

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155231	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/16/2015
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NAME OF PROVIDER OR SUPPLIER  RANDOLPH NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 701 S OAK ST WINCHESTER, IN 47394
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F 0000  Bldg. 00	<p>This survey was for a Recertification and State Licensure Survey.</p> <p>Survey dates: November 9, 10,12, 13 and 16, 2015.</p> <p>Facility number: 000136 Provider number: 155231 AIM number: 100275450</p> <p>Census bed type: SNF/NF 74 Total 74</p> <p>Census payor type: Medicare: 11 Medicaid: 51 Other: 12 Total: 74</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed by 11474 on November 17, 2015.</p>	F 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. this provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and request a desk review of certification of compliance on or after 11/30/15.	
F 0272 SS=D Bldg. 00	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and</p>			

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.

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	<p>periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:                      Identification and demographic information;                      Customary routine;                      Cognitive patterns;                      Communication;                      Vision;                      Mood and behavior patterns;                      Psychosocial well-being;                      Physical functioning and structural problems;                      Continence;                      Disease diagnosis and health conditions;                      Dental and nutritional status;                      Skin conditions;                      Activity pursuit;                      Medications;                      Special treatments and procedures;                      Discharge potential;                      Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and                      Documentation of participation in assessment.</p> <p>Based on interview and record review, the facility failed to accurately complete a Minimum Data Set (MDS) assessment regarding terminal illness for 1 of 2 residents reviewed for MDS coding related to terminal illness (Resident #51).</p>	F 0272	<p>whatcorrective action will be accomplished for those residents found to have beenaffected by the deficient practice.</p> <p>·Resident#51 no longer resides in this facility.</p> <p>Howother residents having the</p>	11/30/2015

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	<p>Findings include:</p> <p>Resident #51's closed clinical record was reviewed on 11/16/15 at 10:27 a.m.</p> <p>Resident #51's admission diagnoses included, but were not limited to, chronic kidney disease, atrial fibrillation, hypertension, respiratory failure and hypertension.</p> <p>Resident #51 had an, 8/24/15, hospital discharge summary which included, but was not limited to, the following: "...was under the care of hospice...the patient is end-stage given his multiple medical problems and previously on hospice."</p> <p>Resident #51 had an, 8/27/15, physician's progress note which indicated "He is at high risk of death in the near future."</p> <p>Resident #51 had an, 8/30/15, physician's order for "...may have hospice services, comfort measures only...."</p> <p>Resident #51 had an, 8/31/15, admission, Minimum Data Set (MDS) assessment which indicated the resident was not terminally ill (Section J 1400).</p> <p>During an, 11/16/15, 1:10 p.m., interview, the MDS Coordinator indicated Resident #51's, 8/31/15, admission, MDS had been coded</p>		<p>potential to be affected by the same deficient practice will be identified and what corrective action will be taken.</p> <p>·All residents with a terminal illness have the potential to be affected by this alleged deficient practice. An audit was conducted of all residents diagnosis to identify those with a terminal illness diagnosis and a review of the MDS was completed. No errors in coding 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 reoccur.</p> <p>·Education has been provided to the MDS Coordinator related to accuracy of the MDS prior to submission.</p> <p>·A review of diagnosis will be completed by the Interdisciplinary Team for all new admissions and the MDS coding verified for any resident with a terminal illness diagnosis prior to submission of the MDS.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not reoccur, i.e., what quality assurance program will be put into place.</p>	

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F 0514 SS=D Bldg. 00	<p>incorrectly regarding terminal illness. She indicated it was simply an error.</p> <p>A current, 10/6/15, facility policy titled "Resident Assessment Instrument (RAI) Completion", provided by the Director of Nursing on 11/16/15 at 1:45 p.m., indicated the following: "Follow guidelines set forth in the CMS's RAI Manual."</p> <p>3.1-31(c)(3)</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to ensure complete and accurate clinical record documentation was completed related to bowel monitoring for 1 of 5 residents reviewed for bowel monitoring. (Resident #29)</p>	F 0514	<p>·AMDS coding audit will be done weekly for four weeks and then monthly for sixmonths. Results will be reviewed monthly during the Quality Assurance meeting.</p> <p>Bywhat date will the systemic changes will be completed.</p> <p>·Completiondate 11/30/15.</p> <p>whatcorrective action will be accomplished for those residents found to have beenaffected by the deficient practice.</p> <p>·Alate entry was documented in the medical record for Resident</p>	11/30/2015	

