

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155543	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/19/2013
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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT HUNTINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1425 GRANT ST HUNTINGTON, IN 46750
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F000000	<p>This visit was for the Recertification and State Licensure Survey.</p> <p>Survey dates: July 15, 16, 17, 18, and 19, 2013</p> <p>Facility number: 000346 Provider number: 155543 AIM number: 100288320</p> <p>Survey team: Linn Macky, RN-TC Angela Selleck, RN Sandra Nolder, RN Jason Mench, RN</p> <p>Census bed type: SNF/NF: 31 Total: 31</p> <p>Census payor type: Medicare: 2 Medicaid: 28 Other: 1 Total: 31</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p>	F000000		

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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F000156 SS=C	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes:</p>			

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	<p>A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits,</p>			

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	<p>and how to receive refunds for previous payments covered by such benefits. Based on observation and interview, the facility failed to have the postings for the contact information for state and federal agencies and resident rights at eye level for all residents. In addition, the facility failed to inform residents of the facility rules upon admission. This practice potentially affected 12 of 28 residents reviewed and were dependent on a wheel chair for mobility.</p> <p>Findings include:</p> <p>1. During the environmental tour of the facility on 7/18/13 at 10:18 a.m., the following signs were not at eye level: "How to apply for Medicaid," Residents' Rights, and the signs containing information for contact of the state and federal agencies. These were posted approximately six feet off the floor.</p> <p>During the Stage 2 portion of the survey, 12 of the 28 residents reviewed were observed using a wheel chair for mobility.</p> <p>During an interview on 7/19/2013 at 10:00 with the Regional Director of Operation, he indicated the facility did not have a policy for posting survey</p>	F000156	<p>This plan of correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Hickory Creek at Huntington desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on 8/18/13.</p> <p><u>F156</u></p> <p>It is the policy of this facility to post and inform residents of his/her rights and the rules/regulations governing resident conduct and responsibilities during his/her stay in the facility, including posting contact information for state and federal agencies and resident rights at eye level for all residents. Residents are also informed of facility rules upon admission.</p> <p>On page 5 of 49 of the CMS-2567 it states that the admission packet was reviewed with the Business Office Manager during the survey and no facility rules were found. While it is unclear why no rules were found in the information that was reviewed, the facility admission booklet that is used for new admissions does contain several pages of resident information including pages marked as "Hickory Creek Rules" (See</p>	08/18/2013

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	results and state and federal contact information. The facility followed the state and federal regulations.		attachment, F156-1). 1. <u>What corrective action will be done by the facility?</u> The information concerning each resident's rights and contact information for state and federal agencies as required by regulation are now posted at eye level in a common area of the facility with open access to all residents. Resident #27 was admitted 5/6/11, and at that time, her daughter acted as guardian who reviewed and signed all required documents upon admission, including the facility rules, resident's rights and responsibilities, the resident's duties, transfer and discharge, and the facility privacy practices. At this time, the daughter is no longer guardian and Resident #27 acts on her own behalf. All of the above information will be reviewed with her in detail to make sure that she is aware of her rights and the facility rules by 8/18/13. In addition, this same information will be reviewed with all members of the Resident Council by 8/18/13. On 7/30/2013 the Director of Nursing, Social Service Director, Dietary Manager, and Activities Director met with the Resident Council to discuss rules that the residents, themselves, wanted to have in place within the facility. After discussion and review by the residents and the interdisciplinary team, the Resident Council		

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			<p>approved a set of rules specific to Hickory Creek at Huntington. These rules will be given to each resident individually and copies of this same information will be sent to guardians and families of those residents who are cognitively impaired or otherwise unable to understand its contents. There will be a note made in the social services progress notes of the date that the facility rules were given to the resident and reviewed with the or the rules were sent to the family/legal representative.</p> <p>2. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></p> <p>-</p> <p>There were no other residents identified as being affected by this practice; however, if the administrator or other team member becomes aware that residents do not have access for review of required postings or that they or their legal representatives have not been notified of a change in facility rules, the administrator will follow up with the interdisciplinary team to make sure that the proper notification has been made and/or posted in the facility. Progressive discipline will be used for continued noncompliance with this requirement.</p>		

