STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 00 B. WING	10/19/2017

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: October 11, 12, 13, 16, 17, 18, and 19, 2017. Facility number: 000103 Provider number: 155196 AIM number: 100290000 Census Type: SN: 18 SNF/NF: 48 Residential: 78 Total: 144 Census payor type: Medicare: 8 Medicaid: 28 Other: 30 Total: 66 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on October 20, 2017.	F 0000	**This plan of correction is to serve as Altenheim Health and Living Community's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Altenheim Health and Living Community or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. We respectfully request a desk review for this deficiency.**	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0164 SS=D Bldg. 00	483.10(h)(1)(3)(i); 483.70(i)(2) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS 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. (h)(3)The resident has a right to secure and confidential personal and medical records. (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. §483.70 (i) Medical records. (2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in			

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	compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. Based on observation, interview, and record review, the facility failed to ensure full visual privacy while using the bathroom for 1 of 1 randomly observed resident of 66 residents residing in the facility. (Resident 220) Findings include: During an observation, on 10/13/17 at 3:53 p.m., Resident 220's room bathroom, which included a sink, toilet and shower, did not contain a door or privacy curtain. During an interview, on 10/16/17 at 11:00 a.m., Resident 220, who was admitted to the facility on 9/28/17, indicated there was no bathroom door or privacy curtain in place since his admission into the facility. Resident 220 chooses to stay in his room most of the day and has frequent visitors including	F 0164	**1. What corrective Actions will be accomplished for those residents found to have been affected by the deficient practice?** A privacy curtain was hung in the doorway to resident #220 bathroom on 10/19/2017. **2. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken?** All residents residing in the Skilled Nursing Facility have the potential to be affected by the alleged deficient practice. Maintenance Director or designee will complete an audit of all the Skilled Nursing Facility resident rooms to verify all rooms have either a bathroom door or privacy curtain in place, to be completed by November 3, 2017	11/03/2017

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	spouse, other family members and community friends. During an interview, on 10/17/17 at 11:38 a.m., the Maintenance Director indicated he was aware Resident 220's bathroom had no door or privacy curtain in place, but was unaware of the reason why. During an interview, on 10/18/17 at 9:10 a.m., the DON (Director of Nursing) indicated she was unaware Resident 220 had no bathroom door or privacy curtain in place. On 10/17/17 at 2:49 p.m., the DON (Director of Nursing) provided an undated policy entitled Caring Hearts Program and indicated it was the current policy in use by the facility. The policy indicated "...When a resident, guest or family member is not satisfied with the resident's room...environment or has any other complaint a "Grievance Form" ...shall be completed." 3.1-3(o)		**3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not occur?** Administrator or designee will educate maintenance staff on ensuring full visual privacy is available in bathrooms to be completed by November 3, 2017. Education will be provided upon hire and annually on ensuring full visual privacy in bathrooms for all maintenance staff. **4. How will the corrective actions be monitored to ensure the deficient practice will not recur, and what quality assurance program?** Auditing using the *Bathroom Privacy and Bathroom Floors in Good Repair Audit Tool,* will be completed daily on various shifts x 4 weeks, 3 times per week x 12 weeks, weekly x 8 weeks and then monthly x 6 months to total 12 months. The results of these audits will be reviewed by the Quality Assurance Committee monthly until compliance is 100%. Frequency and duration of reviews will be increased as needed if compliance is below 100%	

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F 0278 SS=D Bldg. 00	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed.		**Date of compliance: 11.3.17**	

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	(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. Based on observation, record review, and interview, the facility failed to ensure admission Minimum Data Set (MDS) assessments were coded accurately for residents with missing or broken teeth for 2 of 2 residents reviewed for dental services (Resident 180 and 33) and a resident with pressure ulcers for 1 of 1 resident reviewed for pressure ulcers (Resident 220). Findings include: 1. a. The clinical record of Resident 180 was reviewed on 10/13/17 at 2:08 p.m. Diagnoses for the resident included, but	F 0278	**1. What corrective Actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident #180, #33, and #220 had corrected MDS submitted during survey process. **2. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken?** **All residents with mouth/teeth problems and all residents with pressure wounds have the**	11/03/2017

