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	07/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a MDS (Minimum Data Set) 3.0 Focus Survey. Survey Dates: July 20 and 21, 2016 Facility number: 000223 Provider number: 155330 AIM number: 100267680 Census bed type: SNF/NF 71 Total 71 Census payor type: Medicare 13 Medicaid 50 Other 8 Total 71 Sample: 12 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed by 34233 on July 28, 2016.	F 0000	Please find the enclosed plan of correction for the survey ending July 21, 2016. Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Due to the low scope and severity of the survey finding, please find sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance; feel free to contact me with any questions.	
F 0278 SS=D	483.20(g) - (j) ASSESSMENT			

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

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Bldg. 00	ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. 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. Clinical disagreement does not constitute a material and false statement. Based on record review and interview, the facility failed to ensure the Minimum Data Set assessments accurately reflected the residents falls for 2 of 12 residents reviewed. (Residents J and M) Findings include: 1. During the initial tour of the facility on 7/20/2016 from 9:20 a.m. to 9:45	F 0278	1. Resident#J, 6-18-16 MDS was modified to accurately reflect resident fall with injury on7-26-16. Resident #M, 6-23-16 MDS was modified to accurately reflect resident falls on 7-26-16. 2. All residents that have had falls have the potential to be affected by the same alleged deficient practice. RAI Specialist/designee will complete 100% audit of residents that have	08/12/2016

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	a.m., Resident J was identified by the Alzheimer Unit Director as having a recent fall and a fracture. The clinical record was reviewed on 7/20/2016 at 11:00 a.m. The Minimum Data Set (MDS) assessment, dated 6/18/2016, indicated the resident had one fall without injury in the reference period. Nursing progress notes, dated 5/3/2016 at 6:20 a.m., indicated the resident was found on the floor on her right side with a laceration on the back of her head. The resident was sent to the hospital and received three staples to close the laceration. Interview with the ADNS (Assistant Director of Nursing) on 7/21/2016 at 8:20 a.m., indicated the coding on the MDS was an error regarding falls and it should have indicated the resident had one fall with injury. 2. The clinical record for Resident M was reviewed on 7/21/16 at 9:35 a.m. The Quarterly MDS assessment, dated 6/23/16, indicated the resident had one fall without injury during the assessment period. Review of the clinical record indicated the resident had two falls. One had occurred on 6/9/2016. The nursing		had falls, to ensure proper MDS coding by 8-11-16. 3. An in-service will be completed by RAI Specialist with MDSC on 8-11-16 regarding accuracy of MDS coding. The MDS will be reviewed for accuracy during the weekly IDT care plan review utilizing the careplan review tool (See Attachment A) by the MDSC/designee. 4. The MDS Accuracy QA Audit Tool (See Attachment B) will be completed for six months with audits being completed once weekly for one month and monthly for five months by the MDSC/designee. The MDS Accuracy QA Audit Tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 100% threshold is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to andincluding termination of the responsible employee.	

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	progress note indicated the resident was found sitting on the mat beside his bed. The notes indicated there was no injury from the fall. Nursing progress notes, dated 6/20/2016, indicated the resident was found sitting on his knees beside the bed without injury. Interview with the ADNS at 11:20 a.m. on 7/21/2016, indicated the resident had two falls during the assessment period and the coding was incorrect on the MDS. 3.1-31(d)(3)			