STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155670		09/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NEWBURGH	5233 ROSEBUD LN NEWBURGH, IN 47630

(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	This visit was for the Investigation of Complaint IN00178811 and Complaint IN00179051. Complaint IN00178811 - Substantiated, Federal/State deficiencies related to the allegations are cited at F203, F205, F206, and F250. Complaint IN00179051 - Unsubstantiated, due to lack of evidence. Survey dates: September 1, 2, 3, 2015 Facility number: 011049 Provider number: 155670 AIM number: 200258520 Census bed type: SNF/NF: 89 Total: 89 Census payor type: Medicare: 15 Medicaid: 57 Other: 17 Total: 89 Sample: 6	F 0000		

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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	These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. QR was completed by # 02748 on September 8, 2015.			
F 0203 SS=D Bldg. 00	483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section. Except as specified in paragraph (a)(5)(ii) and (a)(8) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged. Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to			

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	allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days. The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.	F 0203	**F203** 1. Residents noted in the citation have not resided at the center for more than 90 days and no notice can be provided at this time. 2.An audit has been completed on the charts of all residents discharged in the past 60 days and proper notices have been provided.	09/30/2015
	Based on interview and record review, the facility failed to provide a notice of transfer/discharge to residents prior to transfer/discharge from the facility, for 2 of 3 closed records reviewed for proper transfer/discharge notification, in a sample of 6. Resident B, Resident C			

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	Findings include: 1. The closed clinical record of Resident B was reviewed on 9/1/15 at 2:15 P.M. A Physician's Communication form, dated 5/20/15 at 6:00 P.M., indicated Resident B was "more confused, chills, very hard to awaken, cyanotic, SOB [short of breath], HA [headache], clammy." A Physician's order, dated 5/20/15, indicated the resident was to be sent to the hospital emergency room for evaluation and treatment. A notice of transfer/discharge was not found in the closed record. On 9/2/15 at 11:55 A.M., during an interview with the Administrator, she indicated the staff was unable to find a notice of transfer/discharge. 2. The closed clinical record of Resident C was reviewed on 9/1/15 at 11:25 A.M. A Resident Transfer Form, dated 5/1/15, indicated the resident was transferred to another nursing facility. A notice of transfer/discharge was not found in the closed record.		3.Licensed Nurses have been retrained on the center policy and procedure for notice of transfer/discharge. Licensed nurses will provide written notice to the resident at the time of the transfer and the business office manager or designee will make a follow up phone call within 24 hours to ensure notice was received. 4.Medical records for all discharged/transferred residents will be reviewed at the morning meeting following the day of discharge/transfer five days per week for three months and then weekly for three months to ensure continued compliance. Repeated failures to provide proper notice at the time of discharge/transfer will result in disciplinary action up to and including discharge from employment. Findings from the record audits will be brought to the facility QAPI meeting monthly for six months for review and recommendation.	

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	On 9/2/15 at 11:55 A.M., during an interview with the Administrator, she indicated the staff was unable to find a notice of transfer/discharge. On 9/2/15 at 12:15 P.M., the Administrator provided the current facility policy "Notice of Transfer or Discharge," dated June 2007. The policy included: "1. Should it become necessary to transfer or discharge a resident from our facility, a representative of administration will provide the resident and family member (representative/sponsor) with a written thirty (30) day advance notice of the transfer or discharge. 2. A transfer or discharge notice will include the following: a. The reason for the transfer or discharge; b. The effective date of the transfer or discharge; c. The location to which the resident is transferred or discharged; d. An explanation of the resident's right to appeal the transfer or discharge to the State; and e. The name, address, and telephone number of the state long-term care ombudsman. 3. The reason(s) for a transfer or discharge will be recorded in the resident's clinical record...." This Federal tag relates to Complaint IN00178811.			

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	3.1-12(a)(6) 3.1-12(a)(9)			
F 0205 SS=D Bldg. 00	483.12(b)(1)&(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and			

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	resume residence in the nursing facility, and the nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section. Based on interview and record review, the facility failed to provide written information regarding the permission to return to the facility or the duration of a bed hold notice to residents prior to transfer/discharge from the facility, for 2 of 3 closed records reviewed for proper bed hold information, in a sample of 6. Resident B, Resident C Findings include: 1. The closed clinical record of Resident B was reviewed on 9/1/15 at 2:15 P.M. A Physician's Communication form, dated 5/20/15 at 6:00 P.M., indicated Resident B was "more confused, chills, very hard to awaken, cyanotic, SOB [short of breath], HA [headache], clammy." A Physician's order, dated 5/20/15,	F 0205	**F 204** 1. Residents noted in the citation have not resided at the center for more than 90 days and no bed-hold can be provided at this time. 2.An audit has been completed on the charts of all residents discharged in the past 60 days and proper notices have been provided. 3.Licensed Nurses have been retrained on the center policy and procedure for providing notice of bed-hold policy at the time of a transfer/discharge. Licensed nurses will provide written notice of the bed-hold to the resident at the time of the transfer and the business office manager or designee will make a follow up phone call within 24 hours to ensure notice was received, and to determine whether the resident/responsible party wishes to hold the bed. 4.Medical records for all discharged/transferred residents will be reviewed at the morning	09/30/2015

