

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/11/2012
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NAME OF PROVIDER OR SUPPLIER LU ANN NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 952 W WALNUT ST NAPPANEE, IN 46550
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F0000	<p>This visit was for a Recertification and State Licensure survey.</p> <p>Survey dates: 9/5-9/11/12</p> <p>Facility number: 000317 Provider number: 155722 Aims number: 100274860</p> <p>Survey Team: Carol Miller, RN, TC Shelly Vice RN Diane Nilson RN (9/6, 9/7, 9/11/12) Julie Wagoner RN (9/10-9/11/2012)</p> <p>Census Bed Type: SNF/NF: 28 Total: 28</p> <p>Census Payor Type: Medicaid: 26 Other: 2 Total: 28</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 9/18/12 Cathy Emswiller RN</p>	F0000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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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F0205 SS=A	<p>483.12(b)(1)&(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR</p> <p>Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility, and the nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return.</p> <p>At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section.</p> <p>Based on record reviews and interview, the facility failed to ensure a Nursing Facility Bed Hold Policy was provided to 1 resident upon being transferred to the hospital. This deficiency affected 1 of 3 discharged residents' reviewed for Bed Hold Policy. (Resident #34).</p> <p>Findings include:</p> <p>The record of Resident #34 was reviewed on 9/11/12 at 9:15 a.m. Resident #34 was transferred to the hospital on 6/7/12.</p>	F0205	<p>F205 1. This facility has in place policies and procedures that ensure that at the time of trafer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specified the duration of the bed-hold policy. The facility failed to ensure a bed-hold policy was provided to a reident upon being transferred to the hospital.</p> <p>II. On 09/11/12 Department Heads were advised of the deficient practice of not ensurig a resident and a family member or legal representative were</p>	09/29/2012	

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	<p>The Bed Hold Policy for the resident was not found in the closed record.</p> <p>On 9/11/12 at 10:00 a.m., the undated 'Discharge Of The Resident policy' was received from the Director Nursing Services (DNS). The policy did not indicate any information in regard to the Bed Hold Policy when a resident transferred to the hospital.</p> <p>On 9/11/12 at 10:30 a.m., during an interview with the DNS in regard to the Bed Hold Policy upon transfer of the resident to the hospital, the DNS indicated LPN #26 was the nurse who had sent the resident out to the hospital. The DNS further indicated she had spoken to LPN #26 by phone and LPN #26 indicated she was unsure if she had filled out the Bed Hold Policy Form.</p> <p>3.1-12(a)(1)</p>		<p>provided written notice which specified the duration of the bed-hold policy. All nurses and QMAs were informed of this deficient practice at the monthly nurse's meeting on 09/20/12, and again at a nurses's meeting on 09/26/12. All nurses and QMAs have read the policy and procedure "Transfer/Discharge/Leave of Absence" by 09/29/12. III. The DON, MDS Coordinator, and/or the Social Service Designee will check charts of residents who have had an Emergency Room visit, a hospital admission, transfer to another facility, or discharge home to ensure that the Notice of Transfer or Discharge has been completed and a copy of the first page placed in the resident's chart. If no Notice of Transfer or Discharge has been completed or no copy made of the first page, the nuse in charge of that discharge or transfer will be counseled. This information has been added to the nurse's orientation sheet. IV. The DON, MDS Coordinator, and/or the Social Service Designee will check charts of residents who have had an Emergency Room visit, a hospital admission, transfer to another facility, or discharge home to ensure that the Notice of Transfer or Discharge has been completed and a copy of the first page placed in the resident's chart. If</p>		

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			no Notice of Transfer or Discharge has been completed or no copy made of the first page, the nuse in charge of that discharge or transfer will be counseled. This information has been added to the nurse's orientation sheet. Any negative findings will be discussed at the monthly nurse's meeting and the monthly QA meeting. V. DON/MDS Coordinator/Social Service Designee/staff nurses/QA F205 Addedum Any negative findings will be discussed at the monthly QA meeting indefinitely.		

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F0223 SS=D	<p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on interviews and record reviews, the facility failed to assure a Resident was not abused. This affected 1 of 3 sampled residents reviewed. (Resident #4)</p> <p>Findings include:</p> <p>On 9/7/12 at 9:23 a.m., an interview was conducted with Resident #4. She indicated a facility staff member, CNA #2, on the "...day shift yells at me to turn off my light ..." and that this had happened before with "...other aides ..." She indicated the situation had been discussed with the DNS at the time but couldn't remember the actual date. She indicated she had been treated roughly by staff. "... (name of CNA #1) is rough with me when she puts me to bed ..."</p> <p>On 9/7/12 at 10:00 a.m., a review of the alleged reports for abuse and neglect were completed. On 7/27/12 an incident occurred involving Resident #4. The incident involved rough treatment during the changing of Resident #4's disposable brief. In the report the Resident stated CNA #3 was "...mean to</p>	F0223	F223 I. The facility has in place policies and procedures that prohibit verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility failed to assure a resident was not abused. All residents have the potential to be affected by this deficient practice. II. On 09/10/12 Department Heads were advised of the deficient practice of not assuring a resident was not abused. At an All Staff meeting on 09/21/12, all staff were informed of the deficient practice. All nurses and QMAs were informed of this deficient practice at the monthly nurses meeting on 09/20/12, and again at a nurses's meeting on 09/26/12 and a meeting with CNAs on 09/27/12. Inservices "Elder Abuse" and "Protecting Residents From Abuse" (which includes abuse prevention) were available for all staff on 09/24/12 and 09/28/12 respectively and will be completed by 10/05/12. All staff were also re-educated on the definitions of the different kinds of	10/05/2012	

