

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155715	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/13/2015
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NAME OF PROVIDER OR SUPPLIER LUTHERAN COMMUNITY HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00179220.</p> <p>Complaint IN00179220 - Substantiated. Federal/State deficiencies related to the allegation are cited at F278 and F356.</p> <p>Survey dates: August 12 and 13, 2015</p> <p>Facility number: 000347 Provider number: 155715 AIM number: 100275440</p> <p>Census bed type: 107 SNF/NF: 107 Total: 107</p> <p>Census payor type: 107 Medicare: 14 Medicaid: 60 Other: 33 Total: 107</p> <p>Sample: 10</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1</p>	F 0000	Submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirements under state and federal law. Please accept this plan of correction as our credible allegation of compliance.	

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. Based on interview and record review, the facility failed to ensure that the</p>	F 0278	F 278 Assessment Accuracy/Coordination/Certified	08/28/2015

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	<p>Minimum Data Set assessment was accurate related to skin problems and skin and ulcer treatment for 3 of 10 residents reviewed for skin problems and skin and ulcer treatment in a sample of 10. (Residents #8001, #8003 and #8008)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #8001 was reviewed on 8/12/2015 at 10:00 a.m. Diagnoses included, but were not limited to, anemia, diabetes mellitus, and dementia.</p> <p>The admission Minimum Data Set (MDS) assessment, with a reference date of 6/12/2015, was coded for turning and repositioning program and not coded for moisture associated skin damage (MASD). The clinical record did not indicate that the resident had a specific turning and repositioning program. The Skin Condition report, dated 6/10/2015, indicated that the resident had MASD.</p> <p>During an interview on 8/13/2015 at 10:25 a.m., the MDS Coordinator, indicated that the facility did not have a specific turning and repositioning program for skin and pressure ulcer treatment and that the facility did not have a policy and procedure for a turning and repositioning program. The MDS</p>		<p>It is the policy of this facility that the assessment accurately reflect the resident's status. Corrective Action for Resident Affected: The OBRA assessments of Resident #8003 was corrected by following these steps. 1. Created a corrected record with all items included, not just the items in error. 2. Completed the required Correction Request Section X items and included them with the corrected record. Item A 0050 had a value of 2, indicating a modification request. 3. Performed a new Significant Correction to Prior Assessment and updated the care plans as necessary. Residents #8001 and #8008 have a more current assessment in progress or completed that includes a correction to the items in error. Therefore, a significant correction to prior assessment was not necessary. Other Residents Having the Potential To Be Affected: All residents with skin problems and skin and ulcer treatments have the potential to be affected. An audit was performed on the last MDS of residents with skin problems and skin and ulcer treatments. The audit was performed to ensure that the coding was accurate on all Section M questions. (Attachment titled Audit For MDS Coding of Skin Conditions). An audit was also completed on all current in-house residents for the proper coding of turning and</p>				

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	<p>Coordinator indicated that the admission MDS assessment, with a reference date of 6/12/2015, for Resident #8001 was not coded accurately.</p> <p>2. The clinical record for Resident #8003 was reviewed on 8/12/2015 at 12:10 p.m. Diagnoses included, but were not limited to, anemia, cerebral vascular accident, and depression.</p> <p>The quarterly Minimum Data Set (MDS) assessment, with a reference date of 6/29/2015, was coded for application of a non-surgical dressing. The clinical record did not indicate that Resident #8003 had an application of a non-surgical dressing.</p> <p>During an interview on 8/12/2015 at 3:40 p.m., the MDS Coordinator, indicated that the quarterly MDS assessment, with a reference date of 6/29/2015, for Resident #8003 was not coded accurately.</p> <p>3. The clinical record for Resident #8008 was reviewed on 8/12/2015 at 2:45 p.m. Diagnoses included, but were not limited to, hip fracture with surgical repair, Parkinson's disease, and hypertension.</p> <p>The admission / Prospective Payment</p>		<p>repositioning. (Attachment titled Audit For Coding of Turning and Repositioning Program). Changes were made following the above outlined steps to correct the assessment and the care plans were updated as necessary. Systemic Changes and Steps To Assure Deficient Practice Does Not Recur: All nurses who complete or participate in the completion of the MDS were re-educated on the gathering of information and supporting documentation of Section M. The nurses read Section M of the RAI manual and signed off on their understanding of the material. (Attachment titled MDS 3.0 Section M Education August 2015). Monitoring of Corrective Action: 25% of all MDS assessments completed weekly will be audited to ensure Section M responses are accurate. (Attachment titled Weekly MDS Section M Audit). Audit results will be reviewed by the Quality Assurance Performance Improvement committee monthly for six months. If at 100% accuracy, weekly audits will stop and 25% will be completed monthly. If opportunities for improvement are identified through the random audit, weekly audits will resume. If after six months of random audits with 100% compliance continues, auditing will stop.</p>				

