

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155506	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/22/2013
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00128517 and IN00125330.</p> <p>Complaint IN00128517-Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00125330 - Substantiated. Federal deficiencies related to the allegation are cited at F323.</p> <p>Survey dates: May 15, 16, 17, 20, 21 & 22, 2013</p> <p>Facility number: 001201 Provider number: 155506 AIM number: 100380860</p> <p>Survey team: Julie Baumgartner, RN-TC Shauna Carlson, RN Shelly Vice, RN</p> <p>Census bed type: SNF:28 SNF/NF:86 Total: 114</p> <p>Census payor type:</p>	F000000		

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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	<p>Medicare 22 Medicaid 54 Other 38 Total 114</p> <p>These deficiencies reflect state finding cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed on May 28, 2013, by Brenda Meredith, R.N.</p>			

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F000156 SS=C	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>The facility must furnish a written description of legal rights which includes:</p>			

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	<p>A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>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.</p> <p>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.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>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,</p>			

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	<p>and how to receive refunds for previous payments covered by such benefits. Based on observation and interview, the facility failed to ensure the ombudsman's name and phone number was correctly posted for 2 of the 6 survey days, 5/15/13 and 5/16/13. This had the potential to affect 114 of 114 residents.</p> <p>Finding includes:</p> <p>On May 15, 2013 at 11 A.M., the posted ombudsman's name and phone number was observed to be incorrect.</p> <p>On May 15, 2013 at 11:42 A.M., the ombudsman indicated that the facility was informed on two occasions that the posted ombudsman's name and phone number was incorrect.</p> <p>On May 16, 2013 at 9:15 A.M., the posted ombudsman's name and phone number was observed to be incorrect.</p> <p>On May 16, 2013 at 10:25 A.M., interview of one of the resident council presidents indicated that she did not know who the ombudsman was or how to contact him if needed.</p> <p>3.1-4(j)(3)(C)</p>	F000156	<p>F-156. What corrective action will be accomplished for those residents found to be affected by the deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. The postings were corrected May 17, 2013. and a meeting with Resident Council was held on June 4, 2013 providing them with the information of Ombudsman and where the postings are located. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Monthly Audits of postings to be completed by Administrator or designee. How the corrective action will be monitored to ensure the deficient practice does not recur; what quality assurance program will be put into place. The monthly audits will be reported the Mission Driven Quality Improvement Committee monthly by the Administrator/Designee until 3 months of 100% compliance. The Committee will then determine need for further monitoring. Date of Compliance June 7, 2013</p>	06/07/2013

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F000323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and staff interview, the facility failed to initiate neurological assessments after an unwitnessed fall for one of one resident record reviewed. (Resident B)</p> <p>Finding includes:</p> <p>On 5-20-13 at 10:00 A.M., record review of a nursing note in Resident B's chart dated 2-12-13 indicated "...The resident stated to this nurse that he fell in his room this am [A.M.]. The fall was unwitnessed and he did not report it at the time. He stated that he did not think anyone would answer the light. He c/o [complained of] left hip and leg pain. Upon assessment there was no apparent bruising as of yet. He said the pain was tolerable. When this nurse went back in 15 minutes later, he stated that he had no pain at all. Family was notified. MD [Medical Doctor] was notified. He recommended that we keep him under observation for now and watch for any possible complication r/t</p>	F000323	<p>It is the intent of Sanctuary at Holy Cross to ensure that the resident environment remains as free of accidents hazards as possible; and each resident receives adequate supervision and assistance device devices to prevent accidents.</p> <p>F323-What corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident B no longer resides at the Facility. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. An audit of residents with falls identifying if neurological assessment had been completed post fall as indicated per policy. Residents that were found to be affected by this deficient practice had neurological assessment completed with physician and responsible representative notification.</p> <p>What measures will be put into place or what systemic change will be made to ensure that the deficient practice does not recur. Policy was reviewed and found to be sufficient. License staff re-education for</p>	06/07/2013

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	<p>[related to] fall...."</p> <p>On 5-20-13 at 10:15 A.M. record review for neurological assessments were not observed in the Resident B's chart.</p> <p>On 5-20-13 at 11:30 A.M., interview with DON (Director of Nursing) indicated neurological assessments are to be initiated for any unwitnessed fall or self report of a fall.</p> <p>On 5-20-13 at 1:37 P.M., interview with DON indicated that neurological assessments are done on a "Neurological Assessment" form and scanned into the computer when completed.</p> <p>On 5-20-13 at 1:50 P.M., record review of form titled "Neurological Assessment" indicated "when" to use as "Completed when Resident hits head. unwitnessed fall and/or per physician order."</p> <p>On 5-20-13 at 2 P.M., interview with DON indicated no neurological assessments were done for Resident B at any time during his admission starting 1-28-2013.</p> <p>This federal tag relates to Complaint #IN00125330.</p>		<p>neurological assessment to be completed for falls, unwitnessed or witnessed with the potential for head injury; also any injury to the head or signs of injury to the head. Education was completed June 7, 2013.</p> <p>How will the corrective action will be monitored to ensure the deficient practice will not recur: what quality measure program will be put into place. Director of Nursing/ designee will complete weekly audits of 3 or 100% if less than 3 in a week, of unplanned occurrence reports that have the potential of head injury for completion of neurological assessment. Audits will be reported to Mission Driven Quality Improvement Committee monthly until 3 consecutive months of 100% compliance. The Committee will determine need for further auditing. Date of compliance June 7, 2013</p>	

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	3.1-45(a)(2)			