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	<p>her ..." and "...mad at me ..." One of the mentioned CNA's above had bumped Resident #4's bottom on the siderail during the transfer and had bumped her knees on the wall and slapped her"</p> <p>On 9/17/12 at 12:00 p.m., an interview was conducted with the DNS about the rough treatment reported by Resident #4 and the report of abuse reviewed in the alleged reports for abuse. She indicated she was aware of the slapping of Resident #4. She indicated the slapping had been a misinterpretation by Resident #4.</p> <p>3.1-27(a)(2)</p>		<p>abuse. The policies "Abuse Prohibition" and "Preventing Resident Abuse" were reviewed. All staff are inserviced at least two (2) times yearly on abuse. If any specific needs arise throughout the year, they are addressed at that time. III. Any allegation of abuse will be reported to the ISDH within 24 hours and investigated promptly. The results of all investigations will be reported to officials in accordance with state law, including the ISDH, within 5 working days of the incident. If the alleged violation is verified, appropriate corrective action will be taken. IV. Any allegation of abuse will be reported to the ISDH within 24 hours and investigated promptly. The results of all investigations will be reported to officials in accordance with state law, including the ISDH, within 5 working days of the incident. If the alleged violation is verified, appropriate corrective action will be taken. Appropriate staff will assist with the investigation. The DON will be responsible for completing the investigation and reporting reporting allegations of abuse to the Administrator, to the ISDH, APS, the Ombudsman, and any other appropriate agencies. The MDS Coordinator and SSD will be responsible to check with the DON to ensure that any investigations have been reported within 5 working days. Any</p>		

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			investigations will be discussed at the monthly QA meeting. V. Administrator/DON/MDS Coordinator/SSD/all staff/QA F223 Addendum Any investigations will be discussed at the monthly QA meeting indefinitely.	

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F0225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interviews and record reviews, the</p>	F0225	F225 I. The facility has in place	10/05/2012			

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	<p>facility failed to immediately report an allegation of abuse to the Administrator. This affected 1 of 3 sampled residents reviewed. (Resident #4)</p> <p>Findings include:</p> <p>On 9/7/12 at 9:23 a.m., an interview was conducted with Resident #4. She indicated a facility staff member, CNA #2, on the "...day shift yells at me to turn off my light ..." and that this had happened before with "...other aides ..." She indicated the situation had been discussed with the DNS at the time but couldn't remember the actual date. She indicated she had been treated roughly by staff. "...(name of CNA #1) is rough with me when she puts me to bed ..."</p> <p>On 9/7/12 at 10:00 a.m., a review of the alleged reports for abuse and neglect were completed. On 7/27/12 an incident occurred involving Resident #4. The incident involved rough treatment during the changing of Resident #4's disposable brief. In the report the Resident stated that CNA #3 was "...mean to her ..." and "...mad at me ..."</p> <p>One of the mentioned CNA's above had bumped Resident #4's bottom on the siderail during the transfer and had bumped her knees on the wall and slapped her"</p> <p>On 9/7/12 at 12:00 p.m., an interview was conducted with the DNS about the rough treatment reported by Resident #4 and the</p>		<p>policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law within 5 working days of the incident, and if the alleged violation is verified, appropriate action must be taken. The facility failed to immediately report an allegation of abuse to the Administrator. All residents have the potential to be affected by this deficient practice.</p> <p>II. On 09/10/12 Department Heads were advised of the deficient practice of not immediately reporting an allegation of abuse to the Administrator. At an All Staff meeting on 09/21/12, all staff were informed of the deficient practice. All nurses and QMAs were informed of this deficient practice at the monthly nurses meeting on 09/20/12, and again at a nurses's meeting on 09/26/12 and a meeting with CNAs on 09/27/12. Inservices "Elder Abuse" and "Protecting Residents From Abuse" were available for all staff on 09/24/12 and 09/28/12 respectively and will be</p>	

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	<p>report of abuse reviewed in the alleged reports for abuse. She indicated she was aware of the incident of CNA #1 and #2 mentioned above. She stated, "... I may not have written that up as a complaint ..." She also indicated she was aware of the incident of CNA #3 and #4 mentioned above. She indicated the Administrator had been made aware of the incident the following working business day 7/30/12.</p> <p>On 9/7/12 at 12:00 p.m., a record review of the alleged abuse for 7/27/12 was reviewed for actual reporting of the incident to the Administrator. The Administrators' signature was dated '7/30/12' on the Resident Grievance/Complaint Investigation Report Form dated 7/27/12 and on the Resident Abuse Investigation Report Form dated 9/5/12.</p> <p>The incident of alleged abuse on the 'Resident Grievance/Complaint Investigation Form dated 7/27/12' had been reported as a 'Resident Abuse Investigation Report Form dated 9/5/12.' The Resident Abuse Investigation Report Form dated 9/5/12 included notification to the Ombudsman, State Licensing Agency and the APS on 9/5/12. There had been no notification of the alleged accusation of abuse to Resident #4 of incident 7/27/12 prior to 9/5/12.</p> <p>There was no form of reporting the alleged</p>		<p>completed by 10/05/12. All staff were also re-educated of the need to immediately report any signs of mistreatment, neglect, and abuse of residents and misappropriation of resident property to the Administrator or the Director of Nursing so that an investigation can be completed. The policy of Reporting Abuse to State Agencies and Other Entities/Individuals was reviewed. All staff receive information on abuse with their orientation. All staff are inserviced at least two (2) times yearly on abuse. If any specific needs arise throughout the year, they are addressed at that time. III. Any allegation of abuse will immediately be reported to the Administrator and to the ISDH within 24 hours. The results of all investigations will be reported to officials in accordance with state law, including the ISDH, within 5 working days of the incident. If the alleged violation is verified, appropriate corrective action will be taken. IV. Any allegation of abuse will immediately be reported to the Administrator and to the ISDH within 24 hours. The results of all investigations will be reported to officials in accordance with state law, including the ISDH, within 5 working days of the incident. If the alleged violation is verified, appropriate corrective action will be taken. Appropriate staff will assist with the investigation. The DON will be responsible for</p>				

