

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155775	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/28/2014
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NAME OF PROVIDER OR SUPPLIER  CUMBERLAND POINTE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1051 CUMBERLAND AVE WEST LAFAYETTE, IN 47906
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00152231.</p> <p>This visit included a State Residential Licensure survey.</p> <p>Complaint IN00152231 unsubstantiated, due to lack of evidence.</p> <p>Survey dates: July 21, 22, 23, 24, 25 and 28, 2014.</p> <p>Facility number: 000547 Provider number: 155775 AIM number: 100267440</p> <p>Survey Team: Rita Mullen, RN, TC Bobette Messman, RN Maria Pantaleo, RN Holly Duckworth, RN</p> <p>Census bed type: Medicare: 12 Medicaid: 22 Other: 94 Total: 128</p> <p>Census payor type: SNF: 33</p>	F000000	<p>Survey Event ID: UHIB11The submission of this POC does not indicate an admission by Cumberland Pointe Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Cumberland Pointe Health Campus. This facility recognized it's obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities (for Title 18/19 programs). To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</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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F000278 SS=D	<p>SNF/NF: 28 Residential: 67 Total: 128</p> <p>Residential sample: 7</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review was completed by Tammy Alley RN on August 1, 2014.</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>			

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	<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 record review, and interview, the facility failed to correctly identify and accurately assess the residents status regarding Hospice for 1 out of 4 residents reviewed for Hospice. (Resident # 27)</p> <p>Findings include:</p> <p>1. The Clinical record for Resident # 27 was reviewed on 7/21/2014 at 9:45 a.m. Diagnoses included but were not limited to left total knee replacement, hypertension, anxiety, acid reflux, chronic confusion, severe dementia, end-stage dementia with anticipated weight loss, Alzheimer's disease, osteopenia, osteoarthritis, diverticulosis, headaches, vitamin B12 deficiency, bilateral cataract removal, muscle weakness, difficulty in walking, contracture of lower leg joint, abnormal posture.</p> <p>A Physician's order, dated 3/7/2014,</p>	F000278	<p>CORRECTIVE ACTION: A corrected MDS assessment was completed for resident #27 on 7-22-14 to modify and accurately reflect that the resident was receiving hospice services and the physician's order of a prognosis of less than six months. IDENTIFY OTHER RESIDENTS: A review of 100% of the MDS assessments for all health center residents was completed to ensure those receiving hospice services were correctly assessed. Three residents were correctly assessed as receiving hospice services but not assessed for the physician order of a prognosis of less than six months. A corrected MDS assessment was completed on 8-12-14 for each of those three residents to modify and accurately reflect the physician's order of a prognosis of less than six months.</p> <p>MEASURES/SYSTEMIC CHANGES: A new policy was</p>	08/27/2014

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	<p>indicated, admission to Hospice on 3/7/2014 with diagnosis of Alzheimer's disease and "...resident has life expectancy of six months or less if the terminal illness runs its normal course...."</p> <p>A significant change Minimum Data Set Assessment (MDS), dated 3/17/2014, indicated Resident #27 was on hospice and did not have a prognosis of less than six months.</p> <p>A quarterly assessment MDS, dated 4/20/2014, indicated Resident #27 was not on Hospice and did not have a prognosis of less than six months</p> <p>A quarterly assessment MDS, dated 7/7/2014, indicated Resident #27 was on Hospice and did not have a prognosis of less than six months.</p> <p>During an interview with the Executive Director and MDS coordinator on 7/21/2014 at 11:30 a.m., regarding the hospice status of Residents # 27, they indicated that hospice was indicated on the MDS and Residents # 27 did not have a prognosis of less than six months on the MDS.</p> <p>During interview with MDS coordinator on 7/24/2014 at 10:30 a.m., regarding the Hospice status of Resident # 27, she</p>		<p>written for hospice services that requires the nurse who is obtaining the order to admit to hospice to also request the order for the prognosis of less than six months. The MDS nurse will then accurately identify and assess the resident's status related to hospice services and the prognosis of less than six months. This policy was reviewed with the nursing managers on 8-12-14. An in-service will be completed for health center nurses to review the policy and ensure understanding of the need for the prognosis order related to admission to hospice services. MONITORING CORRECTIVE ACTION: The nursing unit manager or designee will review all physician orders for admission to hospice to ensure the nurse has obtained the physician order for prognosis of less than six months. The review results will be reported monthly to the QA committee for six months to ensure compliance with the policy. The MDS assessments will be audited by the DHS or designee monthly for six months for all residents on hospice services to ensure the MDS accurately reflects the hospice services and the physician order for prognosis of less than six months. These audits will be reported monthly to the QA committee for six months to ensure compliance.</p>		

