STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 00 B. WING	09/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM CROSSING	200 CONNIE AVE SALEM, IN 47167

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00239712. Complaint IN00239712 - Substantiated. Federal/State deficiencies are cited at F309 and F323. Survey dates: September 13 and 14, 2017 Facility number: 000223 Provider number: 155330 AIM number: 100267680 Census Bed Type: SNF/NF: 81 Total: 81 Census Payor Type: Medicare: 13 Medicaid: 57 Other: 11 Total: 81 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 18, 2017.	F 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review.	
F 0309 SS=G	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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Bldg. 00	HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on interview and record review, the facility failed to administer pain	F 0309	It is the practice of this provider to provide care/services for highest well-being in accordance with	09/28/2017

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	medication to a resident (Resident B) after a fall with complaints of severe pain. This resulted in the resident yelling and moaning out in pain during movement for 1 of 4 residents reviewed for pain control. Findings include: The clinical record for Resident B was reviewed on 9/13/17 at 11:15 a.m. Diagnoses included, but were not limited to, dementia, anxiety, and a history of falls. The initial MDS (Minimum Data Set) assessment, dated 8/16/17, indicated a BIMS (Brief Interview of Mental Status) score of 01 which signified severely impaired cognition. The nurse's note, dated 8/25/17 at 6:34 p.m., indicated the resident was found sitting on the floor in the hallway with no significant injury found. The nurse's note, dated 8/26/17 at 11:13 a.m., indicated the resident had extreme pain to the left hip and left upper leg. A new order was obtained from the physician for an x-ray. The nurse's note, dated 8/26/17 at 12:45 p.m., included, but was not limited to, the following: "Resident noted with extreme pain to left hip and leg upon attempting		State and Federal law. 1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice? Resident B no longer resides in the facility. 2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. All residents will be reviewed to ensure pain relief is being met by September 28, 2017. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The DNS/designee will conduct in-service with nursing staff on Pain Management policy (See Attachment A) by September 28, 2017. 4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place? The DNS/designee will be responsible for the completion of Pain Management QA tool (See Attachment B) weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these	

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	to self ambulate. Staff assisted resident back...sitting position with resident yelling out in pain. Staff assisted resident to lay down abed to rest. Resident restless attempting to self ambulate. Staff assisted times two into recliner in common area. Resident continues to moan. MD [medical doctor] updated on resident's continuing pain...send resident to [name of hospital]...." The incident report, dated 8/27/17 at 3:40 p.m., indicated the resident was admitted to the hospital with an intertrochanteric fracture (hip fracture) of the proximal left femur. The August 2017 medication administration record indicated the resident received Norco (pain medication) 5-325 milligrams at 8:00 a.m., prior to the onset of extreme pain. The August 2017 medication administration record indicated the resident had a physician order, dated 8/10/17, for Tramadol (pain medication) 50 milligrams every 8 hours as needed for pain, which was last given on 8/25/17 at 10:12 p.m. During an interview on 9/13/17 at 4:24 p.m., LPN (Licensed Practical Nurse) 3 indicated pain medication was not given		audits will be reviewed by the CQI committee overseen by the ED. If threshold of 90% is not achieved, an action plan will be developed.	

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	due to the resident not having pain when he was not being moved. The clinical record lacked documentation of the administration of any as needed pain medication when the resident complained of extreme pain at 11:13 a.m. on 8/26/17 and was not transferred to the hospital until 12:45 p.m. This Federal tag relates to Complaint IN00239712 3.1-37(a)			
F 0323 SS=D Bldg. 00	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.			

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	(1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. Based on observation, interview, and record review, the facility failed to ensure a resident (Resident C) residing on a secured unit did not exit the facility, unsupervised, for 1 of 4 residents reviewed for accidents. Findings include: The clinical record for Resident C was reviewed on 9/13/17 at 11:40 a.m. Diagnosis included, but was not limited to, dementia. The admission MDS (Minimum Data Set) assessment, dated 5/25/17, indicated a BIMS (Brief Interview of Mental Status) score of 10 which signified moderately impaired cognition. The care plan, dated 5/1917, indicated the resident was at risk for elopement and would remain safely in the facility through the next review.	F 0323	It is the practice of this provider to provide care/services for highest well-being in accordance with State and Federal law. 1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice? Resident C is safe on the secured unit. New elopement risk assessment completed. Wanderguard is in place. Windows have been secured. 2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. All residents will be reviewed by IDT for elopement risk with all interventions in place by September 28, 2017. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?	09/28/2017

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	The nurse's note, dated 8/25/17 at 12:31 a.m., indicated the resident continued to stand around at the nurse's station asking to "get out of here" and stating "I don't belong here". The nurse's note, dated 9/2/17 at 1:01 a.m., indicated the resident had been in and out of his room multiple times with no sleep. The nurse's note, dated 9/1/17 at 4:18 a.m., indicated CNA (Certified Nursing Assistant) 6 reported to the nurse, during bed check, the resident was not in his room. Upon entering the resident's room, the window was seen to have been manipulated and was open with the nightstand moved over by the window. The resident was last seen at 4:05 a.m. in the common area. The resident was located outside the facility and returned. The resident stated "I wanted to go home". The behavior event report, dated 9/1/17 at 7:00 a.m., indicated at 4:18 a.m. on 9/1/17, the resident had broken the lock off the window, climbed out, and that he was last seen at 4:05 a.m. The incident report, dated 9/1/17 at 4:18 a.m., indicated the resident was found		The DNS/designee will in-service all staff on Elopement policy (See Attachment C) by September 28, 2017. 4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place? The DNS/designee will be responsible for the completion of Elopement Risk QA tool (See Attachment D) weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed.	

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	approximately 0.3 miles away from the facility sitting on apartment steps and brought back to the facility. During an interview on 9/13/17 at 3:40 p.m., LPN (Licensed Practical Nurse) 5 indicated CNA 6 went to the resident's room during a bed check and found the window open. "I got in my car, drove around and found him sitting on the apartment steps. He had a small skin tear to his hand and a mark on the back of his leg. Once we got back to the building he said, 'Well I almost made it'." On 9/14/17 at 2:30 p.m., the Administrator provided a current copy of the document titled "Elopement (Risk and Missing Resident)", dated 10/13. It included, but was not limited to, the following: "Policy: It is the policy of the facility that staff who have residents under their care are responsible for knowing the location of those residents...." This Federal tag relates to Complaint IN00239712 3.1-45(a)(1)			

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