

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155691	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/27/2015
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00180215.</p> <p>Complaint IN00180215 - Substantiated. Federal/State deficiencies related to the allegation are cited at F278 and F356.</p> <p>Survey dates: August 26 and 27, 2015</p> <p>Facility number: 000422 Provider number: 155691 AIM number: 100291030</p> <p>Census bed type: 101 SNF/NF: 101 Total: 101</p> <p>Census payor type: 101 Medicare: 16 Medicaid: 62 Other: 23 Total: 101</p> <p>Sample: 10</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	<p>Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. The plan of correction is prepared and executed solely because it is required by Federal and State Law. The plan of correction is submitted in order to respond to the allegation of non-compliance during the surveyprocess.</p> <p>Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</p>	
F 0278	483.20(g) - (j)			

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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SS=D Bldg. 00	<p>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 urinary tract infection for 1 of 5 residents reviewed for urinary tract infection, falls for 2 of 10 residents reviewed for falls, type of assessment after readmission to the facility for 1 of 4 residents reviewed for readmission to the</p>	F 0278	An in-service was provided to the MDS Coordinators on 9/2/15 to review MDS coding guidelines in the areas of fall coding, medication use coding, UTI diagnosis coding, and on coding properly whether the assessment is the first assessment since the most recent admission/entry or reentry. The in-service included a post test. (see attachment C for	09/02/2015

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	<p>facility, and antipsychotic medications for 1 of 6 residents reviewed for antipsychotic medications in a sample of 10. (Residents #1040, #1070, and #1090)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #1040 was reviewed on 8/26/2015 at 5:00 p.m. Diagnoses included, but were not limited to, dementia, diabetes mellitus, and Parkinson's disease.</p> <p>The significant change and Prospective Payment System (PPS) 5 day Minimum Data Set (MDS) assessment, with a reference date of 8/2/2015, for Resident #1040 indicated that the resident was readmitted to the facility on 7/27/2015. The MDS assessment was coded "no" in response to the question as to whether or not the MDS assessment was the first assessment since the most recent admission/entry or reentry to the facility. The fall history sections that indicate whether or not the resident had a fall within the last month and within the past 2-6 months and whether or not the resident had a fracture related to a fall in the 6 months prior to admission were not coded. The clinical record indicated that the resident had a fall on 6/29/2015.</p> <p>During an interview on 8/27/2015 at</p>		<p>In-service and post tests) The MDS staff will also be attending a webinar within the next three weeks through Myers and Stauffer regarding supportive documentation requirements and RUG IV 48 Grouper. The DON or Designee will audit 3 MDS assessments each week for 4 weeks then will audit 5 per month for the following 5 months. (see attachment D for audit tool). Any areas of concerns will be addressed via the Quality Assurance team.</p>	

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	<p>11:00 a.m., MDS Coordinator #1, indicated that the significant change and PPS 5 day MDS assessment, with a reference date of 8/2/2015, for Resident #1040 was not coded accurately for type of assessment and falls.</p> <p>2. The clinical record for Resident #1070 was reviewed on 8/26/2015 at 2:00 p.m. Diagnoses included, but were not limited to, anemia, hypertension, and atrial fibrillation. The PPS 14 day MDS assessment, with a reference date of 8/14/2015, indicated that the resident's cognition was not impaired.</p> <p>The admission and Prospective Payment System (PPS) 5 day Minimum Data Set (MDS) assessment, with a reference date of 8/7/2015, for Resident #1070 indicated that the resident had a urinary tract infection (UTI) and a fall within the past 2-6 months. The PPS 14 day MDS assessment, with a reference date of 8/14/2015, for Resident #1070 indicated that the resident had a UTI. The clinical record did not indicate a significant laboratory finding for a UTI. The clinical record did not indicate that the resident had a fall within the past 2-6 months.</p> <p>During an interview on 8/26/2015 at 4:00 p.m., Resident #1070 indicated that, prior to their fall on 7/28/2015, the last fall that</p>				

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	<p>they had was about a year ago.</p> <p>During an interview on 8/27/2015 at 10:30 a.m., MDS Coordinator #2, indicated that the clinical record for Resident #1070 did not validate that the resident had a fall within the past 2-6 months or a significant laboratory finding for a UTI. The MDS Coordinator indicated that the admission and PPS 5 day MDS assessment, with a reference date of 8/7/2015, and the PPS 14 day MDS assessment, with a reference date of 8/14/2015, for Resident #1070 were not coded accurately .</p> <p>3. The clinical record for Resident #1090 was reviewed on 8/26/2015 at 3:15 p.m. Diagnoses included, but were not limited to, dementia and psychotic disorder.</p> <p>The significant change and Prospective Payment System (PPS) 5 day Minimum Data Set (MDS) assessment, with a reference date of 8/13/2015, for Resident #1090 indicated that the resident received antipsychotic medications 3 days during the assessment reference period of 8/7/2015 through 8/13/2015. The August 2015 medication administration record (MAR) indicated that the resident received Seroquel (antipsychotic medication) 2.5 milligrams 2 days during</p>			

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F 0356 SS=C Bldg. 00	<p>the assessment reference period of 8/7/2015 through 8/13/2015.</p> <p>During an interview on 8/27/2015 at 9:45 a.m., MDS Coordinator #1, indicated that the significant change and PPS 5 day MDS assessment, with a reference date of 8/13/2015, for Resident #1090 was not coded accurately for antipsychotic medications.</p> <p>This Federal tag relates to Complaint IN00180215.</p> <p>3.1-31(i)</p> <p>483.30(e) POSTED NURSE STAFFING INFORMATION 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</p>			

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	<p>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 information was posted in a prominent place readily accessible to residents and visitors; indicated the total and actual number of hours worked for licensed and unlicensed nursing staff for the entire facility; and included the total and actual number of hours worked for registered nurses, licensed practical nurses, and certified nurse aides.</p> <p>Findings include:</p> <p>Observation on 8/26/2015 at 9:20 a.m., indicated that the daily Report of Nursing Direct Care Staff was not posted at either entrance to the facility.</p> <p>The daily Report of Nursing Direct Care Staff did not indicate the total and actual number of hours worked for licensed and unlicensed staff for the entire facility.</p>	F 0356	<p>Effective September 1st, the nursing hours report has been modified to reflect RN vs LPN hours worked, in addition to hours worked for the long and short term care areas (attachment B) At the time of the survey, hours were being posted at the nurses' stations in a location that we felt was readily accessible to our residents and visitors, however, based upon the information provided by the surveyors, we have moved this information nearer to the entrance, Information was provided to staff members responsible for completing the form (attachment A) As part of the facility Quality Improvement program, the DON or designee will audit the staff posting 3 times weekly for 4 weeks and then weekly for 6 months, Any concerns will be discussed by the QI team,</p>	09/01/2015

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	<p>The daily nurse staffing information indicated data for only one unit.</p> <p>The daily Report of Nursing Direct Care Staff did not indicate the total and actual number of hours worked for registered nurses, licensed practical nurses, and certified nurse aides.</p> <p>During an interview on 8/27/2015 at 1:55 p.m., the Administrator and the Director of Nursing (DON), indicated that the daily Report of Nursing Direct Care Staff was posted on each unit and only indicated the nurse staffing information for each unit, not for the entire facility. The Administrator and DON indicated that the report did not indicate the total and actual number of hours worked for registered nurses, licensed practical nurses and certified nurse aides.</p> <p>This Federal tag relates to Complaint IN00180215.</p>				