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	were not limited to, depressive episodes and heart disease. The resident was admitted to the facility on 7/6/17. An admission Minimum Data Set (MDS) assessment, dated 7/11/17, indicated the resident was not edentulous (without teeth), had no dental problems, and was cognitively independent in his ability to make decisions. Interview on 10/1317 at 2:29 p.m., Resident 180 indicated he had not had any teeth for years, had not been seen by the dentist, and would be interested in getting dentures. Observation at that time indicated the resident did not have any teeth. The resident did not have a care plan for being edentulous. Interview on 10/13/17 at 3:07 p.m., the MDS nurse indicated, "I should have coded the resident as edentulous and then a care plan would have been initiated with interventions." b. The clinical record of Resident 33 was reviewed on 10/16/17 at 9:52 a.m. Diagnoses for the resident included, but were not limited to, anxiety disorder and heart failure. The resident admitted to the facility on 8/24/17.		**potential to be affected by the alleged practice.** All current residents with mouth/teeth problems and all current residents with pressure wounds will have their most recent MDS reviewed for accuracy, to be completed by November 3, 2017. Inaccurate coding on MDS will be corrected immediately if indicated. **3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not occur?** Education will be provided to MDS personnel regarding accurate MDS coding by the MDS Consultant or designee by November 3, 2017.Education will be provided upon hire and annually for MDS staff regarding accurate MDS coding. **4. How will the corrective actions be monitored to ensure the deficient practice will not recur, and what quality assurance program?** MDS Accuracy Audits will be completed for residents with mouth/teeth pain and residents with pressure wounds will be	

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	Interview on 10/11/17 at 2:09 p.m., Resident 33 indicated he had missing and broken lower teeth. Observation, at that time, indicated missing and broken teeth in the resident's lower jaw. An admission Minimum Data Set assessment, dated 8/31/2017, indicated the resident did not have any broken or missing natural teeth. The resident did not have a care plan for broken or missing teeth. Interview on 10/16/17 at 3:07 p.m., the MDS nurse indicated, "I should have coded the resident as having broken and missing teeth." On 10/13/17 at 3:07 p.m., the Director of Nursing indicated the Minimum Data Set assessments trigger the creation of care plans. If the residents had been coded as being edentulous or having broken and missing teeth, care plans would have been created and implemented with care interventions. 2. The clinical record of Resident 220 was reviewed on 10/17/17 at 9:26 a.m. Diagnoses for the resident included, but were not limited to, pressure ulcer and peripheral vascular disease. The resident		completed, daily Monday through Friday x 4 weeks, 3 times per week x 12 weeks, weekly x 8 weeks, and then monthly x 6 months to total 12 months. The results of these audits will be reviewed by the Quality Assurance Committee monthly. Frequency and duration of reviews will be increased as needed if compliance is below 100% **Date of compliance: 11.3.17**	

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	admitted to the facility on 9/28/17. An admission Minimum Data Set (MDS) assessment, dated 10/5/17, indicated Resident 220 had an unhealed pressure ulcer, but no Stage or dimensions were documented. A 14 day MDS assessment, dated 10/11/17, indicated the resident did not have any unhealed pressure ulcers. On 10/17/17 at 3:08 p.m., the Director of Nursing (DON), who is also the facility's wound nurse, provided a Weekly Pressure Ulcer Log. The Pressure Ulcer Log is completed by the DON, and includes the Stages and dimensions of the pressure ulcers and when they were identified. After the weekly pressure ulcer log is completed, copies are given to the Unit Managers and the Minimum Data Set nurse. On 10/3/17, the Weekly Pressure Ulcer Log indicated Resident 229 was admitted on 9/28/17, with an unstageable pressure ulcer on his left heel, and a Stage 2 pressure ulcer on his coccyx. This information would have been received by the MDS nurse prior to completion of the admission MDS assessment on 10/5/17. On 10/10/17, the Weekly Pressure Ulcer			

