STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155377	A. BUILDING 00 B. WING	02/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEYMOUR CROSSING	707 S JACKSON PARK DR SEYMOUR, IN 47274

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00216171, IN00218640, and IN00220670. Complaint IN00216171 - Substantiated. Federal/State deficiencies related to the allegation are cited at F323. Complaint IN00218640 - Substantiated. No deficiencies related to the allegation are cited. Complaint IN00220670 - Substantiated. Federal/State deficiencies related to the allegation are cited at F309. Survey dates: February 2, 3, and 7, 2017 Facility number: 000272 Provider number: 155377 AIM number: 100274710 Census bed type: SNF/NF: 87 Total: 87 Census payor type: Medicare: 6 Medicaid: 71 Other: 10 Total: 87	F 0000		

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

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	These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 8, 2017.			
F 0309 SS=G Bldg. 00	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR 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 (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,			

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	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 ensure a resident's pain medication was available for administration, after admission to the facility, for 1 of 3 residents reviewed for pain. This deficient practice caused harm in one resident (Resident E). (Resident E's) expressed pain with no relief for 12 hours. Findings include: The clinical record for Resident E was reviewed on 2/2/17 at 2:20 p.m. Diagnoses included, but were not limited to, chronic pancreatitis and spinal stenosis. The progress note, dated 1/24/17 at 4:15 p.m., indicated Resident E was admitted to the facility and physician orders were transcribed and sent to pharmacy. The admission observation report, dated 1/24/17 at 4:15 p.m., indicated Resident E was oriented to person, place and time. The resident expressed almost constant	F 0309	We request a face to face IDR due to disagree with scope and severity of tag 309 F 309 Provide Care/Services For Highest Well Being What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; 1 Resident E received PRN narcotic pain medication. Resident E has now discharged. 2 Review of EDK per DNS of contents inventory/dosages with updates completed. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: 1 All residents receiving PRN narcotic Pain medication have the potential to be affected. 2 Audit completed by DNS/Designee identifying all residents admitted to the facility within the last 60 days with PRN narcotic pain medication. Interviews were completed to ensure timely administration of PRN narcotic pain medication.	02/21/2017

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	pain located in the low back. The pain occurred morning, afternoon, evening, and night. She described the pain as penetrating, sharp, shooting, staffing, and throbbing. On a numeric scale the pain was a 9 out of 10, that being the worst. The 72 hour Admission Shift Charting, dated 1/24/17 at 6:47 p.m., indicated the resident complained of moderate to severe pain in the left leg, thigh, and groin area. The physician order, dated 1/24/17, indicated Resident E was to have hydromorphone (pain medication) 4 milligrams, every 4 hours as needed, for moderate pain and a Fentanyl patch (pain medication), 150 micrograms, every 72 hours. The progress note, dated 1/24/17 at 9:37 p.m., indicated the resident was grimacing, holding her left hip, and told the nurse she was in pain. The progress note, dated 1/24/17 at 10:55 p.m., indicated Resident E's daughter told the nurse that she needed her pain medication. The IDT (Interdisciplinary Team) Pain Interview, dated 1/25/17 at 12:53 p.m., indicated the resident had almost constant		3 In-service all nurses to notify DNS/Designee of a resident triggering for pain upon admission, in-service per DNS/Designee by 2/17/17. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; 1 Admitting nurse will complete a pain assessment on all residents admitted to the facility and notify DNS/Designee of a resident triggering for pain upon admission. 2 Admitting nurse will notify NP/MD if a back-up prescription is required. 3 DNS/Designee will review admitting orders and ensure medication has arrived and has been administered per physicians orders. 4 In-service to be completed by DNS/Designee by 2/17/17 on DNS/Designee notification of a resident triggering pain upon admission and NP notification for a narcotic prescription/CVS is back-up pharmacy. How the corrective action(s) will be	

