

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155830	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/25/2016
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NAME OF PROVIDER OR SUPPLIER HARRISON'S CROSSING HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 395 8TH AVENUE TERRE HAUTE, IN 47804
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey dates: May 18, 19, 20, 23, 24, and 25, 2016</p> <p>Facility number: 013335 Provider number: 155830 AIM number: 201290670</p> <p>Census bed type: SNF: 46 SNF/NF: 8 Residential: 19 Total: 73</p> <p>Census by payor source: Medicare: 34 Medicaid: 8 Other: 12 Total: 54</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed 5/26/16 by 29479.</p>	F 0000	<p>Preparation or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged, or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and executed solely because it is required by Federal and State law. This plan of correction is submitted in order to respond to the allegations of noncompliance cited during a recertification/licensure survey review concluding on May 26, 2016. Please accept this plan of correction as the provider's credible aggregation of compliance effective on or before June 10, 2016.</p>	
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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 0272 SS=D Bldg. 00	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and 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 record review and interview, the facility failed to ensure a</p>	F 0272	F 272 Resident #24 suffered no ill effects from the alleged deficient	06/10/2016

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	<p>comprehensive nutritional assessment was completed on 1 of 4 residents reviewed for nutritional assessments (Resident #24). Finding includes: The clinical record for Resident #24 was reviewed on 5/23/16 at 9:45 a.m. Resident #24 was admitted to the facility on 3/27/16. The most recent Minimum Data Set (MDS) was completed on 4/24/16 and indicated the resident required supervision, oversight, encouragement or cueing, and one person assistance with eating. The record did not indicate a comprehensive dietary assessment had been completed. During an interview on 5/23/16 at 10:22 a.m., the Director of Health Services (DHS) indicated Resident #24 did not have a nutritional assessment done. On 5/23/16 at 1:18 p.m., the RN (Registered Nurse) Clinical Campus Support indicated the RD (Registered Dietitian) should have assessed the resident upon admission or within 14 days of admission and should have done a comprehensive nutritional assessment. During an interview with the RD (Registered Dietician) on 5/24/16 at 11:18 a.m., she indicated she missed completing a comprehensive nutritional risk assessment for Resident #24. A policy and procedure titled, "Nutrition Assessment Best Practice Guideline" was</p>		<p>practice. Resident #24 had a comprehensive assessment completed per the RD on June 7, 2016. All residents have the potential to be affected by the deficient practice and through alterations in processes and in servicing the campus will ensure that the campus will complete a nutritional assessment on or before day 14 for each Resident. An audit has been completed to assure all assessments have been completed in the campus with current residents. Completion Date: June 10, 2016 RD has been in serviced on the facility policy concerning completing nutritional assessments for each resident on or before 14 days residing in the campus. Systemic change is MDS coordinator will monitor when completing admission assessments to assure nutritional assessments completed as per policy. Completion Date: June 10, 2016 ED/designee to audit three random resident's admission nutritional assessments to assure completed timely 5x a week for a month then 3x a week for a month then weekly with results forwarded to QA committee monthly x6 months and quarterly thereafter for review and further suggestions/comments Completion Date: June 10, 2016</p>	

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F 0278 SS=D Bldg. 00	<p>received from the RN Clinical Campus Support on 5/23/16 at 1:19 p.m. and was identified as current. The policy indicated, "Guideline: ...A comprehensive nutrition assessment is completed within 14 days of admission then annually...."</p> <p>3.1-31(c)(5)</p> <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>			

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	<p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the accuracy of the functional status used for coding range of motion for 1 of 1 resident reviewed for accurate Minimum Data Set (MDS) assessment. (Resident #49).</p> <p>Finding includes:</p> <p>On 5/18/16 at 2:48 p.m., Resident #49 was observed to be lying in bed with rolled washed cloths in her bilateral hands.</p> <p>During a stage 1 interview on 5/18/16 at 3:38 p.m., LPN #1 indicated Resident #49 had contracted bilateral hands, legs, and feet.</p> <p>The clinical record was reviewed on 5/23/16 at 3:03 p.m. Diagnoses included but were not limited to, hereditary and idiopathic neuropathy and Alzheimer's disease. Resident #49's Annual Minimum Data Set (MDS), dated 3/31/16, Section G (G0400) titled, "Functional Limitation in Range of Motion," indicated a code 0 (no impairment) for upper extremity and a code 0 (no impairment) for lower extremity.</p>	F 0278	<p>F 278Resident 48 suffered no ill effects from the alleged deficiency. A ROM assessment has been completed on this resident. Completion Date: June 10, 2016 All residents have the potential to be affected by the deficient practice and through alterations in processes and in servicing will ensure each resident's Minimum data Set (MDS) assessment accurately reflects the residents ROM status. All resident's have had their ROM assessed for accuracy. Completion Date: June 10, 2016 MDS nurses have been in serviced on coding the section G0400. Systemic change is the MDS nurse will utilize a current ROM assessment for coding the MDS. Completion Date: June 10, 2016 DHS/designee will review 2 random residents MDS to assure accuracy 5x a week for a month then 3x a week for a month then weekly with results forwarded to QA committee monthly x6 months and quarterly thereafter for review and further suggestions/comments Completion Date: June 10, 2016</p>	06/10/2016