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			<p>3. <u>What measures will be put into place to ensure this practice does not recur?</u></p> <p>-</p> <p>As indicated in question #1, all residents and/or legal representatives will receive a copy of the facility rules approved by the Resident Council. A copy of these rules will also be included with the Admission packet that is reviewed and signed by residents/legal representatives that are new to the facility.</p> <p>Any change to the information for contact of state or federal agencies or facility rules will be brought to the next scheduled morning interdisciplinary management meeting that occurs at least 5 days a week for review and discussion by the interdisciplinary team. Notification and posting of changes (if required) will be discussed and planned at that time. Completion of the notification and posting will be reported back to the management meeting at the time designated for completion.</p> <p>The interdisciplinary team members will monitor for posting of required information as part of their Guardian Angel rounds that occur at least 5 days a week. The team members will also check with their assigned residents who are</p>		

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	2. Resident #27 was interviewed on 7/17/13 at 2:20 p.m. When queried whether she was aware of the rules of the facility, during the resident council interview, she indicated, "No I don't think so. I don't remember		<p>cognitively aware regarding their receipt and understanding of the facility rules as part of their regular rounds. If any concerns are identified in either area, it will be addressed at that time by the involved team member and reported to the interdisciplinary team at the next scheduled morning meeting.</p> <p>4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? The Administrator will report the results of the Guardian Angel rounds and interviews to the monthly QA&A Committee meeting for further review and recommendations. Any recommendations will be followed up by the designated team member and the results of those recommendations will be reported back to the next scheduled QA&A meeting. The QA&A committee may decide to stop the reporting of the rounds and interviews when 100% compliance is reached; however, the Guardian Angel rounds and interviews with the residents will continue on an ongoing basis. Date of Compliance: 8/18/13</p>		

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	<p>them."</p> <p>Business Office Manager was interviewed on 7/19/13 at 2:18 p.m. When queried how the residents were informed of the rules of the facility, she stated, "Smoking rules they know on admission. Family knows rules on admission, but not the resident necessarily. Depending on the rule, as it comes up, we would discuss it with the resident."</p> <p>The admission packet was reviewed with the Business Office Manager on 7/19/13 at 2:18 p.m. There were no facility rules located in the packet that was provided to the residents on admission.</p> <p>3.1-4(a)</p>				

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F000167 SS=C	<p>483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE</p> <p>A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.</p> <p>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.</p> <p>Based on observation and interview, the facility failed to have the Indiana State Department of Health Survey Result Book in a readily available place. This had the potential to effect 31 of 31 residents.</p> <p>Findings include:</p> <p>During the environmental tour on 7/18/2013 at 10:20 a.m., a sign was observed posted by the front door. It indicated the survey results were located at the nurse's station.</p> <p>During an interview with LPN # 1, on 7/18/13 at 11 a.m., she indicated the survey results were behind the nurses station and that the door to the nurses station was locked. LPN #1 proceeded to try and find the survey book. She was finally able to locate the book on a top shelf in the nurses station in a black binder. The binder</p>	F000167	<p><u>F167</u></p> <p>It is the policy of this facility to make sure that a notice is posted about the availability and location of the results of surveys and that a binder containing survey results is accessible for those residents who wish to review it.</p> <p>1. <u>What corrective action will be done by the facility?</u></p> <p>-</p> <p>A notice indicating the availability and location of the survey results was posted on the inside wall by the main entrance to the facility indicating the location of the binder containing survey results. Residents and staff will be notified by 8/18/13 of the location of the survey results binder.</p> <p>2. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></p> <p>-</p>	08/18/2013

