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	11/22/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 Recertification and State Licensure Survey. Survey dates: November 15, 18, 19, 20, 21, and 22, 2019 Facility number: 000272 Provider number: 155377 AIM number: 100274710 Census Bed Type: SNF/NF: 85 Total: 85 Census Payor Type: Medicare: 4 Medicaid: 67 Other: 14 Total: 85 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on November 26, 2019.	F 0000	This Plan of Correction constitutes the facility's written allegation of compliance for the deficiencies cited. The submission of this Plan of Correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report. We respectfully request a desk review with paper compliance. Please review the attachments provided with this plan of correction, which include audit and re-education tools. Please feel free to contact Jay Myers, Executive Director, should you need any additional information to support the desk review at 812-752-3499. Thank you for your consideration.	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.			

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 determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	Based on record review and interview, the facility failed to document complete neurological assessments after resident falls for 1 of 3 residents reviewed for accidents. (Resident 50) Findings include: The clinical record for Resident 50 was reviewed on 11/20/19 at 9:26 A.M. A Significant Change MDS (Minimum Data Set) assessment, dated 11/4/19, indicated the resident was cognitively intact. Diagnoses included, but were not limited to, seizure disorder, major depressive disorder, acute kidney injury, and acute respiratory distress. The resident was not steady, and only able to stabilize with staff assistance related to moving from a seated to standing position, walking, turning around, moving on and off the toilet, and surface to surface transfers. During an interview on 11/22/19 at 2:51 P.M., the DON (Director of Nursing) indicated if a resident had an unwitnessed fall or had hit their head during a fall, the neurological (neuro) checks should be initiated. The neuro checks are completed every 15 minutes times 1 hour, every 30 minutes times 2 hours, every 1 hour times 4 hours, and then every eight hours times 72 hours. A "Fall Event", dated 10/17/19, indicated the resident had an unwitnessed fall in his room. He was found by the bedside on his knees. The form indicated to initiate neuro checks if the resident hit his head or if fall was unwitnessed. A "Neurological Assessment", dated 10/17/19, indicated the resident's neuro checks were incomplete on 10/19/19. A "Fall Event", dated 10/21/19, indicated the	F 0689	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? There have been no other residents identified as being affected by alleged deficient practice **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the deficient practice. All nursing staff were in serviced on or before 12/3/2019 on completing Neurological Checks on those residents of which are required. Additionally, staff were in serviced on completion of Neurological Check Form. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** All nursing staff in serviced on completing Neurological Check forms on those residents requiring such checks with Department Manager to review checks daily for completion and accuracy. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** To ensure compliance, Random	12/04/2019

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	resident had an unwitnessed fall in the bathroom. The form indicated to initiate neuro checks if the resident hit his head or if fall was unwitnessed. A "Neurological Assessment",dated 10/21/19, indicated the resident's neuro checks were incomplete on following dates: 10/22/19, 10/23/19, and 10/24/19. The clinical record lacked documentation that the resident was out of the facility during the neuro checks assessments. During an interview on 11/22/19 at 4:08 P.M., the DON indicated the neuro checks should have been completed. The current facility policy titled "Fall Management Program" with a revision date of 11/2017, was provided by the DON on 11/22/19 at 4:16 P.M. The policy indicated, "...Post fall...Any resident experiencing a fall will be assessed immediately by the charge nurse for possible injuries and necessary treatment will be provided...A neurological assessment will be initiated on all un-witnessed falls...A neurological assessment will be initiated on all residents with a suspected head injury based upon the fall..." 3.1-45(a)(2) 3.1-37(a)		Audits of check sheets will be completed by the Director of Nursing or Designee 5x weekly for 30 days followed by 3x weekly for 60 days and then 2x weekly for 60 days and then 1x weekly for 30 days with results being forwarded to the Quality Assurance Committee for follow up and review. If audit results show less than ninety percent compliance over review period audits will continue along with individual re-education until such time compliance threshold is achieved. **Date of Compliance:** December 4, 2019	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the			

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	facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on record review and interview, the facility failed to document meal consumption for 1 of 1 residents reviewed for nutrition. (Resident 58) Findings include: The clinical record for Resident 58 was reviewed on 11/19/19 at 2:14 P.M. An Admission MDS (Minimum Data Set) assessment, dated 09/21/19, indicated the resident was moderately cognitively impaired. Diagnoses included, but were not limited to, anxiety, depression, borderline personality disorder, chronic pain, and spinal stenosis. A Care Plan titled "Nutritional Status" included, but was not limited to, an intervention to monitor food and fluid intake at meals with a start date of 09/06/19. The "Vitals Intake" record was provided by the Administrator on 11/21/19 at 4:23 P.M. The record lacked documentation for the following dates and meals:	F 0692	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** There have been no residents identified as being affected by alleged deficient practice **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the deficient practice. All nursing staff were in serviced on or before 12/3/2019 on completing food and fluid intakes within the Matrix System on those residents designated. **What measures will be put into place or what systemic changes you will make to ensure that the deficient**	12/04/2019

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	- 09/30/19 lunch and dinner - 10/05/19 lunch - 10/13/19 breakfast - 10/30/19 breakfast - 11/02/19 dinner - 11/03/19 lunch and dinner - 11/04/19 dinner - 11/05/19 lunch and dinner - 11/08/19 dinner - 11/13/19 lunch - 11/15/19 breakfast and lunch The clinical record/computer lacked documentation that the resident refused the meals or was out of the facility during the meals. During an interview on 11/22/19 at 1:36 P.M., CNA (Certified Nurse Aide) 3 indicated they would document meal intakes on the computer. They would document every meal and would document if the resident refused. During an interview on 11/22/19 at 3:45 P.M., the Administrator indicated that no policy could be provided related to monitoring meal intakes. 3.1-46(a)(1)		**practice does not recur?** All nursing staff in serviced on entering food and fluid intake within the Matrix System on those residents requiring such checks with Unit Manager to review checks daily for completion and accuracy. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** To ensure compliance, Random Audits of food and fluid intake will be completed by the Director of Nursing or Designee 5x weekly for 30 days followed by 3x weekly for 60 days and then 2x weekly for 60 days and then 1x weekly for 30 days with results being forwarded to the Quality Assurance Committee for follow up and review. If audit results show less than ninety percent compliance over review period audits will continue along with individual re-education until such time compliance threshold is achieved. **Date of Compliance:** December 4, 2019	