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	Log indicated Resident 229 still had an unstageable pressure ulcer on his left heel and a Stage 2 pressure ulcer on his coccyx. This information would have been received by the MDS nurse prior to completion of the 14 day assessment on 10/11/17. 3.1-31(d)			
F 0279 SS=D Bldg. 00	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS			

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	483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate			

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	its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.			
	Based on observation, record review, and interview, the facility failed to ensure care plans were developed for residents with missing or broken teeth for 2 of 2 residents reviewed for having dental care plans. (Residents 180 and 33) Findings include: 1. a. The clinical record of Resident 180 was reviewed on 10/13/17 at 2:08 p.m. Diagnoses for the resident included, but were not limited to, depressive episodes and heart disease. The resident was admitted to the facility on 7/6/17. An admission Minimum Data Set (MDS) assessment, dated 7/11/17, indicated the	F 0279	**1. What corrective Actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident #180 MDS record was reviewed and an edentulous care plan was initiated during the survey process. Resident #33 MDS record was reviewed and a natural tooth loss care plan was initiated during survey process. **2. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken?** All	11/03/2017

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	resident was not edentulous (without teeth), had no dental problems, and was cognitively independent in his ability to make decisions. Interview on 10/1317 at 2:29 p.m., Resident 180 indicated he had not had any teeth for years, had not been seen by the dentist, and would be interested in getting dentures. Observation, at that time, indicated the resident did not have any teeth. The resident did not have a care plan for being edentulous. Interview on 10/13/17 at 3:07 p.m., MDS nurse 5 indicated, "I should have coded the resident as edentulous and then a care plan would have been initiated with interventions." b. The clinical record of Resident 33 was reviewed on 10/16/17 at 9:52 a.m. Diagnoses for the resident included, but were not limited to, anxiety disorder and heart failure. The resident admitted to the facility on 8/24/17. Interview on 10/11/17 at 2:09 p.m., Resident 33 indicated he had missing and broken lower teeth. Observation, at that time, indicated missing and broken teeth in the resident's lower jaw.		residents with mouth/tooth related problems have the potential to be affected by the alleged deficient practice. All current residents with mouth/tooth related issues will have their most recent MDS reviewed for accuracy and care plans will be initiated if indicated, to be completed by November 3, 2017. **3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not occur?** Education will be provided to the MDS personnel regarding comprehensive care plans needed for residents with mouth/tooth related problems by MDS consultant/designee by November 3, 2017. Education will be provided annually for MDS personnel regarding comprehensive care plans for residents with mouth/tooth related problems. **4. How will the corrective actions be monitored to ensure the deficient practice will not recur, and what quality assurance program?** MDS accuracy audits, *using the MDS accuracy and Care Plan initiated audit tool,* will be completed for	

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	An admission Minimum Data Set assessment, dated 8/31/2017, indicated the resident did not have any broken or missing natural teeth. The resident did not have a care plan for broken or missing teeth. Interview on 10/16/17 at 3:07 p.m., MDS nurse 5 indicated, "I should have coded the resident as having broken and missing teeth." On 10/13/17 at 3:07 p.m., the Director of Nursing indicated the Minimum Data Set assessments trigger the creation of care plans. If the residents had been coded as being edentulous or having broken and missing teeth, care plans would have been created and implemented with care interventions. 3.1-35(a)		residents with mouth/tooth related problems daily, Monday-Friday x 4 weeks, 3 times per week x 12 weeks, weekly x 8 weeks, and then monthly x 6 months to total 12 months. The results of these audits will be reviewed by the Quality Assurance Committee monthly. Frequency and duration of reviews will be increased as needed if compliance is below 100% **Date of compliance 11.3.17**	
F 0465 SS=D Bldg. 00	483.90(i)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON (i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.			