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	<p>report of abuse of CNA #1 and CNA #2</p> <p>An interview was conducted on 9/11/12 at 10:00 a.m., with the Administrator. He indicated he had been made aware of the incidents mentioned above the following working business date as noted in the alleged report of abuse and had not followed up with the DNS. He also indicated he had not been made aware of the allegation of abuse of CNA #1 and #2.</p> <p>3.1-28(c)</p>		<p>completing the investigation and reporting allegations of abuse to the Administrator, to the ISDH, APS, the Ombudsman, and any other appropriate agencies. The MDS Coordinator and SSD will be responsible to check with the DON to ensure that any investigations have been reported within 5 working days. Any investigations will be discussed at the monthly QA meeting. V. Administrator/DON/MDS Coordinator/SSD/all staff/QA F225 Addendum Any investigations will be discussed at the monthly QA meeting indefinitely.</p>		

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F0226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record reviews and interviews, the facility failed to implement the facility's policy and procedure for preventing, investigating and reporting alleged abuse.</p> <p>This affected 1 of 3 sampled resident's reviewed. [resident # 4]</p> <p>Findings include:</p> <p>On 9/17/12 at 9:23 a.m., an interview was conducted with Resident #4 in which she indicated an incident of alleged abuse that she had reported to the DNS at an unspecified date.</p> <p>On 9/17/12 at 10:00 a.m., a review of the alleged reports for abuse and neglect was completed. A report dated 7/27/12 of alleged abuse was noted upon review. The reported of 7/27/12 was reported as a 'compliant/ grievance.' A report dated 9/5/12 of alleged abuse, comprised of the exact content of alleged abuse dated 7/27/12, was reported as a 'resident abuse investigation.' The information indicated during the interview with Resident #4 was not noted in the review above.</p> <p>On 9/17/12 at 12:00 noon, an interview</p>	F0226	<p>F226 I. The facility has in place policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. The facility failed to implement our policy, Abuse Prohibition Policy, dated 03/04/08. The policy states that "All alleged/ suspected violations and all substantiated incidents of abuse will be promptly reported to appropriate state agencies and other entities or individuals..." All residents have the potential to be affected by this deficient practice.</p> <p>II. On 09/11/12 Department Heads were advised of the deficient practice of not following our policy, Abuse Prohibition Policy, dated 03/04/08. At an All Staff meeting on 09/21/12, all staff were informed of the deficient practice. All nurses and QMAs were informed of this deficient practice at the monthly nurses meeting on 09/20/12, and again at a nurses's meeting on 09/26/12 and a meeting with CNAs on 09/27/12. Inservices "Elder Abuse" and "Protecting Residents From Abuse" were available for all staff on 09/24/12 and 09/28/12 respectively and will</p>	10/05/2012			

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	<p>with DNS was conducted. She indicated the incident of alleged abuse indicated by Resident #4 during the interview at 9:23 a.m. had been investigated yet not reported. She indicated the allegation of abuse reviewed in the alleged reports had been reported to appropriate agencies on 9/5/12. She stated, "...I actually started working on the report on 9/4 before the survey began ...the more I got thinking about it, the more I thought it should be reported to the state ... so, I did ..." The DNS also indicated she had not reported either incident to the family of Resident #4 due to "... they (the family of Resident #4) are going through so much right now and I just didn't want to add more to them ..." She stated she had investigated the alleged abuse dated 7/27/12.</p> <p>On 9/17/12 at 2:00 p.m., a record review of the Abuse and Neglect Policy and Procedures for the LuAnns Health Care Center was conducted. Under the title 'Abuse Prohibition Policy' under "Policy. 7) Reporting. It is the responsibility of all employees to promptly report any incident or suspected incident of neglect or abuse to facility management. All alleged/ suspected violations and all substantiated incidents of abuse will be promptly reported to appropriate state agencies and other entities or individuals as may be required by law ..."</p>		<p>be completed by 10/05/12. All staff were also re-educated of the need to immediately report any signs of mistreatment, neglect, and abuse of residents and misappropriation of resident property to the Administrator or the Director of Nursing so that an investigation can be completed. The policy of Reporting Abuse to State Agencies and Other Entities/Individuals was reviewed. All staff receive information on abuse with their orientation. All staff are inserviced at least two (2) times yearly on abuse. If any specific needs arise throughout the year, they are addressed at that time. III. The results of all investigations will be reported to officials in accordance with our policy, Abuse Prohibition Policy, and state law, including the ISDH, within 5 working days of the incident. If the alleged violation is verified, appropriate corrective action will be taken. IV. The results of all investigations will be reported to officials in accordance with our policy, Abuse Prohibition Policy, and state law, including the ISDH, within 5 working days of the incident. If the alleged violation is verified, appropriate corrective action will be taken. Appropriate staff will assist with the investigation. The DON will be responsible for reporting allegations of abuse to the Administrator, completing the investigation and reporting such to the ISDH, APS, the</p>				

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	Also noted under "Abuse Investigations" titled Policy Interpretation and Implementation 1). Should an incident or suspected incident of resident abuse, neglect or injury of an unknown source be reported, the Administrator, or his/her designee, will appoint a member of management to investigate the alleged incident. 2) The Administrator will provide to the person in charge of the investigation a completed copy of the "Resident Abuse Report Form" and any supporting documents relative to the alleged incident ...6) The individual in charge of the abuse investigation will notify the ombudsman that an abuse investigation is being conducted ...10) The individual in charge of the investigation will consult with the administrator on a daily basis concerning the progress/findings of the investigation. 11) The Administrator will keep the resident and his/her representative (sponsor) informed of the progress of the investigation ...13) a copy of the completed "Resident Abuse Investigation Report Form" will be provided to the Administrator within 1 (one) working days of the reported incident. 14) The Administrator will inform the resident and his/her representative (sponsor) of the results of the investigation and corrective action taken within 1 (one) days of the completion of the investigation.		Ombudsman, and any other appropriate agencies. The MDS Coordinator and SSD will be responsible to check with the DON to ensure that any investigations have been reported within 5 working days. Any investigations will be discussed at the monthly QA meeting. V. Administrator/DON/MDS Coordinator/SSD/all staff/QA F226 Addendum Any investigations will be discussed at the monthly QA meeting indefinitely.		

