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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 06/11/2015 |
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| NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE, THE | STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006 |
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|------------------------|--|---------------|---|----------------------|
| F 0000 Bldg. 00 | <p>This visit was for the Investigation of Complaint IN00174641.</p> <p>Complaint IN00174641 - Substantiated. Federal/State deficiencies related to the allegation are cited at F278.</p> <p>Survey dates: June 10 & 11, 2015</p> <p>Facility number: 000138 Provider number: 155233 AIM number: 100266500</p> <p>Census bed type: SNF/NF: 70 Total: 70</p> <p>Census payor type: Medicare: 7 Medicaid: 38 Other: 25 Total: 70</p> <p>Sample: 10</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> | F 0000 | | |

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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| F 0278 SS=D Bldg. 00 | <p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED 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 that the Minimum Data Set assessment was accurate related to pressure ulcer and antipsychotic medication assessments for 2 of 2 residents reviewed for pressure ulcers and for 1 of 4 residents reviewed</p> | F 0278 | This is not an actual complaint survey. This survey is a new type of focused survey piloted per CMS to assess MDS 3.0 coding practices in 5 states, as noted in the letter provided per the surveyors upon entrance to our facility. The surveyors also explained that staffing would be | 06/27/2015 |

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| | <p>for antipsychotic medication in a sample of 10. (Residents #2001, 2009 and 2010)</p> <p>Finding includes:</p> <p>1. The clinical record for Resident #2001 was reviewed on 6/10/2015 at 1:00 p.m. Diagnoses included, but were not limited to, quadriplegia, anemia, and chronic lung disease.</p> <p>The quarterly Minimum Data Set (MDS) assessment, with reference date 5/15/2015, indicated the resident had one Stage 3 pressure ulcer, four Stage 4 pressure ulcers and two unstageable pressure ulcers.</p> <p>The Wound Assessment, dated 5/12/2015, indicated the resident had one Stage 3 pressure ulcer, six Stage 4 pressure ulcers, and two unstageable pressure ulcers.</p> <p>The quarterly Minimum Data Set assessment, with reference date 4/14/2015, indicated the resident had three Stage 3 pressure ulcers, one Stage 4 pressure ulcer and two unstageable pressure ulcers.</p> <p>The Wound Assessment, dated 4/14/2015, indicated the resident had one Stage 2 pressure ulcer, two Stage 3</p> | | <p>reviewed during this pilot survey. We had no complaints attached to this survey. The preparation and/or execution of this plan of correction does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. This plan of correction is submitted as proof of compliance with state and federal law. We respectfully request a desk review of this plan of correction for F tag 278. All corrections are in place at the time of submission. This facility does ensure that the MDS assessments are accurate for pressure ulcer and antipsychotic medication assessments. 1. No residents were directly affected. The MDS for residents #2001, 2010, and 2009 have been modified. 2. MDS assessments and nursing assessments that support the MDS coding for wounds and antipsychotic medications have been audited per The MDS Coordinator and the Director of Nursing to ensure coding is correct for the most current, completed MDS assessments. If inconsistencies were found, they have been modified. The Nursing staff has been re-educated on wound assessments. The MDS Coordinator and/or designee will count meds charted on the MAR and then re-check the number of meds to ensure an accurate count of antipsychotic</p> | | |

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| | <p>pressure ulcers, one Stage 4 pressure ulcer, and three unstageable pressure ulcers.</p> <p>During an interview on 6/11/2015 at 10:05 a.m., the MDS Coordinator indicated the Wound Assessment, dated 0/12/2015, should have been used to code the quarterly assessment of 5/15/2015 and the Wound Assessment, dated 4/14/2015, should have been used to code the quarterly assessment of 4/14/2015. The MDS Coordinator indicated both quarterly assessments for Resident #2001 were not coded accurately.</p> <p>2. The clinical record for Resident #2010 was reviewed on 6/11/2015 at 11:00 a.m. Diagnoses included, but were not limited to, dementia with psychosis, anxiety and depression.</p> <p>The discharge Minimum Data Set (MDS) assessment, with reference date 3/10/2015, indicated the resident received Risperdal (an antipsychotic medication) 6 of the 7 days of the observation period of 3/4/2015 through 3/10/2015. The Medication Administration Record indicated the resident received the Risperdal 5 of the 7 days of the observation period.</p> <p>During an interview on 6/11/2015 at 1:30</p> | | <p>medications. 3. The MDS Coordinator and the DON and/or designees will compare skin sheets and MARs to MDS assessments during weekly QA IDT(Quality meeting with Interdisciplinary team) meetings to ensure accuracy of the MDS assessments. If inconsistencies are identified, appropriate corrections will be completed. This will be an ongoing program to ensure accuracy on a continuous basis. 4. The findings from the weekly QA IDT meetings will be presented in Quarterly QA meetings for review during Quarterly meetings for 4 quarters. If any inconsistencies are identified past this 12 month period of review during these 4 quarters, the quarterly review will continue until no coding issues found for at least 2 consecutive quarters. Thereafter, random audits may be performed and presented to the QA committee and/or scheduled audits may be performed and reviewed per the QA committee, based on the continuous weekly reviews as noted above in #3. 5. 6/27/15</p> | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| | p.m., the MDS Coordinator, indicated the discharge assessment for Resident #2010 was not coded accurately. | | | | |