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	indicated the resident was to be sent to the hospital emergency room for evaluation and treatment. A written notice of bed hold was not found in the closed record. On 9/2/15 at 11:55 A.M., during an interview with the Administrator, she indicated the staff was unable to find a bed hold notice in the record. 2. The closed clinical record of Resident C was reviewed on 9/1/15 at 11:25 A.M. A Resident Transfer Form, dated 5/1/15, indicated the resident was transferred to another nursing facility. A written notice of bed hold was not found in the closed record. On 9/2/15 at 11:55 A.M., during an interview with the Administrator, she indicated the staff was unable to find a bed hold notice in the record. On 9/2/15 at 12:15 P.M., the Administrator provided the current facility policy, "Facility Bedhold," undated. The policy included: "The Facility will notify the resident/responsible party of the facility's bed hold and re-admission policies at		meeting following the day of discharge/transfer five days per week for three months and then weekly for three months to ensure continued compliance. Repeated failures to provide proper bed-hold notice at the time of discharge/transfer will result in disciplinary action up to and including discharge from employment. Findings from the record audits will be brought to the facility QAPI meeting monthly for six months for review and recommendation.	

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	admission and anytime a resident is transferred to the hospital or goes out on therapeutic leave. The Facility will also notify the resident/responsible party in writing of the reason for transfer/discharge to another legally responsible institution...The facility's written bed hold information will include the duration of the facility's bed-hold policy...." This Federal tag relates to Complaint IN00178811. 3.1-12(a)(25)			

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F 0206 SS=D Bldg. 00	483.12(b)(3) POLICY TO PERMIT READMISSION BEYOND BED-HOLD A nursing facility must establish and follow a written policy under which a resident whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, is readmitted to the facility immediately upon the first availability of a bed in a semi-private room if the resident requires the services provided by the facility; and is eligible for Medicaid nursing facility services. Based on interview and record review, the facility failed to ensure a resident who was transferred to the hospital for emergency services was able to return to the facility, for 1 of 3 discharged residents reviewed, in a sample of 6. Resident B Findings include: On 9/1/15 at 2:15 P.M., the closed record of Resident B was reviewed. The resident was admitted to the facility on 7/14/11 with diagnoses including, but not limited to, morbid obesity and leg varicosity with ulcer. A quarterly Minimum Data Set (MDS) assessment, dated 4/21/15, indicated Resident B scored a 15 out of 15 for cognition, with 15 indicating no memory	F 0206	**F 206** 1. A call was placed to resident B on July 7, 2015 to offer a bed in the center and the resident declined. 2.No other residents were impacted by the alleged violation. 3.All department leaders have been retrained on the center policy on permitting readmission to the nursing center beyond bed-hold. 4.The attached tracking tool will be used daily 5 times per week on an ongoing basis to ensure that residents are routinely re-admitted to the center per state and federal guidelines. Results of the tracking will be reported to the facility QAPI committee for six months for review and recommendation.	09/30/2015

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	impairment. The MDS assessment indicated the resident did not ambulate, and had transferred "only once or twice" in the previous 7 days with the assistance of two+ staff. The resident's weight was documented as 658 pounds. A Social Service Note, dated 4/21/15, indicated, "[Resident B] depends on staff assistance for her ADL's [activities of daily living] and getting around the facility in her w/c [wheelchair]... [Resident B] is able to express her wants/needs without difficulty...is alert and oriented....plans to remain LTC [long term care] at this facility...." A Dietician note, dated 4/30/15, indicated, "...POC [plan of care] is appropriate. With essential stability, res [resident] will be reviewed monthly." The most recent physician's note, dated 5/9/15, indicated, "...Noncompliance [with] diet/fluid restricts...Alert, Distress - None...Has gained 40# due to dietary noncompliance...." A Dietician note, dated 5/14/15, indicated, "...Dietary is keeping a log of requests from res to verify # [number] of requests made...POC is appropriate." A Physician Communication Form, dated			