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	<p>Also reviewed was the Policy titled "Investigating Grievances/Complaints." Located under the title "Policy Interpretation and Implementation4) The resident, or person acting in behalf of the resident will be informed of the findings of the investigation, as well as any corrective actions recommended, within 1 (one) working days of filing of the grievance or complaint. 7) Administrative policies governing abuse investigations are outlined in a separate policy of this section entitled "Abuse Investigations."</p> <p>On 9/11/12 at 10:00 a.m., an interview was conducted with the Administrator. He indicated he had been made aware of the alleged report of abuse dated 7/27/12 and then filed as a report of abuse to the state agencies on 9/5/12. He indicated he had not proceeded with inquiry into the investigation of 7/27/12 and could not justify the lack of reporting to the agencies until 9/5/12. He also indicated he had not been made aware of the incident of alleged abuse by Resident #4 noted during an interview on 9/7/12 at 9:23 a.m. He also indicated there was no rationale to the lack of following the policy and procedure of the facility. He did state, "...I would have followed the allegations more closely 'IF' she (Resident #4) had told the family ... I rely on the family telling me</p>			

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	what's happening with her (Resident #4) ..." 3.1-28(a)			

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F0241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, the facility failed to provide privacy for Resident #24 during a transfer. This affected 1 of 28 residents sampled.</p> <p>Finding include:</p> <p>During observation on 9/06/2012 at 10:32 A.M., Resident #24 was being transferred by CNA #4 and QMA #27. The family and visitors arrived during the transfer of Resident #24. They could visualize the transfer of resident # 24 as evidenced by the ability to see them from the hallway.</p> <p>3.1-3(t)</p>	F0241	<p>F241 I. The facility has in place policies and procedures that promote care for residents in a manner and in an environment that maintains or enhances each resident's privacy, dignity, and respect in full recognition of his or her individuality. The facility failed to provide privacy for a resident during transfer. All residents have the potential to be affected by this deficient practice. II. On 09/10/12 Department Heads were advised of the deficient practice of not providing privacy during a transfer. At an All Staff meeting on 09/21/12, all staff were informed of the deficient practice. All nurses and QMAs were informed of this deficient practice at the monthly nurses meeting on 09/20/12, and again at a nurses's meeting on 09/26/12 and in a meeting with CNAs on 09/27/12. An inservice "Dignity and Privacy" was available for all staff on 09/24/12 and will be completed by 10/05/12. All nursing staff will read the policy and procedure "Privacy and Dignity During Care" by 10/05/12. III. The charge nurse or QMA will observe at all times to assure the dignity and privacy of residents. Spot checks</p>	10/05/2012	

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			of CNAs with transfers and/or personal care will be conducted three (3) times weekly for one (1) month then monthly for six (6) months across all shifts by staff nurses to monitor for compliance with the privacy policy. The "Dignity and Privacy" inservice will be part of new employee orientation. Privacy and dignity are discussed at least annually at the all staff meeting. IV. The charge nurse or QMA will observe at all times to assure the dignity and privacy of residents. Spot cheks of CNAs with transfers and/or personal care will be conducted three (3) times weekly for one (1) month then monthly for six (6) months across all shifts to monitor for compliance with the privacy policy. The "Dignity and Privacy" inservice will be part of new employee orientation. Privacy and dignity are discussed at least annually at the all staff meeting. Any negative findings regarding privacy and dignity will be discussed at the monthly QA meeting, the monthly nurse's meeting, and the monthly CNAs meeting. V. DON/Staff nurses/QMAs/CNAs/ All Staff/QA F241 Addendum Any negative findings will be discussed at the quarterly QA meeting for one (1) year.		

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F0282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interviews, the facility failed to ensure the care plan regarding behaviors was followed for 1 of 10 residents reviewed for unnecessary medications.(Resident #27)</p> <p>Finding includes:</p> <p>1. The clinical record for Resident #27 was reviewed on 09/10/12 at 10:00 A.M. Resident #27 had diagnoses, including but not limited to, hypertension, hyperlipidemia, dementia, seizure disorder, osteoporosis, arthritis, depression, history of a cerebral vascular accident (stroke) with right hemiparesis, peripheral vascular disease, dysphasia, impaired glucose metabolism, anxiety, and chronic kidney disease.</p> <p>The current medication regimen for Resident #27, current for the month of September 2012, included the an order for the antianxiety medication, Lorazepam .5 mg three times a day as needed for anxiety.</p>	F0282	<p>F282 I. The facility has servies provided by qualified persons in accordance with each resident's written plans of care. The facility failed to ensure the care plan regarding behaviors was followed. Twenty-four (24) residents have the potential to be affected by this deficient practice.</p> <p>II. On 09/11/12 Department Heads were advised of the deficient practice of not ensuring a care plan regarding behaviors was followed. At an All Staff meeting on 09/21/12, all staff were informed of the deficient practice. All nurses and QMAs were informed of this deficient practice at the monthly nurse's meeting on 09/20/12, and again at a nurses's meeting on 09/26/12 and in a meeting with CNAs on 09/27/12. The interventions on each resident's behavior care plan have been highlighted on the Behavior Monitoring Record for those who have behavior care plans. This will inform staff immediatly the interventions that are most appropriate for that individual resident and in accordance with their individual care plans. The inservice "Anxiety: Causes, Symptoms, and Care" was available for all staff on</p>	10/05/2012			