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F 0465 SS=D	<p>On 5/23/16 at 3:36 p.m., Director of Health Services (DHS) indicated Resident # 49 had bilateral upper and lower extremity contractures. She further indicated the annual MDS assessment had not been coded correctly for the resident's range of motion.</p> <p>The CMS RAI Version 3.0 Manual, G0400: "Functional Limitation in Range of Motion" coding instructions for G0400A, Upper Extremity; G0400B, Lower Extremity indicated, "Code 0, no impairment: if resident has full functional range of motion on the right and left side of upper/lower extremities." Code 1, impairment on one side: if resident has an upper and/or lower extremity impairment on one side that interferes with daily functioning or places the resident at risk of injury." Code 2, impairment on both sides: if resident has an upper and/or lower extremity impairment on both sides that interferes with daily functioning or places the resident at risk of injury...."</p> <p>3.1-31(d)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR</p>			

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Bldg. 00	<p>TABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the restorative dining room was functional and comfortable for 1 of 2 observed dining rooms.</p> <p>Finding includes:</p> <p>On 5/24/16 at 1:00 p.m., during an environmental tour with the Director of Plant Operations and the Corporate Director of Plant Operations, the following issues were observed in the restorative dining area:</p> <p>a. East wall: Black scuffed marks above the baseboard and across the middle of the wall with 3 dime-sized chipped areas with exposed drywall, and 2 deep gouged areas on the left of the wall socket.</p> <p>b. North wall: 4 unsanded plastered areas with several paint chipped areas of varied sizes extending the length of the mid portion of the wall and a marred area to the top left of the wall socket with exposed drywall.</p> <p>c. West wall: A black scuffed area extending from the corner to the mid-point of the wall.</p>	F 0465	<p>All areas mentioned on the 2567 have been resolved. Completion Date: June 10, 2016 All residents have the potential to be affected by the alleged deficient practice and through alterations in processes and in servicing will ensure the campus provides a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. Completion Date: June 10, 2016 DPO has been in serviced on preventative maintenance rounds and documentation Systemic change is Home office DPO support will round monthly in the campus to assure preventative maintenance and rounding completed. Completion Date: June 10, 2016 ED/designee will complete environmental rounds to ensure dining rooms are functional and comfortable 5x a week for a month then 3x a week for a month then weekly with results forwarded to QA committee monthly x6 months and quarterly thereafter for review and further suggestions/comments Completion Date: June 10, 2016</p>	06/10/2016

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	<p>d. South wall: A scuffed area extending the length of the mid wall with a quarter-sized gouge at the mid-point of the scuff area.</p> <p>On 5/24/16 at 1:10 p.m., the Corporate Director of Plant Operations indicated he was aware of the condition of the restorative dining area. He indicated the facility had a preventative maintenance program designed to find and repair such conditions.</p> <p>A copy of the "Preventative Maintenance Master Calendar," dated 1/1/08, provided by the Corporate Director of Plant Operations on 5/24/16 at 1:14 p.m., indicated the dining rooms were scheduled for preventative maintenance checks monthly.</p> <p>A policy titled, "Preventative Maintenance Procedures," dated 1/1/08, provided by the Corporate Director of Plant Operations on 5/24/16 at 1:14 p.m., indicated, "Policy: Preventative maintenance is a systemic process aimed at prolonging the life expectancy of the campus...It is imperative that scheduled maintenance be followed...Procedures: 1. An annual maintenance calendar is provided...that lists each task to be performed...3. To assist...the Plant</p>			

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R 0000 Bldg. 00	<p>Operations Director...we have provided several check lists...These check lists are broken down into daily, monthly...inspections...."</p> <p>3.1-19(f)</p> <p>This visit was for a State Residential Licensure Survey.</p> <p>Residential Census: 19 Sample: 07</p> <p>Harrison's Crossing Health Campus was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Survey.</p>	R 0000	Preparation or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged, or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and executed solely because it is required by Federal and State law. This plan of correction is submitted in order to respond to the allegations of noncompliance cited during a recertification/licensure survey review concluding on May 26, 2016. Please accept this plan of correction as the provider's credible aggregation of compliance effective on or before June 10, 2016.	