STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155230	A. BUILDING 00 B. WING	07/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEBUD VILLAGE	2050 CHESTER BLVD RICHMOND, IN 47374

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F 0000 Bldg. 00	This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN00233531 completed on July 10, 2017. This visit was in conjunction with a PSR to the Investigation of Complaint IN00226575, Complaint IN00227190, Complaint IN00230907 and Complaint IN00232339 completed on June 16, 2017. Complaint IN00233531 - Not corrected Complaint IN00226575-Correected Complaint IN00227190-Corrected Complaint IN00230907-Corrected Complaint IN00232339-Corrected Facility number: 000135 Provider number: 155230 AIM number: 100266820 Census Bed Type: SNF/NF: 89 SNF: 3 Total: 92 Census Payor Type:	F 0000		

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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	Medicare: 8 Medicaid: 60 Other: 24 Total: 92 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 1, 2017			
F 0278 SS=D Bldg. 00	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification			

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	(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) 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 (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. Based on interview and record review, the facility failed to ensure an admission Minimum Data Set (MDS) assessment was completed and submitted to CMS's (Centers for Medicare and Medicaid) Quality Improvement Evaluation System (QIES) in a timely manner for 1 of 3 residents reviewed for bathing and hygiene services. (Resident S) Findings include: The clinical record of Resident S was reviewed on 7-31-17 at 10:35 a.m. Her diagnoses included, but were not limited to atrial fibrillation, congestive heart failure, right shoulder pain and generalized muscle weakness. It indicated she was admitted on the secured memory care unit of the facility on 6-14-17.	F 0278	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Resident S MDS was completed on 7/31/17 and submitted to CMS. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents have the potential to be affected by the same deficient practice. Query report ran by RAI specialist on August 1, 2017 to find any other MDS's that are considered untimely—more than 14 days past the ARD date and were completed and submitted to CMS by August 11, 2017. **What measures will be put into**	08/11/2017

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	Review of the admission MDS, dated 6-21-17, indicated it was identified as "in process," and thus incomplete and not submitted to QIES. In review of this admission MDS, 12 of the 20 sections were incomplete and/or blank, specifically Sections G, GG, H, I, J, L, M, N, O, Q and V. Section G reflects activities of daily living, such as bathing and hygiene. In an interview with Traveling MDS Staff #1 on 7-31-17 at 2:07 p.m., she explained, "This facility has been without its own MDS staff for six months or more. When I come in here to do the MDS's, I do what I am told. I receive a list of what needs done and I do that. I'm not sure who creates that list. There are different means to call up various tasks that may need done. I have no idea how this resident's MDS would have been left not completed for over a month." She indicated she completed and submitted Resident S's admission MDS on 7-31-17. The Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.14, October 2016, was retrieved from the CMS website on 7-31-17. In Chapter 5.1 and 5.2, the manual states all Medicare or		**place or what systemic changes will be made to ensure that the deficient practice does not recur?** Education to all nursing staff on proper ADL coding and importance of running ADL report 30 minutes before the end of the shift to ensure charting is completed by August 11, 2017. RAI specialist/designee to inservice traveling MDSC and current MDSC, Dietary Manager, Social Services, Memory Care Facilitator, Activity Director and RSM on importance of timely MDS completion and submission. DNS/Designee will educate nursing on importance of ADL coding and running point of care compliance report one half hour before end of shift by end of shift August 11, 2017. RAI specialist to train new full time MDSC and educate on the importance of timely MDS submission by end of shift August 11, 2017. **How will the corrective actions be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** To ensure compliance, the DNS/designee is responsible for completion of the MDS QAPI tool weekly x 4 weeks, monthly x 6 months and then quarterly until continued compliance is maintained for the two consecutive quarters.	

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	Medicaid certified nursing homes must transmit required MDS data to CMS's QIES Assessment and Processing system in a timely manner. For an admission assessment, it specifies the MDS completion date must be no later than 13 days after the entry date. In Chapter 1.3, this manual explains the MDS is to include items that accurately reflect the resident's acuity level, including diagnoses and treatments, an evaluation of the resident's functional level from multiple sources, such as the resident, the resident's family, significant other or legal representative, direct care staff, physician and medical records. Chapter 1.3 continues its explanation of the purposes of the MDS assessments as primarily as an assessment tool to identify resident care problems that should be translated onto an individualized care plan. It also is used for skilled nursing facilities' Prospective Payment System, for many State Medicaid reimbursement systems and for monitoring of quality of care provision to nursing home residents. This deficiency was cited on 7-10-17. The facility failed to implement a systemic plan of correction to prevent reoccurrence. 3.1-31(a)		The results of these audits will be reviewed during monthly QAPI meeting, overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance and disciplinary action taken as needed. DNS/designee is responsible for completion of the ADL QAPI tool weekly x 4 weeks, monthly x 6 months and then quarterly until continued compliance is maintained for the two consecutive quarters. The results of these audits will be reviewed during monthly QAPI meeting, overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance and disciplinary action taken as needed.	

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