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	<p>Review of the current health care plans for Resident #27, current through 09/26/12 included a plan to address the resident's anxiety and behaviors. The plan included the following interventions: place husband within eyesight, 1:1 support, remove from situation, and ask family to come talk with her.</p> <p>Review of the behavior documentation, located in a binder at the nurse's station indicated the resident had a behavior on 07/22/12 at 12:45 P.M. The staff attempted the following interventions: provided 1:1 care, changed a caregiver, used redirection, provided reality orientation, attempted distraction, attempted to de-escalate the issue, and using soothing touch, but the behavior lasted 16 - 60 minutes. On 07/27/12 at 5:00 P.M., the resident had a behavior and the staff took the resident to the bathroom, but the behavior lasted 1 - 3 hours. However the staff did not ensure the resident's spouse was in eyesight or the resident's family was not notified to come in and talk to the resident</p> <p>Review of the September 2012 behavior record for Resident #27 indicated she had behaviors of falsely</p>		<p>09/28/12 and will be completed by 10/05/12. All nurses and QMAs have read the policy and procedure "Psychotropic Medication Use" by 09/29/12.</p> <p>III. The Social Service Designee will check the Behavior Monitoring Records and the Medication Administration Record (MAR) to monitor for compliance with the "Psychotropic Medication Use" policy on a weekly basis. If an as needed (prn) psychotropic medication is given without first attempting non-pharmalogical interventions per that resident's care plan, that nurse or QMA will be counseled. Behavior Monitoring Record documentation has been added to CNAs, QMAs, and nurses orientation checklists.</p> <p>IV. The Social Service Designee will check the Behavior Monitoring Records and the Medication Administration Record (MAR) to monitor for compliance with the "Psychotropic Medication Use" policy on a weekly basis. If an as needed (prn) psychotropic medication is given without first attempting non-pharmalogical interventions per that resident's care plan, that nurse or QMA will be counseled. Behavior Monitoring Record documentation has been added to CNAs, QMAs, and nurses orientation checklists. Any negative findings will be discussed at the monthly CNAs meeting if appropriate, the monthly nurse's meeting, and the monthly QA meeting. V.</p>		

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	<p>accusing staff and delusional thoughts on 09/07/12 at 11:30 A.M. The staff attempted the following interventions: provided 1:1, use redirection, provide routine, provide structure, and reality orientation but the resident's behaviors were unchanged for 16 - 60 minutes. On 09/07/12 at 11:30 A.M., the resident displayed increased anxiousness and staff attempted the following interventions: provided 1:1, redirection, change in caregiver, provided structure and routine, and eventually gave the resident an antianxiety medication.</p> <p>Interview with the Social Service Director, on 09/11/12 at 11:30 A.M. indicated the nursing assistants generally documented the behaviors and interventions in the behavior monitoring record forms and the licensed nurses sometimes documented the interventions and behaviors in the nurse's notes.</p> <p>Review of the nurse's notes for July 22, 2012 indicated the nursing staff had documented one the interventions which was care planned such as putting the resident's spouse near her. However, there was no documentation regarding the resident's behaviors for 07/27/12,</p>		SSD/nurses/QMAs/CNAs/all staff/QA F282 Addendum Any negative findings will be discussed at the monthly QA meeting indefinitely.				

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	09/07/12, or 09/09/12 when the resident was medicated for her behaviors with the antianxiety medication, Lorazepam. 3.1-35(g)(2)				

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F0322 SS=D	<p>483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>Based on observation, record review, and interview, the facility failed to ensure placement of the Gastrostomy Tube was checked for 1 Resident (#10) prior to giving medications through the tube. This affected 1 of 1 resident who was reviewed for feeding tubes.</p> <p>Findings Include:</p> <p>During medication pass, at 11:45 a.m., on 9/6/12, and accompanied by LPN #26, the LPN gave Phenytoin (a medication given for seizures) and Diazepam (a medication given for anxiety and seizures) through the Gastrostomy Tube, with 60 cubic centimeters (cc) of water. The LPN did not check for residual, nor did she check for placement of the G-Tube prior to giving the medication. On 9/6/12 at 11:45 a.m. the LPN indicated the resident was on Hospice and had not received any tube</p>	F0322	<p>F322 I. The facility has in place policies and procedures that ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. The facility failed to ensure placement of a gastrostomy tube was checked prior to giving medications through the tube. One resident had the potential to be affected by this deficient practice. II. On 09/10/12 Department Heads were advised of the deficient practice of not ensuring placement of the gastrostomy tube prior to giving medications through the tube. All nurses and QMAs were informed of this deficient practice at the monthly nurse's meeting on 09/20/12, and again at a nurses's meeting on 09/26/12. The annual inservice QMA Lesson #52 "Administering Medications via the Gastrostomy Tube (G-Tube)</p>	09/29/2012	

