

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155665	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/03/2014
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NAME OF PROVIDER OR SUPPLIER JENNINGS HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN 47265
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F000000	<p>This visit was for the Investigation of Complaints IN00156847 and IN00154497.</p> <p>Complaint IN00156847 - Substantiated. Federal/state deficiencies related to the allegations are cited at F157 and F202.</p> <p>Complaint IN00154497 - Unsubstantiated due to lack of evidence.</p> <p>Survey dates: October 2 and October 3, 2014</p> <p>Facility number: 010996 Provider number: 155665 AIM number: 200232210</p> <p>Survey team: Jennifer Carr, RN - TC</p> <p>Census bed type: SNF/NF: 108 Total: 108</p> <p>Census payor type: Medicare: 5 Medicaid: 95 Other: 8 Total: 108</p> <p>Sample: 3</p>	F000000	<p>Preparation and/or execution of this plan of correction in general, or this correction action in particular, does not constitute an admission or agreement by Jennings Healthcare Center of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal law. Jennings HealthCare respectfully requests desk review r/t the most serious deficiencies to be isolated deficiency with no actual harm. We allege compliance on 10/27/14</p>	

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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F000157 SS=D	<p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed on October 10, 2014, by Brenda Meredith, R.N.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or</p>						

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	<p>roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to inform the resident or legal representative of transfer and discharge from the facility for 1 of 3 residents reviewed for notification of change (Resident B).</p> <p>Findings include:</p> <p>Resident B's record was reviewed on 10/3/2014 at 11:00 a.m. Diagnoses included, but were not limited to, history of alcoholism and senile dementia with aggression. Resident B's granddaughter was documented to be his Power of Attorney [POA].</p> <p>The Minimum Data Set (MDS) assessment, dated 8/25/2014, indicated a Brief Interview for Mental Status (BIMS) score of 4 of 10; indicating Resident B was moderately cognitively impaired. Functional status indicated Resident B was independently ambulatory.</p> <p>A Daily Skilled Nurse's Note, dated 8/25/2014 at 11:30 p.m., indicated, "[At]</p>	F000157	F157 1. The identified resident has been discharged from the facility. 2. All Residents have the potential to be affected by this citation. DCS or designee audited all discharges for the last 90 days for proper notification of legal representative. 3. The Administrator in serviced DCS and or designee of citation F157 notification of change on 10-22-14. 4. DCS and or designee will audit all discharges for proper notification of legal representative daily in clinical for 1 month, weekly x 3 months and then monthly x 4 months. The findings will be brought to monthly Quality Assurance Performance Improvement Committee meetings. 5. Date of Compliance: 10/27/14.	10/27/2014

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	<p>the beginning of the shift another res. [resident] pulled one of the nurses aside and expressed fear of [Resident B], she stated he threatened to kill everyone if that was what it would take....[Resident B] stepped toward this nurse with clinched fist. The other nurse said we were instructed to call 911 in cases like this. Police came [and] interviewed staff [and Resident B]. Because res. had intimidated staff [and] other res., he was...taken into custody....ADON [Assistant Director of Nursing], DON [Director of Nursing] and Administrator were notified."</p> <p>The following Daily Skilled Nurse's Note, dated 8/29/2014 at 8:00 a.m., indicated, "[Resident B] DC'd [discharged] from facility into police custody on 8/25/14. Released into comm. [community] @ [at] midnight on 8/29/14 - [no] further action required by facility. RDCS [Regional Director of Clinical Services] and adm. [Administrator] made aware of release @ [at] time of release."</p> <p>On 10/3/2014 at 12:10 p.m. the Administrator indicated, "Late one evening [8/25/2014] they [staff] called me...he was being belligerent with the staff, so we called the police and the</p>			

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	<p>police came and took him to jail. He was discharged from the facility."</p> <p>On 10/3/2014 at 12:12 p.m., the Director of Nursing (DON) indicated, "I would say in the scuffle of things, it [physician's order] just didn't get put down [documented]....I don't think they [family/POA] were [notified]....He [Resident B] wanted to go back to jail."</p> <p>On 10/3/2014 at 12: 30 p.m., the Administrator indicated that there was no documentation of a Physician's Order for transfer and/or discharge from the facility or that Resident B's family/POA was notified following his arrest on 8/25/2014. She stated, "They [staff] should have wrote [sic] an order and notified the family."</p> <p>Resident B's daughter was interviewed via phone on 10/3/2014 at 1:11 p.m. She indicated that her daughter was Resident B's POA. She indicated that the facility "didn't notify anyone" of her father's arrest and subsequent discharge from the facility. She indicated, "He was arrested at 10:58 p.m. and they [jail] opened the</p>			

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	<p>door and let him out right before midnight less than 24 hours later...he was wandering the streets."</p> <p>RN #1 was interviewed on 10/3/2014 at 2:40 p.m. She indicated that she was present on the evening of 8/25/2014, stating, "You couldn't approach him [Resident B] because he looked like he was going to swing at one of us...The police were called and I was here when the officer came...We didn't know when [Resident B] left [for jail] what was going to happen. I was here 2 days later when we got a call from the jail. I was the one who answered....They were calling [LPN #1] as victim notification of his release...I know that the doctor was notified [the night of his arrest]. I heard them [staff] say that they notified the doctor. I know [DON] and [Administrator] were aware."</p> <p>On 10/3/2014 at 2:54 p.m. the Administrator indicated, "[DON] called me that night [8/29/2014] saying they had released [Resident B] from jail. We called [RDCS]. I was under the assumption that he was discharged and</p>			

