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
	155718		07/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY NORTHVIEW CARE CENTER	1235 W CROSS ST ANDERSON, IN 46011

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00177984. Complaint IN00177984-Substantiated. Federal/State deficiencies related to the allegation are cited at F156 and F278. Survey dates: July 16 and July 17, 2015 Facility number: 000562 Provider number: 155718 AIM number: 100267150 Census bed type: 67 SNF/NF: 67 Total: 67 Census Payor type: Medicare: 16 Medicaid: 44 Other: 7 Total: 67 Sample: 10 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1	F 0000	This Plan of Correction constitutes the written allegation of compliance for deficiencies cited However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly The Plan of Correction is submitted to meet requirements established by state and federal law This facility respectfully requests a paper compliance review for these tags	
F 0156	483.10(b)(5) - (10), 483.10(b)(1)			

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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SS=D Bldg. 00	NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting			

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NAME OF PROVIDER OR SUPPLIER COMMUNITY NORTHVIEW CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1235 W CROSS ST ANDERSON, IN 46011	

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	personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous			

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	payments covered by such benefits. Based on interview and record review, the facility failed to ensure that a Medicare beneficiary received the Notice of Medicare Non-Coverage for skilled care services no later than two days before termination of Medicare services for 1 of 1 Medicare beneficiaries reviewed with termination of Medicare services in a sample of 10. (Resident #5005) Findings include: The clinical record for Resident #5005 was reviewed on 7/17/2015 at 9:00 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, atrial fibrillation, and hypertension. The Notice of Medicare Non-Coverage in the clinical record indicated that the skilled care services for Resident #5005 would end 7/17/2015. The Notice of Medicare Non-Coverage indicated the resident received and signed the notice on 7/16/2015. During an interview on 7/17/2015 at 10:25 a.m., the Social Service Consultant, indicated Resident #5005 had received the Medicare Notice of Non-Coverage for skilled care services	F 0156	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:The plan for Resident 5005 was to return home on 7/18/15 The error was in not having the notice of non-coverage signed two days prior to his last day of coverage. This did not affect the resident' discharge date and he returned home on 7/18/15 as planned. HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTION WILL BE TAKEN: All resident being covered by Medicare A or B could be affected All residents covered under Medicare A or B will receive the notice of non-coverage at least two (2) days prior to non-coverage by the Social Service Director. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: A log has been developed by the Social Service Director to assist in tracking the discharge dates This log will be utilized as notices are received regarding the discharges of all Medicare A or B residents. HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE	08/14/2015

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	less than two days before termination of Medicare services. 3.1-4(f)(2)		DEFICIENT PRACTICE WILL NOT RECUR, IE, WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: The tracking log will be brought to the weekly Medicare meeting to update. In addition, the results of the log will be discussed during the monthly QA meetings. This will continue until 100% compliance is achieved to assure no further issues. After 100% compliance is achieved for three (3) months, the QA committee will make a recommendation regarding continuance of the log.	
F 0278 SS=D Bldg. 00	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. 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			

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	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. Clinical disagreement does not constitute a material and false statement.			
	Based on interview and record review, the facility failed to ensure that the Minimum Data Set assessment was accurate related to pressure ulcer, antipsychotic medication, and urinary tract infection assessments for 2 of 7 residents reviewed for pressure ulcers, for 1 of 3 residents reviewed for antipsychotic medication, and for 2 of 3 residents reviewed for urinary tract infection in a sample of 10. (Residents #5001, 5003, 5004, and 5010). Findings include: 1. The clinical record for Resident #5003 was reviewed on 7/16/2015 at 1:00 p.m. Diagnoses included, but were not limited to, multiple sclerosis, anxiety, and major depressive disorder. The quarterly Minimum Data Set (MDS) assessment, with reference date 5/8/2015, indicated Resident #5003 did not receive an antipsychotic medication in the assessment reference period between 5/2 and 5/8/2015. The medication	F 0278	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: 1 Resident 5003 received the medication as ordered by the physician and suffered no ill effects. 2 Resident 5004 was admitted to the facility with a pressure ulcer The coding on the MDS has been corrected The pressure ulcer is healing Resident 5004 also was positive for a UTI that was not coded correctly The UTI was treated and has been resolved 3 Resident 5010 has never had a pressure ulcer The admission assessment was incorrect The MDS was correct on the 14 day but incorrect on the 5 day assessment due to the original incorrect admission note 4 Resident 5001 did not have a diagnosis of a UTI. The MDS was coded incorrectly. HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTION WILL BE TAKEN: 1. All residents in the	08/14/2015