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	<p>feedings for approximately 6 weeks, per family request. The LPN indicated she used to check for residual and placement of the tube prior to stopping the tube feedings, but when the feedings were stopped there were no physician orders to check for residual or placement of the tube, so she no longer checked. LPN #26 further indicated after the resident was given her earlier medications through the tube this morning, she had vomited a small amount.</p> <p>The Director of Nursing Services (DNS), was interviewed, at 10:10 a.m., on 9/7/12, and indicated she could not find the policy for medications given through the Gastrostomy Tube, however she indicated she would always check for placement when giving medications through a G-Tube.</p> <p>Review of the Medication Administration through an enteral tube, provided by the DNS, at 10:30 a.m. on 9/10/12, indicated prior to giving medications through the feeding tube Policy, "check for proper tube placement per facility policy. "</p> <p>Review of the enteral nutritional</p>		<p>or Jejunal Tube (J-Tube) for QMAs was revised to include information on Enteral Feedings for nurses and was available for nurses and QMAs on 09/24/12 and will be completed by 09/29/12. All nurses and QMAs have read the policies and procedures "Enteral Nutritional Therapy" and "Medication Administration through an Enteral Tube" by 09/29/12. III. In the event another resident with a G-tube enteral feeding/G-tube medications is admitted or orders received for G-tube placement of a current resident, the policies "Enteral Nutritional Therapy" and "Medication Administration through an Enteral Tube" will be reviewed with all nurses and QMAs. An order for placement check with feedings, medications, and flushes will be obtained. The MAR will be checked no less than monthly by the DON for compliance. IV. In the event another resident with a G-tube enteral feeding/G-tube medications is admitted or orders received for G-tube placement of a current resident, the policies "Enteral Nutritional Therapy" and "Medication Administration through an Enteral Tube" will be reviewed with all nurses and QMAs. An order for placement check with feedings, medications, and flushes will be obtained. The MAR will be checked no less than monthly by the DON for compliance. Any negative</p>				

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	<p>therapy policy, provided by the DNS, at 10:30 a.m. on 9/10/12, indicated it was the policy of the facility to provide food and fluids to residents, whether by mouth or other means.</p> <p>The procedure indicated, "check position of tube by gently inserting 30 cubic centimeters of air into the tube while listening for a gurgling sound with the stethoscope placed over the stomach area. "</p> <p>The DNS was interviewed, at 9:28 a.m. on 9/11/12, and indicated she had received the above policies on G-Tube feedings and medication administration from the nurse consultant for the pharmacy.</p> <p>The resident record was reviewed, at 9:30 a.m. on 9/11/12.</p> <p>The resident was admitted to the facility on 2/14/11. Diagnoses included, but were not limited to: aphasia, dysphagia, gastroparesis, seizure disorder, history of vegetative state, failure to thrive, and dementia.</p> <p>Physician orders, dated 7/15/12, indicated to discontinue the Jevity feeding, per family request, and discontinue checking residuals, and to give 60 cc water flush with all medication passes.</p>		<p>findings will be discussed at the monthly nurse's meeting and the monthly QA meeting. V. DON/staff nurses/QMAs/QA F322 Addendum Any negative findings will be discussed at the monthly QA meeting indefinitely.</p>				

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	<p>Review of nursing notes, dated 7/24/12, indicated the resident was non-verbal, did not communicate in any other form, was dependent on staff for all care, has episodes of seizure activity and vomiting.</p> <p>A care plan for the feeding tube, dated 2/8/12, and updated most recently on 7/15/12 when the tube feeding was discontinued, indicated, "Check G-Tube for placement prior to giving medications."</p> <p>3.1-44(a)(2)</p>				

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F0323 SS=E	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>1. Based on observation and interviews the facility failed to ensure one fire exit door located on the south hall was not blocked. This deficiency had the potential to affect 8 of 24 residents located on the South hall.</p> <p>2. Based on record reviews, observations and interviews, the facility failed to assure 1 side rail was not loose for 1 of 14 sampled residents (Resident #19) and failed to secure a chemical disinfectant and disposable sharps (needles) This deficiency had the potential to affect 6 of 12 residents.</p> <p>Findings include:</p> <p>1. On 9/5/12 at 1:45 p.m. and 9/6/12 at 9:20 a.m. an observation of a Geri chair (G-chair) covered with a blanket was in front of the South fire exit door by Resident # 18's door. The G- chair was stored to the left of the fire exit door where the fire door handle was located. There was enough room for a staff member to get around the G chair and open the door. There was a second fire exit door on the south hall for emergency use. The Gerry chair was 4 feet away from the fire exit door.</p>	F0323	<p>F323-1a I. The facility will promote a resident resident environment that remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. The facility failed to ensure one fire exit door located on the south hall was not blocked. All residents have the potential to be affected by this deficient practice. II. On 09/10/12 Department Heads were advised of the deficient practice of not ensuring one fire exit door was not blocked. Red tape has been placed twelve (12) feet away from all fire exit doors to remind staff to not block the fire doors. At an All Staff meeting on 09/21/12, all staff were informed of the deficient practice. All nurses and QMAs were informed of this deficient practice at the monthly nurse's meeting on 09/20/12, and again at a nurses's meeting on 09/26/12 and a meeting with CNAs on 09/27/12. III. A visual inspection of the fire doors will be completed at least daily by the Administrator or nursing staff. A drill obstructing the exit door will be conducted no less than</p>	09/29/2012	

