL, MM, OO, RR, VV, and WW)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. An observation was made of Resident LL's dresser in her room on 2/5/20 at 10:29 a.m. The dresser had a broken drawer and chipped laminate. 2. An observation was made of Resident MM's room on 2/4/20 at 11:21 a.m. The wall behind the bed was missing the wooden chair rail. 3. An observation was made of Resident OO's room on 2/5/20 at 2:22 p.m. The wooden chair rail was missing on the wall behind the bed, and the bottom of the wall had missing trim. 4. An observation was made of Resident RR's room on 2/4/20 at 11:06 a.m. There were nicks in flooring and missing floor tile under the air condition unit. 5. An observation was made of Resident VV's room on 2/4/20 at 11:36 a.m. The wall was missing paint by the sink and missing floor tiles under the sink. 6. An observation was made of Resident WW's bathroom on 2/05/20 at 9:55 a.m. The bathroom tile 	F 0921	<p>It is the practice of this provider to provide each resident the right to safe, functional, sanitary, and comfortable environment. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident LL received a new dresser drawer, Resident MM & OO chair rail repaired, Resident RR/VV/WW floor tile repaired. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents who reside in facility have the potential to be affected by this deficient practice. ED/Designee will be in-service staff on filling out maintenance repair forms when observing damaged equipment or areas by 03.12.20. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Maintenance Director/ Designee will conduct audits on each floor daily to ensure that preventative maintenance is being monitored</p>	03/12/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>was coming off the wall.</p> <p>An environmental tour was conducted with the Maintenance Supervisor (MS) and the Housekeeping Supervisor (HS) on 12/11/20 at 9:25 a.m. During the tour Resident LL, MM, OO, RR, VV and WW's rooms were observed. The following was observed in each resident's room:</p> <p>Resident LL's room - dresser had a broken drawer and chipped laminate, Resident MM's room - missing the wooden chair rail on the wall, Resident OO's room - missing wooden chair rail and bottom trim piece that goes along the bottom of the wall, Resident RR's room - nicks in the flooring and missing floor tiles under the air condition, Resident VV's room - missing paint on the wall behind the sink and missing floor tiles, Resident WW's room - bathroom tiles were missing and coming off the wall and part of the ceiling hanging with a gouge in it.</p> <p>An interview was conducted with the MS during the tour on 12/11/20 at 9:45 a.m. He indicated he was unaware of the broken drawer in Resident LL's dresser. Resident VV's room had been repaired in November, and he just hadn't gotten to it to finish. Resident MM and OO's wooden chair rails were damaged by the residents' bed rising up and down, and it had been like that for a couple of weeks now. Resident RR's air condition was replaced about a year ago, and he just had not had the time to replace the flooring. He had received a work order approximately a week ago regarding Resident WW's bathroom needing repairs. MS indicated he has a new assistant that has been assisting with the repairs in the building.</p>		<p>and repairs completed for a safe, functional, and comfortable environment. ED/Designee will be in-service staff on filling out maintenance repair forms when observing damaged equipment or areas by 03.12.20.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur? Environmental Manager / designee will complete the Annual POC (QA) tool weekly for one month, bi-weekly for two months, and then monthly for six months. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee.</p>	

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

PRINTED: 03/12/2020
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/11/2020
NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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	
	<p>A Maintenance Request form for Resident WW's room was provided by the MS on 2/11/20 at 10:22 a.m. It indicated a repair request dated 2/3/20 for the ceiling tile needing to be replaced and wall needed painted.</p> <p>An environmental repair policy was provided by the Director of Nursing on 2/11/20 at 3:05 p.m. It indicated "Painted/Stained Surfaces. Frequency: Monthly. Check painted and stained surfaces monthly for scuffing, deterioration, and peeling. Repaint...or touch up as needed..."</p> <p>This Federal tag relates to complaint IN00317816.</p> <p>3.1-19(e)</p>				