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	<p>could not be reached from outside the nurses station.</p> <p>During an observation on 7/19/2013 at 8:00 a.m., there was no one available at the nurses station.</p> <p>During an interview on 7/19/2013 at 10:00 a.m., with the Regional Director of Operation, he indicated the facility did not have a policy for posting survey results and other posting.</p> <p>3.1-7(a)(2)</p>		<p>All residents had the potential to be affected by this practice. The members of the Resident Council will be notified on 8/15/13 regarding the location of the survey binder. For future reference, the residents were also notified where the sign is posted reminding them of the location of the survey binder.</p> <p>3. <u>What measures will be put into place to ensure this practice does not recur?</u></p> <p>The Administrator will check the location of the survey binder sign and survey binder itself as part of his regular rounds during each tour of duty. If he should find that the sign or the binder has been taken down or misplaced, he will make sure that it is replaced as soon as possible. He will also check to see why the issue has occurred. If he finds that staff was involved in removing either one, he will retrain them at that time on the reason for posting the sign and making sure the binder is placed where indicated.</p> <p>4. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u></p> <p>The Administrator will report any noted absence of the survey sign or binder and action taken to reinstate them to the members of the QA & A Committee at the next scheduled</p>		

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			monthly meeting. Any recommendations will be followed up by the Administrator who will report the results back to the Committee at the next scheduled meeting. This will occur on an ongoing basis. Date of Compliance: 8/18/13	

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F000224 SS=D	<p>483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROP RIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on observation, record review and interview, the facility failed to ensure verbal and physical abuse did not occur with 1 of 6 residents who met the criteria for abuse. (Resident # 29 and #34)</p> <p>Findings include:</p> <p>During an observation on 7/15/13 at 2:05 p.m., in the facility dining room, while activities were in progress, Resident #29 stated "Shut the hell up" to Resident #34 and "Get her the hell away from me." The Activities Director heard the statements but failed to respond. Resident #29 backed up from the table in his wheelchair. Resident #34 wheeled toward Resident #29 and slapped his left arm with her right hand. The Activities Director separated Resident #29 and Resident #34.</p> <p>On 7/16/13 8:53 a.m., Resident #34 tried to follow Resident #29 into his room. Resident #29 stated "get out of</p>	F000224	<p><u>F224</u> It is the policy of this facility to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of property, including verbal and physical abuse of one resident to another.</p> <p>1. <u>What corrective action will be done by the facility?</u> Resident #34 has been discharged to another setting to better meet her needs. All staff will be in-serviced by 8/18/13 regarding the facility's abuse policy, including the need to monitor and react quickly to prevent resident to resident abuse and to accurately document and report all instances of abuse that are ongoing, regardless of staff intervention.</p> <p>2. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></p> <p>- All residents have the potential to be affected by this practice. The DON will review the 24 hour report,</p>	08/18/2013			

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	<p>here." LPN #3 intervened and redirected Resident #34 into the opposite direction and then checked on Resident #29 to see if he was ok.</p> <p>The clinical record for Resident # 29 was reviewed on 7/17/13 at 11:42 a.m. The resident had diagnoses which included, but were not limited to: anemia, urinary tract infection (last 30 days) hyponatremia, hyperkalemia, dementia, hemiplegia or hemiparesis, Parkinson's disease, depression, and schizophrenia.</p> <p>A quarterly Minimum Data Set (MDS) Assessment, dated 5/23/13, indicated the Resident # 29 was not cognitively impaired.</p> <p>During an interview with Resident #29 on 7/18/13 at 11:35 a.m., Resident #29 stated, "[Resident # 34] is always bugging me. They had to put a stop sign up on my door to keep her from coming in my room. She don't pay attention of what she does. She kept coming up, hitting me in the knee, and wouldn't stop. She just keeps up, I try to be nice but then I yell at her. She grabs hold of other resident's arm or whatever, she just don't care. She goes into other people's rooms all the time."</p>		<p>incident reports, and focus charting at least 5 days a week as part of her tour of duty. She will bring those items, plus new physician orders to the next scheduled morning management interdisciplinary meeting for further review and discussion. The social services director will bring the behavior logs and resident care plans for review of specific behaviors and the outcome of the interventions put into place by the staff. Results of Guardian Angel rounds will also be reviewed including those that demonstrate issues with resident behaviors that are affecting other residents.</p> <p>Recommendations made by the team will be followed up by the designated team member(s). Any changes to the behavior log and care plan will be made at the same time as the review, with the results of those recommendations brought back to the next scheduled morning meeting for further review and discussion. The DON will make sure that the CNA assignment sheet is updated as needed and will indicate a change in interventions or behavior plan on the 24 hour report form to make sure that communication is extended to other shifts.</p> <p>3. <u>What measures will be put into place to ensure this practice does not recur?</u></p>		