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F000279 SS=D	<p>indicated that Hospice was not indicated on the MDS quarterly review for 4/20/2014 and Resident # 27 did not have a prognosis of less than six months. She indicated this was an oversight and mistake.</p> <p>3.1-31(c)(6)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p>			

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	<p>Based on record review and interview, the facility failed to ensure a care plan was updated related to reflect the death of a residents spouse and the deceased spouses prior participation in the residents care for 1 of 31 residents reviewed for care plans. (Resident # 12)</p> <p>Findings include:</p> <p>The clinical record for Resident #12 was reviewed on 7/23/2014 at 10:30 a.m. The resident's diagnoses included, but were not limited to, chronic airway obstruction, muscle weakness, closed fracture of patella, abdominal pain, difficulty in walking, abnormality of gait, restless leg syndrome, hypotension, constipation, right foot drop, polio, depression, Vitamin B 12 deficiency, history of shingles, leukocytosis, chronic obstructive pulmonary disease, COPD (chronic obstructive pulmonary disease) exacerbation.</p> <p>A care plan, titled " Activities of Interest", dated 2/13/2014 indicated the following:</p> <p>"I am independent in deciding what I am to do but I rely on my husband (name of husband) to transport me to and from throughout the building...Please evaluate my interest by 5/13/14."</p>	F000279	<p>CORRECTIVE ACTION: The care plan for resident #12 was updated on 7-24-14 to reflect the death of the resident's spouse and to alter care plan interventions to remove all reference to the spouse's participation in care. IDENTIFY OTHER RESIDENTS: The care plans for all health center residents were reviewed to ensure that the care plan was updated and correct if the resident had experienced a loss of a spouse or family member. No other residents were identified as being affected by this deficient practice. MEASURES/SYSTEMIC CHANGES: A new policy was developed related to promptly updating the resident's care plan if a staff member becomes aware of the loss of a resident's spouse or family member who participates in the plan of care. The charge nurse for the resident will record that information on the 24-hour report sheet, which is reviewed by the care plan team daily Monday through Friday. The care plan team will update the resident's care plan that day to reflect the change in the resident's plan of care. Staff nurses on the health center will be in-serviced regarding the new policy for reporting of knowledge of resident loss of a spouse or family member. MONITOR CORRECTIVE ACTION: A</p>	08/27/2014			

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	<p>A care plan titled "Cognition," dated 6/2/2014, indicated the following:</p> <p>"I enjoy visiting with my husband (who resides with me) as well as others off the unit."</p> <p>A care plan titled "Moods and Behaviors", dated 6/2/2014, indicated the following:</p> <p>" I enjoy spending a great deal of time in my apartment with my husband. CPHC (Cumberland Pointe Health Campus) is now our home."</p> <p>During an interview with the Unit Manager #2 on 7/23/2014 at 10:30 a.m., she indicated Resident # 12's spouse passed away on 5/5/2014.</p> <p>During an interview with the Activities Director on 7/24/2014 at 4:24 p.m., she indicated the care plan was not updated.</p> <p>During an interview with the Social Services Director on 7/24/2014 at 10:45 a.m., she indicated the care plan was not updated and it was just an oversight.</p> <p>3.1-35(a)</p>		<p>monthly audit of 10% of health center resident care plans will be completed for six months by the Social Service department or designee to ensure care plans have been timely and accurately updated after the loss of a spouse or family member who participated in the plan of care. The results of the audit will be reported monthly to the QA committee for six months.</p>	