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	<p>On 9/6/12 at 12:15 p.m. the Administrator and Director Nursing Service were interviewed in regard to the G- chair in front of the South fire exit door indicated the G chair had been in the south hall in front of the fire exit door for the past 2 weeks. The Administrator indicated there should had been tape on the floor to indicate to keep equipment 12 feet away from the fire exit door.</p> <p>On 9/6/12 at 11:00 a.m. and 9/07/2012 at 10:34 a.m. observations on the Clean Utility area on the South hall there was of a bottle of disinfectant under the sink in an unlocked cabinet. The Rediquat solution label indicated caution to keep out of reach of children. The cabinet under the sink did not have a lock on it.</p> <p>On 9/11/12 at 11:30 a.m. an interview with the Administrator in regard to the Rediquat Solution indicated the quat solution should had been locked up in the locked cabinet.</p> <p>On 9/11/12 at 12:00 p.m. an interview with CNA #2 in regard to the quaternary solution and indicated the Quaternary solution should have been locked up in the cabinet.</p> <p>On 9/11/12 at 12:15 p.m. an observation at the North Nurses station of the unlocked clean utility room there was an unlocked cabinet door for storage of sterile needles used for laboratory blood draws.</p> <p>ON 9/11/12 at 12:15 p.m. an interview with the Director Nursing Service indicated she did not have a key to lock the cabinet.</p> <p>On 9/11/12 at 1:15 p.m. the Administrator provided an undated Form in regard to the Quaternary solution indicated the solution</p>		<p>monthly across all shifts by the DON. This topic will be discussed at the annual all-staff meeting and will also be added to the facility orientation sheet. IV. A visual inspection of the fire doors will be completed at least daily by the Administrator or nursing staff. A drill obstructing the exit door will be conducted no less than monthly across all shifts by the DON. This topic will be discussed at the annual all-staff meeting and will also be added to the facility orientation sheet. Any negative findings will be discussed at the monthly nurse's meeting, the monthly CNAs meeting, and the monthly QA meeting. V. Administrator/DON/staff nurses/QMA/All Staff/QA 09/27/12 F323-1a Addendum Any negative findings will be discussed at the monthly QA meeting indefinitely. F323-1b I. The facility has in place a policy and procedure that ensures that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. The facility failed to secure a chemical disinfectant. All residents have the potential to be affected by this deficient practice. II. On 09/11/12 Department Heads were advised of the deficient practice of not securing a chemical disinfectant. At an All Staff meeting on 09/21/12, all staff were informed</p>				

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	<p>was hazardous to humans and causes eye and skin irritation and harmful if swallowed.</p> <p>On 9/11/12 at 2:00 p.m. an interview with the Administrator indicated there were no ambulatory residents with confusion currently residing in the facility.</p> <p>2. On 9/5/2012 3:12 p.m. when observed Resident #19's 1/2 siderails was observed to be loose. The resident's siderail attached to the bed was observed to move easily back and forth.</p> <p>On 9/10/12 at 1:00 p.m., resident observed in his room in bed with 1/2 siderails in the up position.</p> <p>The record of Resident #19 was reviewed on 9/10/12 at 10:15 a.m., and indicated Resident #19's diagnoses included, but were not limited to, congestive heart disease, chronic renal disease, and osteoarthritis.</p> <p>The Care Plan updated on 8/12/12 indicated the resident was at risk for fall injury. The goal for the resident was to have a reduced risk of fall related to injury by utilizing fall precautions. The interventions included the use of 1/2 side rail to</p>		<p>of the deficient practice. All nurses and QMAs were informed of this deficient practice at the monthly nurse's meeting on 09/20/12, and again at a nurses's meeting on 09/26/12 and a meeting with CNAs on 09/27/12. All nursing staff have read the policy and procedure "Readiquat Spray" by 09/29/12. II. A visual inspection of the locked cabinets where the Readiquat Spray is stored will be completed at least daily by the Administrator or nursing staff. An inspection of the locked cabinets where the Readiquat Spray is stored will be done at least weekly for one (1) month and then at least monthly across all shifts by the DON or her designee. Securing Readiquat Spray in a locked cabinet will be added to the Orientation Checklist for all staff. IV. A visual inspection of the locked cabinets where the Readiquat Spray is stored will be completed at least daily by the Administrator or nursing staff. An inspection of the locked cabinets where the Readiquat Spray is stored will be done at least weekly for one (1) month and then at least monthly across all shifts by the DON or her designee. Securing Readiquat Spray in a locked cabinet will be added to the Orientation Checklist for all staff. Any negative findings will be discussed at the monthly nurse's meeting, the monthly CNAs meeting, and the</p>	

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	<p>assist in bed mobility and transfers.</p> <p>Quarterly MDS (Minimum Data Set) Assessment dated 7/11/12 cognitive BIMS indicated the resident had moderate cognitive impairment.</p> <p>On 9/6/12 at 3:45 p.m. an interview with the Administrator in regard to the resident's loose siderail indicated he checks all the siderails every month and he had last checked Resident #19's siderails on 8/11/12 .</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p>		<p>monthly QA meeting. V. Administrator/DON/staff nurses/QMA/all staff/QA 09/29/12 F323-1b Addendum Any negative findings will be discussed at the monthly QA meeting indefinitely. F323-1c I. The facility will promote a resident environment that remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. The facility failed to secure disposable sharps (needles). All residents have the potential to be affected by this deficient practice. II. On 09/11/12 Department Heads were advised of the deficient practice of not securing disposable syringes. On 09/11/12 a new lock was placed on the cabinet storing laboratory supplies, including sterile needles. One key for this cabinet was placed on the North Hall Nurse's key ring and another placed in an inconspicuous place in the clean utility room for laboratory staff to use. Laboratory staff have been informed to keep this cabinet locked and a sign has been placed on the cabinet door "Laboratory Supplies: This cabinet must be locked at all times." At an All Staff meeting on 09/21/12, all staff were informed of the deficient practice. All nurses and QMAs were informed of this deficient practice at the monthly nurse's meeting on 09/20/12, and again at a nurses's</p>		

