STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. BUILDING _____ B. WING _____	**07/30/2020**

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0919 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Make sure that a working call system is available in each resident's bathroom and bathing area.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure a resident had a call light that was within the reach for 1 of 3 residents observed for call lights. (Resident G) Findings include: On 7/29/2020, from 2:20 p.m. until 2:33, observed Resident G in bed. Resident was awake and was heard to request a urinal. The resident's call light was observed to be hanging from the wall and onto the floor, next to the bed, and out of the resident's reach. During an interview, at that time, Resident G indicated, I have to ask staff for my call light every 2 to 3 days, because sometimes it is out of my reach. Interview, on 7/29/2020 at 2:33 p.m., Licensed Practical Nurse (LPN) 1, indicated all the residents should have a call light in reach. Observed LPN 1 obtain a urinal and then hand the resident his call light. During an observation, on 7/30/2020, from 8:33 a.m. until 8:39 a.m., observed Resident G in his bed. His call light was observed to be on the floor. The call light cord was hanging from the wall and resting on the floor next to the bed. The call light was out of the reach of the resident. Interview, on 7/30/2020 at 8:39 a.m., LPN 1 indicated all the residents should have a call light within reach. Observed LPN 1 hand the call light to the resident, at that time. Interview, on 7/30/2020 at 12:10 p.m., LPN 1 indicated, Resident G's call light does not have a clip. All the call lights should have a clip to ensure the placement of the call light. The clip will secure the call light, so that it remains within the reach of the residents. On 7/29/2020 at 2:45, the clinical record of Resident G was reviewed. [DIAGNOSES REDACTED]. An annual Minimum Data Set (MDS) assessment, dated 4/17/2020, indicated Resident G had a severe cognitive deficit. A care plan, dated 6/25/2019 and current through 10/2/2020, indicated Resident G was at risk for falling. Approaches included but were not limited to, Cue/remind resident to utilize call light to seek assist as needed. On 7/28/20 at 12:50 p.m., the Director of Nursing provided a policy titled: Answering the Call Light, dated September 2003, and indicated it was the current policy being used by the facility. A review of the policy indicated General Guidelines .5. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident. This Federal tag relates to Complaint IN 175. 3.1-19(u)

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 that other safeguards 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.