

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155401	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  10/30/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  BEN HUR HEALTH AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 1375 S GRANT AVE CRAWFORDSVILLE, IN 47933
---	---

(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.</p> <p>Survey Dates: October 26, 27, 28, 29 &amp; 30, 2015</p> <p>Facility number: 000461 Provider number: 155401 AIM number: 100275290</p> <p>Census Bed Type: SNF/NF: 85 Total: 85</p> <p>Census Payor Type: Medicare: 7 Medicaid: 62 Other: 16 Total: 85</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2 -3.1. Quality review completed 11/5/15 by 29479.</p>	F 0000		
F 0278 SS=D Bldg. 00	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED			

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155401	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  10/30/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  BEN HUR HEALTH AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 1375 S GRANT AVE CRAWFORDSVILLE, IN 47933
---	---

(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 assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly 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 an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on interview and record review, the facility failed to ensure the accuracy of the functional status assessment used for the coding of the Quarterly Minimum Data Set for 1 of 1 resident reviewed with contractures. (Resident #19.)</p> <p>Finding includes:</p> <p>During a Stage 1 staff interview, on</p>	F 0278	I. The correctiveaction taken was that the MDS assessment of 7/1/15 for Resident #19 wascorrected to indicate proper coding of the resident's functional status inSection G. II. As all residentshave the potential to be affected, an audit was completed for residents withlimited range of motion, and MDS assessments were evaluated for proper codingof Section G. Following the audit,modifications to the	11/12/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155401		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  10/30/2015	
NAME OF PROVIDER OR SUPPLIER  BEN HUR HEALTH AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 1375 S GRANT AVE CRAWFORDSVILLE, IN 47933			
(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>10/26/15 at 2:38 p.m., the Director of Nursing (DON) indicated Resident #19 had an impairment of right sided contractures from a stroke.</p> <p>A review, on 10/29/15 at 11:50 a.m., of Resident #19's Quarterly Minimum Data Set (MDS) assessment, dated 7/1/15, Section G (G0400), titled " Functional Limitation in Range of Motion, " indicated a code of 0-no impairment for upper and lower extremities. A review of Resident #19's Quarterly Minimum Data Set (MDS), dated 9/24/15, Section G (G0400), titled " Functional Limitation in Range of Motion, " indicated a code of 1-impairment on one side for upper and lower extremities.</p> <p>On 10/29/15 at 2:13 p.m., the MDS Coordinator indicated Resident #19 had right sided contractures in the upper and lower extremities. The MDS Coordinator further indicated the quarterly MDS for July, 2015 was coded incorrectly, which indicated Resident #19 had no contractures. The MDS Coordinator indicated she had not coded the functional status correctly.</p> <p>The Administrator, on 10/29/15 2:45 p.m., indicated the facility policy was to follow the Center for Medicare Services (CMS) Resident Assessment Instrument</p>		<p>MDS of specific residents were made as necessary. III. The systemic change that will be implemented is that with each new admission or quarterly review, the Interdisciplinary Team will utilize the IDT Care Plan Review Tool to ensure that all concerns regarding joint mobility and/or contractures are addressed. This system will be utilized ongoing with all new admissions and for quarterly reviews in accordance with the care plan schedule. This audit tool will be completed weekly for 4 weeks, monthly for 3 months, and quarterly thereafter to ensure a 95% or greater threshold for accuracy. Additionally, the MDS coordinator has been given re-instruction in the CMS RAI Version 3.0 Manual – specifically in relation to Section G. IV. To ensure compliance, the Registered Nurse who is assigned responsibility for completion of the MDS will review Section G, and will notify the MDS coordinator if changes or modifications are necessary. Facility administrative nursing staff will monitor for proper MDS documentation through the Continuous Quality Improvement Program weekly for four weeks, then monthly for three months, with identified inaccuracies being reported at monthly Quality Assurance meetings. At the end of four months the program will be</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155401		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  10/30/2015	
NAME OF PROVIDER OR SUPPLIER  BEN HUR HEALTH AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 1375 S GRANT AVE CRAWFORDSVILLE, IN 47933			