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	<p>[RDGS] was too, so no, there was nothing to do. "</p> <p>A copy of the current Your Rights As A Nursing Home Resident was provided by the Administrator on 10/3/2014 at 9:00 a.m. Transfer and Discharge Rights included, but were not limited to, "You have a right to: Be notified in writing before you are to be transferred or discharged from the nursing home."</p> <p>A current copy of Discharge of Resident to Home or Other Facility was provided by the Administrator on 10/3/2014 at 12:59 p.m. The policy indicated, "When a resident is ready for discharge home, or to another facility, the nurse will oversee the completion of discharge documents."</p> <p>On 10/3/2014 at 2:32 p.m., the DON indicated that discharge documents, as indicated in the policy above, included Notice of Transfer or Discharge, Resident Transfer Form, and Discharge Instructions for Care. She further indicated that none of the discharge documentation was completed for Resident B.</p> <p>A copy of Resident B's Admission and Financial Agreement, dated 7/1/2014, indicated, "Facility Agrees To: ...Arrange for the transfer of the Resident to the</p>						

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F000202 SS=D	<p>hospital when ordered by the physician or as required in an emergency situation, and to notify the Resident's Responsible Party for such transfer."</p> <p>This Federal tag relates to Complaint IN00156847.</p> <p>3.1-5(a)(4) 3.1-5(b)(2)</p> <p>483.12(a)(3) DOCUMENTATION FOR TRANSFER/DISCHARGE OF RES When the facility transfers or discharges a resident under any of the circumstances specified in paragraph (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by the resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and a physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section. Based on record review and interview, the facility failed to ensure physician documentation for 1 resident's transfer and subsequent discharge from the facility for 1 of 3 residents reviewed for transfer/discharge (Resident B).</p>	F000202	F202 1. The identified resident has been discharged from the facility. 2. All Residents have the potential to be affected by this citation. DCS or designee audited all discharges for the last 90 days for proper physician documentation. 3. The Administrator in serviced DCS	10/27/2014

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	<p>Finding includes:</p> <p>Resident B's record was reviewed on 10/3/2014 at 11:00 a.m. Diagnoses included, but were not limited to, history of alcoholism and senile dementia with aggression. Resident B's granddaughter was documented to be his Power of Attorney [POA].</p> <p>The Minimum Data Set (MDS) assessment, dated 8/25/14, indicated a Brief Interview for Mental Status (BIMS) score of 4 of 10; indicating Resident B was moderately cognitively impaired. Functional status indicated Resident B was independently ambulatory.</p> <p>A Daily Skilled Nurse's Note, dated 8/25/14 at 11:30 p.m., indicated, "[At] the beginning of the shift another res. [resident] pulled one of the nurses aside and expressed fear of [Resident B], she stated he threatened to kill everyone if that was what it would take...[Resident B] stepped toward this nurse with clinched fist. The other nurse said we were instructed to call 911 in cases like this. Police came [and] interviewed staff [and Resident B]. Because res. had intimidated staff [and] other res., he was...taken into custody....ADON [Assistant Director of Nursing], DON [Director of Nursing] and Administrator</p>		<p>and or designee of citation F202 Documentation for discharge on 10-22-14. 4. DCS and or designee will audit all discharges for proper physician documentation daily in clinical for 1 month, weekly x 3 months and then monthly x 4 months. The findings will be brought to monthly Quality Assurance Performance Improvement Committee meetings. 5. Date of Compliance: 10/27/14.</p>	

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	<p>were notified."</p> <p>The following Daily Skilled Nurse's Note, dated 8/29/2014 at 8:00 a.m., indicated, "[Resident B] DC'd [discharged] from facility into police custody on 8/25/14. Released into comm. [community] @ [at] midnight on 8/29/14 - [no] further action required by facility. RDCS [Regional Director of Clinical Services] and adm. [Administrator] made aware of release @ [at] time of release."</p> <p>On 10/3/2014 at 12:10 p.m. the Administrator indicated, "Late one evening [8/25/2014] they [staff] called me...he was being belligerent with the staff, so we called the police and the police came and took him to jail. He was discharged from the facility."</p> <p>On 10/3/2014 at 12:12 p.m., the Director of Nursing (DON) indicated, "I would say in the scuffle of things, it [physician's order] just didn't get put down [documented]...I don't think they [family/POA] were [notified]....He [Resident B] wanted to go back to jail."</p> <p>On 10/3/2014 at 12:30 p.m., the</p>			

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	<p>Administrator indicated that there was no documentation of a Physician's Order for transfer and/or discharge from the facility or that Resident B's family/POA was notified following his arrest on 8/25/2014. She stated, "They [staff] should have wrote [sic] an order and notified the family."</p> <p>RN #1 was interviewed on 10/3/2014 at 2:40 p.m. She indicated that she was present on the evening of 8/25/2014, stating, "You couldn't approach him [Resident B] because he looked like he was going to swing at one of us....The police were called and I was here when the officer came...We didn't know when [Resident B] left [for jail] what was going to happen. I was here 2 days later when we got a call from jail. I was the one who answered....They were calling [LPN #1] as victim notification of his release....I know that the doctor was notified [the night of his arrest]. I heard them [staff] say that they notified the doctor. I know [DON] and [Administrator] were aware."</p> <p>On 10/3/2014 at 2:54 p.m., the</p>			

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	<p>Administrator indicated, "[DON] called me that night [8/29/2014] saying they had released [Resident B] from jail. We called [RDCS]. I was under the assumption that he was discharged and [RDCS] was too, so no, there was nothing to do."</p> <p>There was no documentation completed by the physician to indicate the resident had been discharged because other residents may be endangered.</p> <p>This Federal tag related to Complaint IN00156847.</p> <p>3.1-12(a)(5)</p>				