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	<p>LPN #5 was interviewed on 7/17/13 at 2:41 p.m. She indicated the protocol was to immediately separate and redirect the two residents if an altercation was occurring.</p> <p>CNA #6 was interviewed on 7/17/13 at 3:41 p.m. She indicated the protocol was to separate the residents, calm the residents down, then notify the nurse and note the behavior in the behavior book.</p> <p>The Director of Nursing was interviewed on 7/18/13 at 10:18 a.m. She indicated the protocol was to report any allegations of abuse to the State. She also indicated the facility should monitor and adjust care to reduce negative outcomes.</p> <p>Review, on 7/18/13 at 10:32 a.m., of "Resident Mistreatment, Neglect, Abuse & Misappropriation of Property Policy," dated 12/1999, indicated "Residents will be free from mistreatment, neglect, abuse, misappropriation of resident funds and property, verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion...Physical Abuse: Includes hitting, slapping, pinching and kicking. It also includes controlling behavior through corporal punishment. Mental</p>		<p>In addition to the process outlined in question #2, the Administrator, DON, and Social Services Director will monitor residents' environment and any indication of discomfort or unease with other residents as part of their frequent rounds that occur during each tour of duty. Any concern expressed by any resident regarding another resident will be documented on a resident concern form and will be brought to the attention of the Administrator immediately, if he is not the one who has received the concern first hand. Once the staff and the Administrator have made sure that safety is assured for all residents involved, the Administrator will bring the interdisciplinary team and related documentation together to discuss the concern expressed by the resident.</p> <p>The Administrator will also notify the Indiana State Board of Health if the concern meets the guidelines as a "reportable incident" and will begin an investigation. The attending physician and family/legal representative will be notified of the occurrence – if directed by the attending physician, the psychologist will also be notified. The facility will follow through on the physician's recommendations and will document the results. If necessary, the resident who is</p>		

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	<p>Abuse: Includes, but is not limited to, humiliation, harassment, threats of punishment, or deprivation...Residents are to receive emergency short-term monitored separation due to temporary behavioral symptoms (such as brief catastrophic reactions or combative/aggressive behaviors which pose a threat to the resident, other residents, staff, or others in the facility) only if considered the least restrictive approach for the minimum amount of time, and is being done according to the resident's needs and not for staff convenience. Emergency short-term monitored separation must be approved by a physician and included as a part of the resident's behavioral management plan...The facility management will identify residents at risk for potential abuse, neglect or misappropriation of property and appropriate preventative measures will be put in to place. Residents identified as being at risk will have appropriate plans of care developed and communicated to staff to ensure their needs are identified and met by the staff. Those residents at risk include, but are not limited to, the following:...Residents who are demented, comatose, and/or are disoriented to the environment...Residents who exhibit</p>		<p>causing discomfort, fear, or intrusion with other residents may be transferred to acute care for further evaluation.</p> <p>4. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u></p> <p>-</p> <p>The Administrator and Social Services Director will report any occurrences of resident-to-resident abuse and other ongoing behaviors, along with the results of specific interventions designed to prevent the abuse situation, to the monthly QA&A Committee meeting for further review and recommendations. Recommendations will be followed up by the designated person who will report the results of those recommendations at the next Committee meeting. This will continue on an ongoing basis.</p> <p>Date of Compliance: 8/18/13</p>	

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	<p>or have a history of behavioral symptoms that include, but are not limited to, intrusive wandering, aggressive behavior, combativeness, self-injurious tendencies...."</p> <p>3.1-28(a)</p>			

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F000225 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 record review and</p>	F000225	<u>F225</u>	08/18/2013			