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(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
	(5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. Based on observation, interview, and record review, the facility failed to ensure the bathroom floor and cove base was in good repair for 1 of 35 resident rooms observed out of 87 resident rooms in the facility. (Resident 33) Findings include: During an observation, on 10/13/17 at 3:20 p.m., Resident 33's bathroom floor had dark marred substances noted on the cove base and in front of the toilet there were three areas noted where the non-skid tape had been pulled from the floor, which caused the paint to peel off the floor. During an observation, on 10/17/17 at 11:00 a.m., during the facility tour with the Maintenance Director, Resident 33's bathroom was observed to have dark marred substances on the cove base and in front of the toilet there were three areas where the non-skid tape had been pulled from the floor, which caused the paint to peel off the floor. During an interview, on 10/16/17 at	F 0465	**1. What corrective Actions will be accomplished for those residents found to have been affected by the deficient practice?** Residents #33 bathroom floor was immediately repaired during the survey process. **2. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken?** All residents residing in the Skilled Nursing Facility have the potential to be affected by the alleged deficient practice. Maintenance Director/designee will complete audit of Skilled Nursing Facility bathroom floors to verify all bathroom floors are in good repair, to be completed by November 3, 2017. Maintenance Director/designee will immediately repair any noted bathroom floors not in good repair. **3. What measures will be put into place or what systematic**	11/03/2017

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	155196	A. BUILDING 00 B. WING	10/19/2017

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	12:00 p.m., LPN (Licensed Practical Nurse) 4 indicated the non-skid tape had been removed from the floor and the painted floor was not touched up. "The bathroom floor does not look very nice." During an interview, on 10/17/17 at 11:00 a.m., the Maintenance Director indicated he had not received any work orders for Resident 33 and he was unaware the bathroom floor and cove base needed to be repaired. On 10/17/17 at 2:49 p.m., the DON (Director of Nursing) provided an undated policy entitled Caring Hearts Program and indicated it was the current policy in use by the facility. The policy indicated "...When a resident, guest or family member is not satisfied with the resident's room...environment or has any other complaint a "Grievance Form" ...shall be completed." On 10/17/17 at 3:25 p.m., the DON provided the Preventative Maintenance-TEL's policy and procedure, dated 2/15/12, and indicated it was the current policy in use by the facility. The policy indicated the data entry process for submitting maintenance work orders into the electronic system.		**changes will be made to ensure that the deficient practice does not occur?** Administrator/designee will provide education to maintenance personnel on verifying all Skilled Nursing Facility resident bathrooms are in good repair to be completed by November 3, 2017. Education will be provided upon hire and annually on ensuring full visual privacy in bathrooms for all maintenance staff. **4. How will the corrective actions be monitored to ensure the deficient practice will not recur, and what quality assurance program?** Bathroom Privacy and Floors in Good Repair Audit Tool will be completed 7 days a week on various shifts x 4 weeks, 3 times per week x 12 weeks, weekly x 8 weeks, then monthly x 6 months to total 12 months. The results of these audits will be reviewed by the Quality Assurance Committee monthly. Frequency and duration of reviews will be increased as needed if compliance is below 100%. **Date of compliance: 11.3.17**	

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	3.1-19(f)			
F 0514 SS=D Bldg. 00	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required			

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	under §483.50. Based on observation, record review, and interview, the facility failed to ensure assessments of the location of a resident's skin tear were accurately documented for 1 of 1 resident reviewed for abuse prohibition. (Resident 42) Findings include: The clinical record of Resident 42 was reviewed on 10/16/17 at 9:21 a.m. Diagnoses for the resident included, but were not limited to dementia and stroke. On 10/12/17 at 1:45 p.m., Resident 42 indicated she had received a cut on her arm when a certified nursing assistant was roughly assisting her in the bathroom. A 2 inch by 2 inch bandage was observed on the resident's right arm, approximately 2 and 1/2 inches above her wrist. No other alterations in skin integrity, or bruising, were observed on the resident's arms or hands. A nursing progress note, dated 10/8/17 at 11:20 a.m. indicated, "Resident noted to have a skin tear to RFA [right forearm] measuring 2 centimeters (cm) by 3 cm..." A note, dated 10/12/17 at 2:36 p.m. indicated resident "told the nurse [on	F 0514	**1. What corrective Actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident #42 documentation on noted skin tear was immediately corrected during the survey process. **2. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken?** All residents with documented skin tears have the potential to be affected by the alleged deficient practice. Unit Manager/designee will audit all current residents with noted skin tears for accurate documentation on location of skin tear. Corrections will be initiated if indicated, to be completed by November 3, 2017 **3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not occur?** Director of Nursing/designee will provide education to nursing personnel on documenting	11/03/2017