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F000465 SS=E	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE 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 and interview, the facility failed to ensure a sanitary and home like environment related to 7 of 31 observed resident rooms (Room #'s 103, 104, 107, 108, 111, 112, and 114) and 1 of 2 resident spas. This deficient practice impacted 14 of 14 residents utilizing resident rooms and 37 of 38 residents utilizing resident spas.</p> <p>Findings include:</p> <p>1. During stage one observations, on 7/21/14 between 10:30 a.m. and 11:30 a.m., the following were observed:</p> <p>Room 103: room door was marred and gouged. 18 pushpin holes in a 12 inch x 12 inch area were noted on the bedroom</p>	F000465	<p>CORRECTIVE ACTION: The area of a brown, smeared substance on the spa floor in front of the linen hamper was immediately cleaned on 7-24-14 when the surveyor brought it to the attention of the staff. All door frames for doors in 103, 104, 107, 108, 111, 112, and 114 were painted on 8-7-14. Repairs are being completed to the mars and gouges noted on the walls and doors in those rooms as well as repair to baseboards and furniture noted in 112. IDENTIFY OTHER RESIDENTS: The surveyors reviewed all the doors in the health center as well as spa rooms during the survey and no others were identified. An audit is being completed of all health center rooms to ensure no other doors, walls or baseboards are in need of repair. If any are noted</p>	08/27/2014

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	<p>wall. The bathroom door and door frame were chipped and marred.</p> <p>Room 104: The bathroom door was chipped, marred, and gouged. The bathroom door frame was chipped and marred. The bedroom door had a piece of wood (1 inch x 0.5 inch) chipped off of the top right corner. The bottom right edge of the bedroom door was gouged.</p> <p>Room 107: The bathroom door frame had multiple paint chips on lower right side.</p> <p>Room 108: The bedroom door had a deep, 2 inch gouge, 1/3 of way up from bottom.</p> <p>Room 111: The bathroom door had gouges on the bottom and right side of the door. The bathroom door frame was chipped in multiple areas on the lower half.</p> <p>Room 112: The bedroom door had gouges on the inner edge. Wall edges were marred. The bathroom door edge and interior were marred. The bathroom door frame was gouged and chipped throughout the lower half. The bathroom wall was gouged and scraped along bottom with drywall pieces protruding due to the depth of the gouge. Paint was observed cracking and peeling away the</p>		<p>they will be repaired by the correction date.</p> <p>MEASURES/SYSTEMIC CHANGES: A staff inspection form is being created for the spa room that will require staff who enter the room to note by signature that they have inspected the floor before leaving to ensure the floor is clean. Staff in nursing and environmental services will be in-serviced on the use of this inspection form. A daily rounding form was created for the nursing unit managers and it includes inspecting the spa room to ensure it is clean. The rounding form also requires the nursing unit manager to note any doors or door frames that are in need of repair. If any are noted the manager will create a maintenance work order for repair. A monthly rounding form is being created for the plant operations team to conduct audits of the health center rooms to ensure there are no mars or gouges on the doors, door frames or walls in those rooms. If any are noted a word order will be created and repairs completed.</p> <p>MONITOR CORRECTIVE ACTION: The nursing unit manager or designee will audit the inspection forms in the spa room daily Monday through Friday. The results of the audits will be reported to the QA committee monthly for six months. The DHS or designee</p>	

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	<p>from wall above the bathroom sink. Resident furniture, dresser and bed footboard, were marred.</p> <p>Room 114: A base board along an interior wall was loose and coming away from the wall. Gouges were observed on the bathroom door and bedroom door along the sides. The bathroom door frame was chipped in multiple areas on the lower half.</p> <p>During the environmental tour with the Director of Plant Operations (DPO) and Executive Director (ED) on 7/24/2014 at 10:05 a.m., the DPO indicated rooms were checked and repaired every six months as well as when there was a change of resident. The ED indicated the repairs needed to be completed.</p> <p>2. During an observation of the resident Spa Room in the Comprehensive Unit, on 7/24/14 at 10:00 a.m., an area of a brown, smeared substance on the floor was noted in front of the linen hamper.</p> <p>During an interview with CNA #1, on 7/24/14 at 10:10 a.m., it was indicated the staff should leave the room looking like they were never there.</p> <p>3.1-19(f)</p>		<p>will review all daily rounding forms and ensure corrective action was taken if any concerns were noted. Results of these audits will be reported to the QA committee monthly for six months. The ED will audit the monthly plant operations rounding forms for completion and follow-up. Results of these audits will be reported to the QA committee monthly for six months.</p>	