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	5/20/15 at 6:00 P.M., included: "...Chills, Headache Nausea...This started on 5/20/15...Functional Status Changes (compared to baseline...) Weakness, confused...." The resident was transferred to the hospital on 5/20/15. Hospital records included the following notations: 5/21/15 at 11:59 A.M.: "...Begin discharge planning...SW [social worker] met with the patient...Patient was admitted to the hospital from [name of facility] SNF [skilled nursing facility]. Patient is agreeable to return to [name of facility] at discharge." 5/21/15 at 3:16 P.M.: "...SW spoke with [facility Clinical Liaison] at [name of facility], where this patient has resided for the past six years. [Clinical Liaison] advised this patient has been noncompliant with their weight loss program, and has consistently gained weight and outgrown the bariatric equipment they keep buying for her. [Name of physician], the medical director at [name of facility], is considering that they may not be able to meet her needs, as she has not complied and had consistently gained weight while in their			

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	care. [Name of physician] is now advising they cannot accept her back at [name of facility] due to no longer being able to accommodate her bariatric needs...." 5/22/15 at 8:39 A.M.: "...Hospitalist to assume care since she has improved...She will need disposition as her SNF is not accepting this patient due to her size." 5/22/15 at 8:55 A.M.: "...SW met with the patient and advised her that [name of facility] states they cannot accept her back at their facility, due to not being able to accommodate her needs and her not participating in their weight loss program. The patient states she thought she was participating...." 5/26/15 at 11:04 A.M.: "...Pt [patient] was very tearful because [name of facility] unable to accept her back. Pt requested for SW to call [name of facility] again to see if they will be willing to accept her back. SW left vm [voice mail] with [Clinical Liaison]...." 5/27/15 at 9:44 A.M.: "...Spoke with [name of facility] and they stated that they are unable to accept pt back due to her weight. The maximum weight they can accept is 600 lbs [pounds]; pt is 667 lbs...."			

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	On 9/2/15 at 10:00 A.M., during an interview with a hospital Case Manager, she indicated she was familiar with Resident B. She indicated, "The woman was so upset, was crying, because she could not go back." She indicated the resident told her, "That's my home." She indicated the resident "felt like they dumped her." The case manager indicated she had spoken to [name of Clinical Liaison], who informed her that they were unable to accept Resident B back "because of her size." A "Level II Mental Health Assessment," dated 7/8/15, included: "[Resident B] was residing at [name of facility] for the past six years per her report...she also told the [hospital] Discharge Planners she has resided at [name of facility] for the past six years and she wanted to return there after her acute hospital stay (7 days total) but they refused to accept her back due to her weight now reaching over 600 lbs and due to them having to buy bigger equipment for her. They reportedly told her she had to comply with a diet because they didn't want to have to keep buying bigger equipment (bariatric bed, lift etc). She is very depressed at this time and was tearful throughout this assessment telling evaluator that she didn't get to say goodbye to her friends that were basically			

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	her family...She was only in the hospital 7 days...During this evaluation [Resident B] reports she was forced out of her home of six years...when she had to go to the hospital for sepsis and was very ill...she was told that [name of facility] would no longer take her back due to her weight...and they were no longer willing to continue to purchase more equipment to care for her and reportedly due to the fact that she was 'unwilling' to comply with their mandated weight loss programming (pt reported she was trying...[Resident B] had an ordered, logical, sequential thought process...." On 9/2/15 at 10:30 A.M., during an interview with the facility Clinical Liaison, she indicated the maximum weight that the hoyer lift could hold was 600 lbs. She indicated the resident's physician told her to try and find a bariatric program for the resident, but that there was none available that the resident could utilize. She indicated the facility was "struggling" to meet the resident's needs, and had already bought bigger equipment for the resident. On 9/2/15 at 10:55 A.M., the Clinical Liaison indicated the facility had previously been renting equipment, that held the maximum weight of 600 lbs. She indicated she had just discovered that the			

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	current hoyer lift could hold residents up to 750 lbs. She indicated she was unsure when that was obtained. On 9/2/15 at 2:35 P.M., during an interview with the Social Services Director (SSD), she indicated she was not involved in the decision to not readmit the resident. The SSD indicated that she thought the resident was coming back to the facility, because she had been to the hospital in the past and had returned. On 9/2/15 at 1:50 P.M., during an interview with LPN # 1, she indicated Resident B "didn't really get out of bed much." LPN # 1 indicated the resident could stand and pivot. LPN # 2 indicated at that time that she thought the resident would get up once in awhile, and that the staff would use a hoyer lift. On 9/2/15 at 1:55 P.M., during an interview with the Unit Manager, she indicated Resident B "was never officially a hoyer lift." On 9/2/15 at 3:30 P.M., during an interview with CNA # 1, she indicated Resident B did not use a hoyer lift to get up. She indicated the resident could "stand and pivot" on her own. On 9/3/15 at 9:10 A.M., during an			