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	<p>interview, the facility failed to ensure verbal and physical abuse was reported immediately to the Administrator and to the state agency for 1 of 6 residents who met the criteria for abuse. (Resident # 34)</p> <p>Findings include:</p> <p>Review of an allegation of abuse was completed on 7/17/13 at 11:10 a.m. The allegation indicated Resident #34 grabbed Resident #21's arm on 7/16/13 at 4:30 p.m.</p> <p>The DNS (Director of Nursing Services) was interviewed on 7/17/13 at 11:31 a.m., regarding Resident #34 grabbing Resident #21. She indicated the Administrator, the Social Service Director and herself investigated if Resident #34 grabbed Resident #21's arm intentionally to harm her or to get her attention. She indicated this incident was not witnessed, but was reported to staff by Resident #21. She indicated this resident to resident altercation was not reported to the state agency due to the investigation did not determine if Resident #34 intentionally meant to grab Resident #21.</p> <p>The Facility Administrator was interviewed on 7/17/13 at 4:10 p.m.,</p>		<p>It is the policy of this facility to ensure that occurrences of verbal or physical abuse, including resident-to-resident situations, are reported immediately to the Administrator and the state agency.</p> <p>1. <u>What corrective action will be done by the facility?</u> Resident #34 has been discharged to another setting to better meet her needs. All staff will be inserviced by 8/18/13 by the DON and Social Services Director regarding the facility's abuse policy, including the need to monitor and react quickly to prevent resident to resident abuse, to report instances of abuse to the Administrator immediately, and to accurately document and report all instances of abuse that are ongoing, regardless of staff intervention. The Administrator will be re-trained on the facility policy for abuse, including the need for reporting incidents of verbal or physical abuse to the state agency as per Indiana state guidelines by the Nurse Consultant by 8/18/13.</p> <p>2. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> - All residents have the potential to be affected by this practice. The DON will review the 24 hour report, incident reports, and focus charting</p>		

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	<p>regarding a resident to resident altercation between Resident #34 and Resident #21 on 7/16/13 at 4:30 p.m. He indicated he was notified of Resident #34 grabbing Resident #21's arm after she moved into the room with Resident #21 on 7/16/13. He was notified in the morning meeting on 7/17/13 by the Social Service Director. When asked if he had reported this incident to the state agency, he indicated the situation would be discussed with the acting DNS and the Social Service Director to decide what the intent was and if there was any injury.</p> <p>The Regional Director of Operations was present during the interview with the Administrator and when he became aware of the fact that the Administrator did not report the resident to resident altercation on 7/16/13, he discussed with the Administrator that he was to report alleged abuse to the state agency immediately then investigate and decide if it was abuse or not.</p> <p>Review of the facility's resident mistreatment, neglect, abuse and misappropriation of property policy, provided on 7/18/13 at 9:00 a.m., by the Administrator, indicated "All reported incidents of alleged</p>		<p>at least 5 days a week as part of her tour of duty. She will bring those items, plus new physician orders to the next scheduled morning management interdisciplinary meeting for further review and discussion. The social services director will bring the behavior logs and resident care plans for review of specific behaviors and the outcome of the interventions put into place by the staff. Results of Guardian Angel rounds will also be reviewed including those that demonstrate issues with resident behaviors that are affecting other residents.</p> <p>Recommendations made by the team will be followed up by the designated team member(s). Any changes to the behavior log and care plan will be made at the same time as the review, with the results of those recommendations brought back to the next scheduled morning meeting for further review and discussion. The DON will make sure that the CNA assignment sheet is updated as needed and will indicate a change in interventions or behavior plan on the 24 hour report form to make sure that communication is extended to other shifts.</p> <p>3. <u>What measures will be put into place to ensure this practice does not recur?</u></p>		