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	10/8/17] she was bleeding and that she wanted the gauze to wrap her arm..." A note (no time documented), dated 10/13/17 indicated, "ED [Executive Director] spoke CNA [Certified Nursing Assistant][name of CNA], that worked first shift on the 8th, she explained that when she came into work...she saw the band aide on [Resident 42's] hand..." A note (no time documented), dated 10/13/17 indicated, "ED spoke with [name of CNA] she stated that she saw the skin tear on [Resident 42's] hand..." A Weekly Skin Check per Licensed Nurse, dated 10/12/17 at 3:00 p.m. indicated indicated Resident 42 had a skin tear on her left hand (skin tear noted to right hand). On 10/12/17 at 2:01 p.m. the ED sent a report to the ISDH, Incident Number 232. The report indicated, "...There is an old skin tear on her right hand, documented notes from 10/8/17...Follow up: 10/16/17 Regarding a skin tear on resident right hand..." 3.1-50(a)(2)		accurate anatomical location of skin tears, to be completed by November 3, 2017. Licensed nurses will be educated upon hire and annually regarding documenting accurate anatomical location of skin tears. **4. How will the corrective actions be monitored to ensure the deficient practice will not recur, and what quality assurance program?** The *Accurate Anatomical Location Audit,* will be completed 7 days a week on varied shiftsx 4 weeks, 3 times per week x 12 weeks, weekly x 8 weeks and then monthly x 6 months to total 12 months. The results of these audits will be reviewed by the Quality Assurance Committee monthly. Frequency and duration of reviews will be increased as needed if compliance is 100% **Date of compliance: 11.3.17**	

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: October 11, 12, 13, 16, 17, 18, and 19, 2017. Residential Census: 78 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality Review completed on October 20, 2017.	R 0000	**This plan of correction is to serve as Altenheim Health and Living Community's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Altenheim Health and Living Community or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. We respectfully request a desk review for this deficiency.**	
R 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by			

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	licensed nursing personnel or qualified medication aides. Based on record review and interview, the facility failed to ensure sliding scale insulin (a medication used to lower blood glucose levels) was administered as ordered by the physician for 1 of 7 residents reviewed for medication administration. (Resident 12) Findings include: The clinical record of Resident 12 was reviewed on 10/18/17 at 2:50 p.m. Diagnosis for the resident included, but was not limited to, diabetes mellitus. Diabetes is a disease caused by the body's inability to produce enough insulin, causing elevated blood sugar levels. Resident 12 was admitted to the facility on 8/1/17. An admission Service Plan, dated 8/8/17, indicated nursing would administer Resident 12's medications, "per MD [medical doctor] order." A physician's order, dated 8/1/17, indicated Resident 12 was to have her blood sugar checked 3 times per day at 7:00 a.m., 11:00 a.m., and 4:00 p.m., and receive NovoLog insulin injections, depending on the results of the blood sugar test, at 7:30 a.m., 11:30 a.m., and	R 0241	**1. What corrective Actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident #12 Insulin orders were reviewed with Licensed Nurse personnel during survey process. Resident #12 had no negative outcomes related to the alleged deficient practice. **2. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken?** All AL Residents with Sliding Scale Insulin have the potential to be affected by the alleged deficient practice. UM/Designee will review all Assisted Living Residents with Sliding Scale Insulin orders for accuracy, to be completed by November 3, 2017 **3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not occur?** DON/designee will provide education Licensed Nurse	11/03/2017