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	severe, horrible pain in the last five days. The pain had made it hard for her to sleep and limited the day-to-day activity. On 2/3/17 at 11:20 a.m., the Unit Manager provided a copy of the narcotic delivery sheet which indicated Resident E's pain medications did not arrive to the facility, from pharmacy, until 4:33 a.m. on 1/25/17. The clinical record lacked documentation of any other pain assessments for Resident E, and the medication administration record for January 2017 indicated she did not receive any pain medication from the time of admission on 1/24/17 at 4:15 p.m. until 1/25/17 at 4:33 a.m. During a telephone interview on 2/2/17 at 11:56 a.m., Resident E indicated she did not receive any pain medication for over 12 hours, and, at about 1:30 a.m. on 1/25/17, she was crying because her pain was so bad. During an interview on 2/3/17 at 2:15 p.m., RN (Registered Nurse) 3 indicated Resident E was in pain around 12:30 a.m. on 1/25/17. This Federal tag relates to Complaint IN00220670		monitored to ensure the deficient practice will not recur; CQI Audit Tool for Residents with Pain at Admission will be completed weekly x 4 weeks, monthly x 6 months, and quarterly thereafter until compliance is achieved. Results of audit will be reviewed in monthly Quality Assurance meeting which is overseen by the ED. If a threshold of 100% is not achieved and action plan will be developed to ensure compliance. By what date the systemic changes will be completed; Completion date of 2/21/2017.	

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	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. (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 interview and record review, the facility failed to ensure a physician order was in place for a personal safety alarm for a resident (Resident C) for 1 of	F 0323	F 323 Free of Accident Hazards/Supervision/Devices	02/21/2017

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	3 residents reviewed for accidents. Findings include: The clinical record for Resident C was reviewed on 2/3/17 at 9:55 a.m. Diagnoses included, but were not limited to, hypertension and weakness. The record lacked documentation of a physician's order for the bed alarm at the time of the fall on 11/11/16 and lacked documentation of the resident's bed alarm sounding at the time of the fall on 11/25/16. The fall event, dated 11/11/16 at 9:45 p.m., indicated Resident C had gotten up out of bed and attempted to ambulate without assistance. In response the family requested placement of a personal safety alarm. The fall care plan for Resident C indicated, on 11/14/16, a pressure alarm was to be utilized. The progress IDT (Interdisciplinary Team) note, dated 11/15/16 at 9:39 a.m., indicated the resident had an unwitnessed fall on 11/11/16 at 9:45 p.m. and the resident stated he was getting up out of bed. The IDT note indicated the family wanted the resident to have a personal		What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident C has an order for a bed alarm and function and placement is checked per staff every shift and documented. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; 1 Audit completed per DNS/Designee identifying all residents with alarms. 2 All residents with alarms will have an order in place and documentation of function and placement every shift. 3 In-service for nursing staff per DNS/Designee on every shift documentation of alarm placement, and processing of orders. What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not recur; 1 Nursing In-service to be completed on 2/17/17 per DNS/Designee on documenting every shift on alarm placement and	

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	safety alarm and the physician was notified with a new order for the alarm. During an interview on 2/3/17 at 3:10 p.m., RN (Registered Nurse) 3 indicated, prior to the fall, on 11/11/17, the resident was in bed. In response to the fall the family wanted him to have a bed alarm. During an interview on 2/3/17 at 3:20 p.m., the Director of Nursing indicated she could not find an order for the bed alarm on 11/11/16, but knew he had one. The fall event, dated 11/25/16 at 10:24 a.m., indicated, prior to the fall, the resident was standing at the end of his bed with his hand on the foot board and the new intervention initiated was a bed alarm. The progress note, dated 11/25/16 at 10:36 a.m., indicated Resident E was standing at the end of the bed and he passed out, which resulted in several new skin tears. The note also indicated a new order was received for a bed alarm. The physician order, dated 11/25/16 and untimed, indicated the resident was to have a bed alarm and to check placement every shift. This Federal tag relates to Complaint		functioning and processing orders. 2 IDT will review that fall intervention orders have been written and processed. 3 IDT will check resident room that new fall interventions are in place. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: CQI Audit tool for fall/alarm orders and processing will be completed weekly x 4 weeks, monthly x 6 months and quarterly thereafter until compliance is achieved. Results of audit will be reviewed at monthly Quality Assurance meeting which is overseen by ED. If a threshold of 100% is not achieved an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; Completion date of 2/21/2017.	

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	IN00216171 3.1-45(a)(1)			