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	<p>violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported to the Administrator immediately, investigated and reported per state and federal law...."</p> <p>3.1-28(c)</p>		<p>In addition to the process outlined in question #2, the Administrator, DON, and Social Services Director will monitor residents' environment and any indication of discomfort or unease with other residents as part of their frequent rounds that occur during each tour of duty. Any concern expressed by any resident regarding another resident will be documented on a resident concern form and will be brought to the attention of the Administrator immediately, if he is not the one who has received the concern first hand. Once the staff and the Administrator have made sure that safety is assured for all residents involved, the Administrator will bring the interdisciplinary team and related documentation together to discuss the concern expressed by the resident.</p> <p>The Administrator will also notify the Indiana State Board of Health if the concern meets the guidelines as a "reportable incident" and will begin an investigation. He will also notify ISDH of the results of his investigation into the incident as required by Indiana guidelines. The attending physician and family/legal representative will be notified of the occurrence – if directed by the attending physician, the psychologist will also be notified. The facility will follow through on the physician's recommendations</p>		

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			<p>and will document the results. If necessary, the resident who is causing discomfort, fear, or intrusion with other residents may be transferred to acute care for further evaluation.</p> <p>At least twice a month, the Nurse Consultant will review any instances of physical or verbal abuse that have occurred and been reported to the state agency since her prior visit to make sure that reporting and follow up have occurred as required. If she identifies any issues, she will review them with the Administrator and other involved staff and will re-train them in regards to the facility policy and the state/federal regulations.</p> <p>4. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u></p> <p>- The Administrator and Social Services Director will report any occurrences of resident-to-resident abuse and other ongoing behaviors, along with the results of specific interventions designed to prevent the abuse situation, to the monthly QA&A Committee meeting for further review and recommendations. The Administrator will also report any recommendations made by the Nurse Consultant's audits of abuse incidents and subsequent reports.</p>		

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			<p>Recommendations will be followed up by the designated person who will report the results of those recommendations at the next Committee meeting. This will continue on an ongoing basis.</p> <p>Date of Compliance: 8/18/13</p>	

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F000226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to ensure the policy and procedure for verbal and physical abuse was followed for of 3 of 6 residents who met the criteria for abuse. (Resident #21, #29, and #34)</p> <p>Findings include:</p> <p>The Facility Administrator was interviewed on 7/17/13 at 4:10 p.m., regarding a resident to resident altercation between Resident #34 and Resident #29 on 7/15/13 at 2:15 p.m. He indicated he was notified of Resident #34 hitting Resident #29 on the left forearm on that date about 2:15 to 2:30 p.m. by the Activities Director. When asked if he had reported this incident to the state agency, he stated, "Yes. Monday (7/15/13) close to six o' clock or five."</p> <p>The Administrator was also interviewed regarding a resident to resident altercation between Resident #34 and Resident #21 on 7/16/13 at</p>	F000226	<p><u>F226</u> It is the policy of this facility to ensure that occurrences of verbal or physical abuse, including resident-to-resident situations, are reported immediately to the Administrator and the state agency. 1. <u>What corrective action will be done by the facility?</u> Resident #34 has been discharged to another setting to better meet her needs. All staff will be in-serviced by 8/18/13 by the DON and Social Services Director regarding the facility's abuse policy, including the need to monitor and react quickly to prevent resident to resident abuse, to report instances of abuse to the Administrator immediately, and to accurately document and report all instances of abuse that are ongoing, regardless of staff intervention. The Administrator will be re-trained on the facility policy for abuse, including the need for reporting incidents of verbal or physical abuse to the state agency as per Indiana state guidelines by the Nurse Consultant by 8/18/13. 2. <u>How will the facility identify other residents having the potential</u></p>	08/18/2013	