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	interview with the Administrator, she indicated she was not the Administrator at the time the resident was refused to be readmitted. She indicated it was her understanding that the resident required a hoyer lift during her transfer to the hospital when she was ill, and that the resident had not utilized a hoyer lift prior to her illness. On 9/3/15 at 10:30 A.M., during an interview with the Business Office Manager (BOM), she indicated on 5/27/15 the facility census was 92. The BOM indicated the total facility capacity was 104 beds, which indicated there were 12 empty beds. The BOM indicated all of the facility beds were dually certified, so either Medicare or Medicaid residents were eligible for every bed. On 9/3/15 at 10:20 A.M., the Administrator provided the current facility "Notice of Bed Hold Policy," undated. The policy included: "...Regardless of payor source, during the time the resident' bed is on hold, the resident may return to and resume residence in the Center provided that the resident requires the services provided by the Center and the Center is able to meet the needs of the resident. In the event that (1) there is no state Medicaid required bed hold; (2) a Medicaid resident's			

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	hospitalization or therapeutic leave exceeds a state required bed hold periods and the resident doesn't to elect to pay the Private Pay rate to hold the bed...the resident will be readmitted to the Center to the first available bed in a semi-private room if the resident requires the services provided by the Center...." This Federal tag relates to Complaint IN00178811. 3.1-12(a)(25)			

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F 0250 SS=D Bldg. 00	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on interview and record review, the facility failed to ensure residents received a yearly Level II mental health assessment review as recommended, for 3 of 4 residents reviewed with Level II assessments, in a sample of 6. Residents A, F, and B Findings include: 1. The clinical record of Resident A was reviewed on 9/1/15 at 10:55 A.M. Diagnoses included, but were not limited to, depression and anxiety. A Level II Mental Health Assessment, dated 11/12/13, indicated, "...This individual is mentally ill as defined...Services of Less Intensity Than Specialized Services: This individual needs the following mental health services...Yearly RR [resident review] Required, Outpatient MH [mental health] Services, Individual/Group Therapy, Medication Review, Medication	F 0250	**F 250** 1. Resident A had a Level II assessment completed on 09/02/2015. Resident F has a Level II assessment scheduled to be completed on or before 9/25/2015. Resident B no longer resides in the center. 2.All other residents requiring a Level II assessment have been reviewed and assessments have been completed as necessary by the mental health agency. 3.The center social worker has been retrained on the procedure for ensuring completion of Level II mental health assessments annually and as required by state law. Level II assessments will be reviewed by social services with the MDS assessment schedule quarterly and a Level II mental health assessment will be completed as needed. 4.Medical Records or designee will audit charts with quarterly assessments times 12 months to ensure Level II assessments are completed timely. Medical Records	09/30/2015

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	Adjustment, Medication Monitoring...." A more recent Level II was not found in the resident's record. On 9/1/15 at 2:45 P.M., during an interview with the Social Services Director (SSD), she indicated she was unable to find a more current Level II, and that she called the local Mental Health agency, who would come out and do it. The SSD indicated the Mental Health agency "are the ones that keep track of annual Level IIs." 2. The clinical record of Resident F was reviewed on 9/2/15 at 2:00 P.M. Diagnoses included, but were not limited to, depression. A Level II Mental Health Assessment, dated 1/2/13, indicated, "...This individual is mentally ill as defined...Services of Less Intensity Than Specialized Services: Yearly Resident Review, Individual Therapy, Medication Monitoring...." A more recent Level II was not found in the resident's record. On 9/2/15 at 2:10 P.M., the Business Office Manager indicated she would look for a more current Level II in the		and Social Services will report to the center QAPI committee monthly for 12 months for review and recommendations.	

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	resident's financial record. A more recent Level II was not provided prior to survey exit on 9/3/15. 3. The clinical record of Resident B was reviewed on 9/1/15 at 2:15 P.M. Diagnoses included, but were not limited to, depressive history. A Level II Mental Health Assessment, dated 6/20/11, indicated, "...This individual is mentally ill as defined...Services of Less Intensity Than Specialized Services: Yearly Resident Review, Psychiatric Evaluation, Outpatient MH services, Individual/GroupTherapy, Medication Review, Medication Adjustment, Medication Monitoring...." A more recent Level II was not found in the resident's record. On 9/2/15 at 12:05 P.M., during an interview with the Administrator, she indicated the SSD was unable to locate a more recent Level II. She indicated she was unsure whose responsibility it was to ensure the recommendations were followed. On 9/2/15 at 2:35 P.M., during an interview with the Social Services			

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	Director, she indicated she was the staff member who was responsible for keeping a record of those residents requiring Level II assessments. She indicated she was "unsure how she missed those." On 9/2/15 at 4:00 P.M., during an interview with LCSW [Licensed Clinical Social Worker] # 1, she indicated she worked for the local Mental Health agency, and was responsible for performing the Level IIs for residents in the nursing facilities. She indicated it was the facility's responsibility to notify the Mental Health agency of the need for annual Level IIs. She indicated the facility should always follow the recommendations of the Level IIs, including the initial Level II. This Federal tag relates to Complaint IN00178811. 3.1-34(a)			

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