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	<p>System (PPS) 5 day Minimum Data Set (MDS) assessment, with a reference date of 6/22/2015, was not coded for surgical wound care. The Treatment Administration Record (TAR) for the month of June, 2015 indicated that Resident #8008 had a surgical dressing applied from 6/16/2015 through 6/21/2015.</p> <p>During an interview on 8/12/2015 at 5:45 p.m., the MDS Coordinator, indicated that the admission / Prospective Payment System (PPS) 5 day Minimum Data Set (MDS) assessment, with a reference date of 6/22/2015, for Resident #8008 was not coded accurately.</p> <p>This Federal tag relates to Complaint IN00179220.</p> <p>3.1-31(i)</p>			

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F 0356 SS=C Bldg. 00	<p>483.30(e) POSTED NURSE STAFFING INFORMATION</p> <p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation, record review, and interview, the facility failed to ensure that the nurse staffing data with the total number of hours and the actual hours worked for licensed and unlicensed staff was posted in a prominent place readily</p>	F 0356	F 356 Posted Nurse Staffing Information It is the policy of this facility to post the total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for	08/28/2015			

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	<p>accessible to residents and visitors.</p> <p>Findings include:</p> <p>On 8/12/2015 at 9:30 a.m., the daily staffing sheet with the total number of hours and the actual hours worked for licensed and unlicensed staff was not posted at the entrance to the main building of the facility.</p> <p>On 8/12/2015 at 10:15 a.m., the daily staffing sheet with the total number of hours and the actual hours worked for licensed and unlicensed staff was not posted at the entrance to the Forest Path building annex to the facility.</p> <p>Review of the daily staffing sheets on 8/12/2015 at 10:45 a.m. indicated that the nurse staffing data did not include the total number of hours and the actual hours worked for the entire facility.</p> <p>On 8/12/2015 at 10:15 a.m., interview with Licensed Practical Nurse (LPN) #11 indicated that the daily staffing sheet for the Forest Path annex only indicated the daily staffing information for the annex and that the daily staffing sheet was kept in the medication room at the annex. The LPN indicated that the medication room was kept locked except for when staff were present.</p>		<p>resident care per shift: Registered Nurses, Licensed Practical Nurses, and Certified Nursing Assistants. Corrective Action: Nurse Staffing information was available at all nursing units but not at the main entrance. A form was developed that would show all of the individual nursing unit information and then combine all hours for the total hours. (Attachment titled Daily Staffing Report). This form is completed daily and is at the front entrance of the main building and at the main entrance to Forest Path, the small house on the LCH campus. Other Residents Having The Potential To Be Affected: All residents, visitors, and families have the potential to be affected. The information is now available to any one who enters the buildings. Systemic Changes and Steps To Assure Deficient Practice Does Not Recur: It is the responsibility of the Nurse Scheduler to complete the projected staffing numbers at the beginning of the day and then to update the form the next business day with any changes. Once complete, the forms are forwarded to the Administrator for review. Monitoring of Corrective Action: The Administrator will review each daily form. If items are incomplete they will be returned to the Scheduler for adjustment. The Administrator will also round to ensure that the forms are available at each</p>		

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