(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 0463 SS=E Bldg. 00	<p>(RAI), Version 3.0 Manual MDS assessment guidelines for every resident MDS assessment.</p> <p>The MDS Coordinator provided a copy of the Center for Medicare Services (CMS) Resident Assessment Instrument (RAI), Version 3.0 Manual, on 10/29/15 at 3:00 p.m., which included but was not limited to, "...Code 1, impairment on one side: if resident has an upper and/or lower extremity impairment on one side that interferes with daily function or places the resident at risk of injury...."</p> <p>3.1-31(d)</p> <p>483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. Based on observation, interview, and record review, the facility failed to ensure a functioning call system was maintained for 1 of 6 resident units of the facility. This had the potential to affect 19 of 19 residents on the secure Alzheimer's unit (Residents #98, #91, #31, #9, #73, #18, #69, #50, #89, #96, #45, #53, #86, #84, #48, #93, #55, #46, and #85.)</p>			F 0463	<p>reevaluated to assess for efficacy of the system. V. Evidence is submitted of the corrected MDS for Resident #19, notes of the audit completed of all residents for limited range of motion, along with notations of any MDS assessments which were modified following the survey citation. Also attached are copies of the instruction provided to the MDS Coordinator, and copies of the pages of the IDT Care Plan Assessment Tool for use with new admissions and quarterly reviews. In consideration of this evidence, Ben Hur Health and Rehabilitation requests paper compliance for survey tag #F278.</p> <p>I. The corrective action taken was that the contractor for the facility's nurse call system completed repairs to the system, which was fully functional on 10/29/15 with nurse call communication between resident rooms 78, 79, 80, 81, 82, 83, 84, 85, 86 and 87 and the nursing station, as well as dome light operation outside each door. II. As all residents have the potential</p>		11/13/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155401		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  10/30/2015	
NAME OF PROVIDER OR SUPPLIER  BEN HUR HEALTH AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 1375 S GRANT AVE CRAWFORDSVILLE, IN 47933			
(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>Finding includes:</p> <p>On 10/27/15 at 11:50 a.m. Resident #96's room (#78) was observed. Neither call light in the two bed room worked. Rooms #80, #81, #83, #84, and #85, #86, and #87 were checked with the Executive Director present. None of the call lights in the two bed rooms and bathrooms functioned.</p> <p>On 10/27/15 at 2:00 p.m. the Executive Director indicated the system had been interrupted during construction on another unit.</p> <p>On 10/28/2015 at 10:51:30 a.m. one of the contractors was interviewed. The contractor indicated they had disconnected the system last week and had not been aware it affected the secure unit. He indicated it had been about a week, and they were in the process of installing a new system.</p> <p>On 10/30/15 at 2:35 p.m., the Executive Director provided a policy, no title, dated 10/30/15, that included, "Any staff member who observes an issue or item which needs repairs completes a work order (located at the nursing stations, housekeeping carts, and front office), which is submitted to the Executive Director. The Executive Director assigns</p>				<p>to be affected, all other call lights were checked to ensure they were functioning properly – no issues were found.</p> <p>III. The systemic change which has been implemented is that during routine preventive maintenance checks of the call light system, facility maintenance staff will check at least one resident room per wing for proper function of the call light system. This will identify if there is a functional problem with a specific wing or hallway of the facility, and a contractor can be notified to make corrections immediately.</p> <p>IV. To ensure ongoing compliance, as part of the Continuous Quality Improvement process, preventive maintenance records completed by facility staff will be submitted to the Executive Director for review, and will indicate which rooms have been assessed each week for proper call light function. Any issues with proper function of the call light system will be directed to the contracted agency immediately for repair. The Continuous Quality Improvement Tool for call lights will be utilized to document assessment and functional status of facility call lights, with an expectation of a threshold of 95% compliance. Percentage of compliance will be reported to the Executive Director every week for four weeks, and then monthly for three months. Any necessary</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155401	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  10/30/2015
NAME OF PROVIDER OR SUPPLIER  BEN HUR HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1375 S GRANT AVE CRAWFORDSVILLE, IN 47933		
(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 necessary work to the maintenance department accordingly."</p> <p>On 10/30/15 at 11:03 a.m., the Executive Director provided a preventative maintenance log for the month of October. Documentation included, but was not limited to, weekly checks of the nurse call system. The Director indicated not all call lights were checked but were spot checked. The log did not identify what locations had been checked.</p> <p>3.1-19(u)(1) 3.1-19(u)(2)</p>		<p>adjustments to the compliance program for call lights will be determined if the threshold is not attained at the end of four months. Additionally, staff have been provided with inservice education on the reporting of non-functioning call lights to the maintenance department and/or Executive Director immediately, in order to ensure that repairs are made as quickly as necessary.</p> <p>V. Evidence of repairs made by the contracted agency to the nurse call system on 10/28 and 10/29/15 for rooms 78, 79 80, 81,82, 83, 84, 85 86 and 87 is being submitted, along with the most recent weekly preventative maintenance records noting which rooms were evaluated for proper call light functioning the week of 11/2/15 to 11/8/15, and the week of 11/9/15 to 11/15/15. Also, included is documentation of the inservice provided to staff on call light repairs, as well as the CQI tool which will be utilized for the ongoing compliance program. In consideration of this evidence, Ben Hur Health and Rehabilitation request paper compliance for survey tag #F463.</p>		