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	administration record indicated the resident received Abilify (antipsychotic medication) daily between 5/2 and 5/8/2015. During an interview on 7/16/2015 at 4:35 p.m., MDS Coordinator indicated the quarterly MDS assessment, with reference date 5/8/2015, for Resident #5003 was not coded accurately. 2. The clinical record for Resident #5004 was reviewed on 7/16/2015 at 10:00 a.m. Diagnoses included, but were not limited to, anemia, diabetes mellitus, myasthenia gravis and cerebral vascular accident with hemiplegia. The Prospective Payment System (PPS) 14 day Minimum Data Set (MDS) assessment, with reference date 7/9/2015, indicated Resident #5004 did not have a Stage 1 or greater pressure ulcer in the MDS section for determination of pressure ulcer risk. The clinical record indicated the resident had one unstageable pressure ulcer. During an interview on 7/16/2015 at 12:28 p.m., LPN #4, indicated the PPS 14 day MDS assessment, with reference date 7/9/2015, for Resident #5004 was not coded accurately.		facility could be affected. The MDS Coordinator is receiving additional training regarding the accuracy of the MDS and will assure that the MDS is coded correctly. She will be checking the actual MAR against the records to assure accuracy 2. All residents in the facility could be affected. The MDS Coordinator will check the new orders on a daily basis to assure that she has accurate information She will also attend the Huddles we have every morning. 3. All residents could be affected. The nurses were in-serviced prior to this survey on documentation regarding skin issues. The MDS Coordinator has been instructed to check all information against the actual chart and the patient. 4. All residents could be affected. The MDS Coordinator has been instructed to check any and all diagnosis against the chart to assure they are valid diagnosis. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: 1 An audit tool has been developed to assist in assuring the accuracy of the MDS. The MDS Coordinator is also attending the morning huddles as well as going over the physician's orders daily. The audit tool will be used weekly on at least four (4) random charts to assure	

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	The Prospective Payment System (PPS) 14 day Minimum Data Set (MDS) assessment for Resident 2004, with reference date 7/9/2015, was not coded for a urinary tract infection. The clinical record indicated that the resident had a significant laboratory finding on 7/9/2015, a physician diagnosis of urinary tract infection, and signs and symptoms attributed to an urinary tract infection. The resident was treated for the urinary tract infection with an antibiotic. During an interview on 7/16/2015 at 4:00 p.m., the MDS Coordinator, indicated the PPS 14 day MDS assessment, with reference date 7/9/2015, for Resident #5004 was not coded accurately. 3. The clinical record for Resident #5010 was reviewed on 7/16/2015 at 3:00 p.m. Diagnoses included, but were not limited to, arthritis, anemia, left hip replacement, and chronic pain. The admission and Prospective Payment System (PPS) 5 day Minimum Data Set (MDS) assessment, with reference date 6/7/2015, indicated Resident #5010 had two Stage 2 pressure ulcers on admission. The admission nursing assessment, dated 6/1/2015, indicated the resident had no pressure ulcers.		accuracy 2 An audit tool has been developed to assist in assuring the accuracy of the MDS. The MDS Coordinator is also attending the morning huddles as well as going over the physician's orders daily. The audit tool will be used weekly on at least four (4) random charts to assure accuracy 3. An audit tool has been developed to assist in assuring the accuracy of the MDS. The MDS Coordinator is also attending the morning huddles as well as going over the physician's orders daily. The audit tool will be used weekly on at least four (4) random charts to assure accuracy 4. An audit tool has been developed to assist in assuring the accuracy of the MDS. The MDS Coordinator is also attending the morning huddles as well as going over the physician's orders daily. The audit tool will be used weekly on at least four (4) random charts to assure accuracy HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, IE, WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: 1 The results of the audit tool will be discussed during the monthly QA meetings. Once 100% accuracy has been achieved for	

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	During an interview on 7/16/2015 at 5:15 p.m., the MDS Coordinator indicated that the admission nursing assessment, dated 6/1/2015, would have been used to code the admission and Prospective Payment System (PPS) 5 day Minimum Data Set (MDS) assessment, with reference date 6/7/2015. The MDS Coordinator indicated the admission and Prospective Payment System (PPS) 5 day Minimum Data Set (MDS) assessment, with reference date 6/7/2015, for Resident #5010 was not coded accurately.. 4. The clinical record for Resident #5001 was reviewed on 7/17/15 at 9:15 a.m. Diagnoses included, but were not limited to, diabetes, anemia, heart failure, and depression. The quarterly Minimum Data Set (MDS) assessment, with reference date 5/22/15, indicated that the resident had a urinary tract infection (UTI) within the past 30 days. The clinical record indicated that, within the past 30 days prior to 5/22/2015, Resident #5001 did not have a significant laboratory finding for urinary tract infection, a physician diagnosis of urinary tract infection, or signs and symptoms attributed to urinary tract infection. The resident had not been treated for a urinary tract infection in the past 30 days.		three (3) months, the QA committee will make a determination regarding continuance. 2. The results of the audit tool will be discussed during the monthly QA meetings. Once 100% accuracy has been achieved for three (3) months, the QA committee will make a determination regarding continuance. 3. The results of the audit tool will be discussed during the monthly QA meetings. Once 100% accuracy has been achieved for three (3) months, the QA committee will make a determination regarding continuance. 4 The results of the audit tool will be discussed during the monthly QA meetings. Once 100% accuracy has been achieved for three (3) months, the QA committee will make a determination regarding continuance.	

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	During an Interview on 7/17/15 at 10:30 a.m., LPN #6 indicated that the clinical record of Resident #5001 was not coded accurately. This Federal tag relates to Complaint IN00177984. 3.1-31(i)			