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	4:30 p.m., according to the following sliding scale: "If Blood Sugar is 150 to 200, give 2 units [of insulin]. If Blood Sugar is 201 to 250, give 4 units. If Blood Sugar is 251 to 300, give 6 units. If Blood Sugar is greater than 300, give 8 units." On 10/19/17 at 1:25 p.m. the Director of Nursing indicated these orders remained current through August, September, and were still current through end of survey date 10/19/17. Review of Resident 12's Medication Administration Record (MAR) for October, 2017, indicated: 10/16 at 4:00 p.m. blood sugar was 161, 3 units of insulin were given. (should have received 2 units) Review of Resident 12's MAR for September, 2017, indicated: 9/7 at 4:00 p.m. blood sugar was 233, no insulin was given. (should have received 4 units) 9/8 at 4:00 p.m. blood sugar was 303, no insulin was given. (should have received		personnel on administering Sliding Scale Insulin per physician order, to be completed by November 3, 2017. Education will be provided for licensed nurses upon hire and annually. **4. How will the corrective actions be monitored to ensure the deficient practice will not recur, and what quality assurance program?** SSI accuracy audits will be completed daily on varied shifts x 4 weeks, 3 times per week x 12 weeks, weekly x 8 weeks and then monthly x 6 months to total 12 months. The results of these audits will be reviewed by the Quality Assurance Committee monthly. Frequency and duration of reviews will be increased as needed if compliance is below 100% **Date of compliance: 11.3.17**	

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	8 units) 9/9 at 4:00 p.m. blood sugar was 215, no insulin was given. (should have received 4 units) 9/10 at 4:00 p.m. blood sugar was 245, no insulin was given. (should have received 4 units) 9/12 at 4:00 p.m. blood sugar was 264, no insulin was given. (should have received 6 units) 9/19 at 4:00 p.m. blood sugar was 225, 9 units of insulin were given. (should have received 4 units) 9/25 at 11:00 a.m. blood sugar was 273, 4 units of insulin were given. (should have received 6 units) 9/28 at 4:00 p.m. blood sugar was 265, no insulin was given. (should have received 6 units) 9/29 at 4:00 p.m. blood sugar was 286, no insulin was given. (should have received 6 units) Review of Resident 12's MAR for August, 2017, indicated: 8/2 at 7:00 a.m. blood sugar was 175, no			

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	insulin was given. (should have received 2 units) 8/2 at 4:00 p.m. blood sugar was 277. 4 units of insulin was given. (should have received 6 units) 8/21 at 7:00 a.m. blood sugar was 180, 4 units of insulin was given (should have received 2 units) On 10/19/17 at 11:45 a.m. the Director of Nursing provided an undated policy titled, "Medication Administration: General Policies & Procedures," and indicated it was the policy currently used by the facility. The policy indicated, "All medications are to be administered only as prescribed by a physician..."			
R 0408 Bldg. 00	410 IAC 16.2-5-12(c) Infection Control - Noncompliance (c) Each resident shall have a diagnostic			

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	chest x-ray completed no more than six (6) months prior to admission. Based on record review and interview, the facility failed to ensure a diagnostic chest x-ray was completed within 6 months prior to admission to the facility, for 1 of 7 residents reviewed for admission diagnostic chest x-rays. (Resident 43) Finding include: The clinical record of Resident 43 was reviewed on 10/18/2017 at 2:00 p.m. The resident was admitted to the facility on 8/3/2017. Admitting diagnosis included but were not limited to closed fracture of the right lower leg, pressure ulcer to heels, hypothyroidism, polymyalgia, basal cell carcinoma, osteoporosis, and hypertension. The record did not indicate that a diagnostic chest x-ray had been obtained within 6 months prior to admission. Interview on 10/19/2017 at 8:55 a.m., the Director of Nursing (DON) indicated they were unable to locate an admission chest x-ray report. On 10/19/17 at 8:55 the DON provided a policy dated 5/2012, titled "Procedure: Mantoux Testing," and indicated it was the policy currently used by the facility.	R 0408	**1. What corrective Actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident #43 had a chest x-ray completed during the survey process. **2. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken?** All new Assisted Living admissions have the potential to be affected by the alleged deficient practice. Um/designee will complete audit on all new Assisted Living admissions since 1/1/2017 to verify resident has chest x-ray within 6 months of admission, to be completed by 11/3/2017. **3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not occur?** DON/designee will provide education to the Assisted Living Admissions personnel and the Assisted Living Unit Manager that all new admissions must have a	11/03/2017