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			<p>meeting on 09/26/12. III. Lab staff have been informed to keep the cabinet in the clean utility containing lab supplies locked at all times. This information has been added to the staff nurse orientation sheet. The DON or her designee will do a manual check of this cabinet weekly. IV. Lab staff have been informed to keep the cabinet in the clean utility containing lab supplies locked at all times. This information has been added to the staff nurse orientation sheet. The DON or her designee will do a manual check of this cabinet weekly. Any negative inspections will be discussed at the monthly nurse's meeting and the monthly QA meeting. V. DON/staff nurses/lab personnel/QA 09/26/12 F323-1c Addendum Any negative inspections will be discussed at the monthly QA meeting indefinitely. F323-2 I. The facility will promote a resident environment that remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. The facility failed to ensure one siderail was not loose. Twenty-seven (27) residents have the potential to be affected by this deficient practice.</p> <p>II. On 09/10/12 Department Heads were advised of the deficient practice of one siderail being loose. At an All Staff meeting on 09/21/12, all staff</p>		

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			<p>were informed of the deficient practice. All nurses and QMAs were informed of this deficient practice at the monthly nurse's meeting on 09/20/12, and again at a nurses's meeting on 09/26/12 and a meeting with CNAs on 09/27/12. All siderails will be checked weekly by Maintenance. Staff has been informed to notify Maintenance or the Administrator of any siderails noted to be loose.</p> <p>III. All siderails will be checked weekly by Maintenance and check recorded on the Siderail Check Log. Staff has been informed to notify Maintenance of the Administrator of any siderails noted to be loose.</p> <p>IV. All siderails will be checked weekly by Maintenance and check recorded on the Siderail Check Log. Staff has been informed to notify Maintenance of the Administrator of any siderails noted to be loose. Any negative findings will be discussed at the monthly QA meeting.</p> <p>V. Administrator/Maintenance/all staff/QA 09/27/12 F323-2</p> <p>Addendum Any negative findings will be discussed at the monthly QA meeting for six (6) months. The plan will remain in effect indefinitely with weekly siderail checks completed by Maintenance.</p>	

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F0329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview the facility failed to implement non-pharmaceutical interventions prior to the administration of antianxiety medications of 1 of 10 residents reviewed for unnecessary medications. (Res #27)</p> <p>Finding includes:</p> <p>1. The clinical record for Resident #27 was reviewed on 09/10/12 at 10:00 A.M. Resident #27 had</p>	F0329	<p>F329 1. The facility has in place policies and procedures that ensure that each resident's drug regimen is free from unnecessary drugs. The facility failed to implement non-pharmaceutical interventions prior to the administration of an as needed (prn) antianxiety medication. Six (6) residents have the potential to be affected by this deficient practice. II. On 09/11/12 Department Heads were advised of the deficient practice of not implementing non-pharmaceutical interventions prior to the</p>	10/05/2012	

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	<p>diagnoses, including, but not limited to, hypertension, hyperlipidemia, dementia, seizure disorder, osteoporosis, arthritis, depression, history of a cerebral vascular accident (stroke) with right hemiparesis, peripheral vascular disease, dysphasia, impaired glucose metabolism, anxiety, and chronic kidney disease.</p> <p>The current medication regimen for Resident #27, current for the month of September 2012, included the an order for the antianxiety medication, Lorazepam .5 mg three times a day as needed for anxiety.</p> <p>Review of the July 2012 and September 2012 Medication Administration Records indicated the resident was given an antianxiety medication on 07/19/12, 07/27/12, 09/07/12, and 09/09/12.</p> <p>Review of the Behavior Monitoring Record for July 2012 and September 2012 and nursing progress notes for July 2012 and September 2012 indicated there was only documentation of non-pharmacological interventions attempted prior to the administration of the medication on 07/27/12 and 09/07/12.</p>		<p>administration of an as needed (prn) antianxiety medication. The interventions on each resident's behavior care plan have been highlighted on the Behavior Monitoring Record for those who have behavior care plans. This will inform staff immediately the interventions that are most appropriate for that individual resident and in accordance with their individual care plans. All nurses and QMAs were informed of this deficient practice at the monthly nurse's meeting on 09/20/12, and again at a nurses's meeting on 09/26/12. The inservice "Anxiety: Causes, Symptoms, and Care" was available for all staff on 09/28/12 and will be completed by 10/05/12. All nurses and QMAs have read the policy and procedure "Psychotropic Medication Use" by 09/29/12. III. The Social Service Designee will check the Behavior Monitoring Records and the Medication Administration Record (MAR) to monitor for compliance with the "Psychotropic Medication Use" policy on a weekly basis. If an as needed (prn) psychotropic medication is given without first attempting non-pharmacological interventions per that resident's care plan, that nurse or QMA will be counseled. Behavior Monitoring Record documentation has been added to CNAs, QMAs, and nurses orientation checklists. IV. The Social Service</p>		

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	<p>Interview with the Social Service Director, on 09/11/12 at 11:30 A.M. indicated the nursing assistants generally documented the behaviors and interventions in the behavior monitoring record forms and the licensed nurses sometimes documented the interventions and behaviors in the nurse's notes.</p> <p>Interview with the Director of Nursing, on 09/11/12 at 2:00 P.M. indicated the facility did not have a policy regarding the administration of psychoactive medications, including antianxiety medications.</p> <p>3.1-48(b)(1)</p>		<p>Designee will check the Behavior Monitoring Records and the Medication Administration Record (MAR) to monitor for compliance with the "Psychotropic Medication Use" policy on a weekly basis. If an as needed (prn) psychotropic medication is given without first attempting non-pharmalogical interventions per that resident's care plan, that nurse or QMA will be counseled. Behavior Monitoring Record documentation has been added to CNAs, QMAs, and nurses orientation checklists. Any negative findings will be discussed at the monthly CNAs meeting if appropriate, the monthly nurse's meeting, the monthly Behavior Meeting, and the monthly QA meeting. V. SSD/nurses/QMAs/CNAs/all staff/Behavior Committee/QA F329 Addendum Any negative findings will be discussed at the monthly QA meeting indefinitely.</p>		