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	<p>Findings include:</p> <p>The clinical record for Resident #29 was reviewed on 11/12/15 at 2:02 p.m. Diagnoses for Resident #29 included, but were not limited to, constipation, hard stools, and End Stage Renal Disease (ESRD).</p> <p>Current physician orders for Resident #29 included, but were not limited to, the following:</p> <p>a. Docusate (a stool softener) 100 milligrams (mg) by mouth two times a day. This order originated 6/2/15.</p> <p>b. Enulose (a laxative) 10 grams (gm)/15 milliliters (ml) give 30 ml (20 gm) by mouth once a day. This order originated 6/27/15.</p> <p>Resident #29 had a current, 9/16/15, health care plan with a problem of "impaired bowel elimination related to constipation with bleeding hemorrhoids." The goal for this problem was for Resident #29 "to have soft formed BM [bowel movement] at least every three days and no complications related to hemorrhoids such as pain/excessive bleeding." Interventions for this problem included, but were not limited to,</p>		<p>#29 to indicate she had a bowel movement on 8/21/15, 9/6/15, and 9/12/15.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.</p> <ul style="list-style-type: none"> <li>Residents residing in the facility have the potential to be affected by this alleged deficient practice. An audit was conducted to identify resident without a documented bowel movement for more than three days. Residents not having a bowel movement for more than three days will be assessed and provided PRN medication as ordered and as indicated.</li> </ul> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur.</p> <ul style="list-style-type: none"> <li>Nursing staff have been re-educated regarding bowel movement assessment and documentation.</li> <li>Residents identified as not having a bowel movement for more than three days will be assessed and administered PRN medication as indicated. The physician will be notified of those residents not having a bowel movement for more than three days and lacking PRN</li> </ul>	

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	<p>"administer physician ordered medications and assess resident's bowel sounds/abdomen distention/discomfort if no bowel movement in 3 days."</p> <p>The clinical record for Resident #29, which included the "CORP-Resident Bowel and Bladder by Shift Chart" reports, lacked a documented bowel movement on the following dates:</p> <p>8/18/15 to 8/23/15 - 6 days without a documented bowel movement 9/3/15 to 9/7/15 - 5 days without a documented bowel movement 9/9/15 to 9/13/15 - 5 days without a documented bowel movement.</p> <p>Resident #29's clinical record lacked any nurses notes related to bowel movements and/or abdomen assessments on 8/18/15, 8/19/15, 8/20/15, 8/21/15, 8/22/15, 8/23/15, 9/3/15, 9/4/15, 9/5/15, 9/6/15, 9/7/15, 9/9/15, 9/10/15, 9/11/15, 9/12/15, and 9/13/15.</p> <p>The August 2015 and September 2015 Medication Administration Records for Resident #29 indicated no prn (as needed) medications for constipation had been ordered or given to Resident #29.</p> <p>During an interview on 11/16/15 at 8:40 a.m., LPN #2 indicated the CNAs</p>		<p>medicationorders.</p> <p>Howthe corrective action will be monitored to ensure the deficient practice willnot reoccur, i.e., what quality assurance program will be put into place.</p> <p>·Abowel elimination audit will be conducted five days a week for four weeks andthe weekly for four weeks then monthly for six months. Results will be reviewedmonthly during the Quality Assurance meeting.</p> <p>Bywhat date will the systemic changes will be completed.</p> <p>·Completiondate 11/30/15.</p>	

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	<p>documented the resident bowel movements into the computer tracker. A daily report of residents without a bowel movement for the past 9 shifts was printed off for the nurses. The nurses then checked with the alert residents to find out if the resident had a bowel movement which did not get recorded in the tracker. The nurse would document findings and complete the next needed action such as a prn medication for the resident if appropriate.</p> <p>During an interview on 11/16/15 at 12:41 p.m., the Assistant Director of Nursing (ADON) provided "CORP- No BM [bowel movement] in last 9 shifts Cross Tab Report", dated 8/21/15, 9/6/15, and 9/14/15. The ADON indicated the reports were printed off daily and given to the nurses in the morning. The nurses would then talk to the resident if the resident was alert. The nurse would then take the appropriate action. The reports indicated Resident #29 had a bowel movement on 8/21/15, 9/6/15, and 9/12/15. The ADON indicated the reports were not part of the resident's clinical record.</p> <p>Review of the current facility policy, dated 6/14/2, titled "Documentation in the Clinical Record", provided by the Director of Nursing on 11/16/15 at 1:41</p>			

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	<p>p.m., included, but was not limited to the following:</p> <p>"Purpose: Guidelines for documentation of assessment of a resident and changes in the resident's medical or mental condition in the resident's medical record.</p> <p>Procedure:</p> <p>1. Observations, medications administrated, services performed, etc., are documented in the resident's clinical records...."</p> <p>3.1-50(a)(1)</p>				