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	The policy indicate, "The dates and results of the preadmission and annual chest x-ray and/or Mantoux will be recorded in the resident's record. The diagnostic chest x-ray shall be completed no more than six (6) months prior to admission or upon admission..."		chest x-ray within 6 months prior to admission, to be completed by November 3, 2017. Assisted Living Admission Personnel/designee will review all potential residents prior to admission to ensure resident has had a chest x-ray within 6 months of admission. Chest x-ray will be ordered upon admission if indicated. Education will be provided upon hire and annually for the Assisted Living Unit Manager and Admissions personnel. **4. How will the corrective actions be monitored to ensure the deficient practice will not recur, and what quality assurance program?** AL marketing and Admissions personnel will complete an audit using the New Admission Chest X-ray on File Audit tool 7 days a week x 4 weeks, 3 times per week x 12 weeks, weekly x 8 weeks then monthly x 6 months to total 12 months. The results of these audits will be reviewed by the Quality Assurance Committee monthly. Frequency and duration of reviews will be increased as needed if compliance is below 100%	

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			Date of compliance: 11.3.17	
R 0412 Bldg. 00	410 IAC 16.2-5-12(i) Infection Control - Noncompliance (i) Persons with a documented history of a positive tuberculin skin test, adequate treatment for disease, or preventive therapy for infection shall be exempt from further skin testing. In lieu of a tuberculin skin test, these persons should have an annual risk assessment for the development of symptoms suggestive of tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss. If symptoms are present, the individual shall be evaluated immediately with a chest x-ray. Based on record review and interview, the facility failed to ensure a risk assessment for a resident with a history of testing positive for tuberculosis had been completed prior to or on admission to the facility, for 1 of 7 residents reviewed for risk assessment for tuberculosis. (Resident 72) Finding include: The clinical record of resident 72 was reviewed on 10/19/2017 at 9:30 a.m.. The resident was admitted to the facility on 5/30/2017 and had a history of testing positive to the Mantoux tuberculin skin test. The record did not indicate a risk	R 0412	**1. What corrective Actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident #72 had a TB risk assessment completed on 10/27/2017. **2. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken?** All Assisted Living residents with a history of testing positive for Tuberculosis have the potential to	11/03/2017

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	assessment for tuberculosis was obtained prior to or on admission to the facility. Interview on 10/19/2017 at 11:35 a.m. the Director of Nursing (DON) indicated they were unable to locate a risk assessment for tuberculosis for Resident 72. On 10/19/17 at 8:55 a.m. the DON provided a policy dated 5/2012, titled "Procedure: Mantoux Testing " and indicated it was the policy currently used by the facility. The policy indicated, "...Residents with a positive Mantoux administered with the facility shall have an annual risk assessment completed for the development of symptoms suggestive of tuberculosis, including, but not limited to cough, fever, night sweats, and weight loss."		be affected by the alleged deficient practice. UM/designee will complete an audit of existing AL residents, using the TB Risk Assessment Audit Tool, for Assisted Living residents that previously tested positive for tuberculosis to verify annual TB risk assessment is complete, to be completed by November 3, 2017. **3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not occur?** DON/designee will provide education to LN personnel related to completed annual TB risk assessment on residents that have previously tested positive for Tuberculosis. To be completed by November 3, 2017. License nurse personnel will be educated upon hire and annually regarding completing an annual TB risk assessment on residents who have a history of positive TB skin test. **4. How will the corrective actions be monitored to ensure the deficient practice will not recur, and what quality assurance program?**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 00 B. WING	10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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			The *TB Risk Assessment Audit* tool will be completed 3 times per week x 12 weeks, weekly x 12 weeks, then monthly x 6 to total 12 months. The results of these audits will be reviewed by the Quality Assurance Committee monthly until compliance is 100%. Frequency and duration of reviews will be increased as needed if compliance is below 100% **Date of compliance: 11.3.17**	