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	<p>4:30 p.m. He indicated he was notified of Resident #34 grabbing Resident #21's arm after she moved into the room with Resident #21 on 7/16/13. He was notified in the morning meeting on 7/17/13 by the Social Service Director. When asked if he had reported this incident to the state agency, he indicated the situation would be discussed with the acting DNS and the Social Service Director to decide what the intent was and if there was any injury.</p> <p>The Regional Director of Operations was present during the interview with the Administrator and when he became aware of the fact that the Administrator did not report the resident to resident altercation on 7/16/13, he discussed with the Administrator that he was to report alleged abuse to the state agency immediately then investigate and decide if it was abuse or not.</p> <p>Review of the facility's resident mistreatment, neglect, abuse and misappropriation of property policy, provided on 7/18/13 at 9:00 a.m., by the Administrator, indicated "All reported incidents of alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and</p>		<p><u>to be affected by the same practice and what corrective action will be taken?</u></p> <p>- All residents have the potential to be affected by this practice. The DON will review the 24 hour report, incident reports, and focus charting at least 5 days a week as part of her tour of duty. She will bring those items, plus new physician orders to the next scheduled morning management interdisciplinary meeting for further review and discussion. The social services director will bring the behavior logs and resident care plans for review of specific behaviors and the outcome of the interventions put into place by the staff. Results of Guardian Angel rounds will also be reviewed including those that demonstrate issues with resident behaviors that are affecting other residents.</p> <p>Recommendations made by the team will be followed up by the designated team member(s). Any changes to the behavior log and care plan will be made at the same time as the review, with the results of those recommendations brought back to the next scheduled morning meeting for further review and discussion. The DON will make sure that the CNA assignment sheet is updated as needed and will indicate a change in interventions or behavior plan on the 24 hour report</p>				

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	<p>misappropriation of resident property are reported to the Administrator immediately, investigated and reported per state and federal law...."</p> <p>3.1-28(a) 3.1-28(c)</p>		<p>form to make sure that communication is extended to other shifts.</p> <p>3. <u>What measures will be put into place to ensure this practice does not recur?</u></p> <p>In addition to the process outlined in question #2, the Administrator, DON, and Social Services Director will monitor residents' environment and any indication of discomfort or unease with other residents as part of their frequent rounds that occur during each tour of duty. Any concern expressed by any resident regarding another resident will be documented on a resident concern form and will be brought to the attention of the Administrator immediately, if he is not the one who has received the concern first hand. Once the staff and the Administrator have made sure that safety is assured for all residents involved, the Administrator will bring the interdisciplinary team and related documentation together to discuss the concern expressed by the resident.</p> <p>The Administrator will also notify the Indiana State Board of Health if the concern meets the guidelines as a "reportable incident" and will begin an investigation. He will also notify ISDH of the results of his investigation into the incident as</p>		

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			<p>required by Indiana guidelines. The attending physician and family/legal representative will be notified of the occurrence – if directed by the attending physician, the psychologist will also be notified. The facility will follow through on the physician’s recommendations and will document the results. If necessary, the resident who is causing discomfort, fear, or intrusion with other residents may be transferred to acute care for further evaluation.</p> <p>At least twice a month, the Nurse Consultant will review any instances of physical or verbal abuse that have occurred and been reported to the state agency since her prior visit to make sure that reporting and follow up have occurred as required. If she identifies any issues, she will review them with the Administrator and other involved staff and will re-train them in regards to the facility policy and the state/federal regulations.</p> <p>4. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u></p> <p>- The Administrator and Social Services Director will report any occurrences of resident-to-resident abuse and other ongoing behaviors, along with the results of specific interventions designed to prevent</p>	

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			<p>the abuse situation, to the monthly QA&A Committee meeting for further review and recommendations. The Administrator will also report any recommendations made by the Nurse Consultant's audits of abuse incidents and subsequent reports. Recommendations will be followed up by the designated person who will report the results of those recommendations at the next Committee meeting. This will continue on an ongoing basis.</p> <p>Date of Compliance: 8/18/13</p>	

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F000241 SS=E	<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 and interview, the facility failed to ensure residents received and were assisted with meals in a dignified manner for 1 of 24 residents observed in the front dining rooms and failed to ensure clothing protectors were provided after the resident gave permission for 6 of 6 residents observed for clothing protector placement. (Resident # 35, 15, 16, 17, & 26) (Residents #1, 2, 13, 14, 31, & 33)</p> <p>Findings include:</p> <p>1. During a 7/15/13 11:55 a.m. lunch meal observation, LPN # 3 was observed feeding Resident # 35. LPN # 3 stopped assisting Resident #35, to assist other residents. Resident # 35 began to yell out. LPN # 3 returned to assist the resident to eat. Resident # 35 then became quiet.</p> <p>During a 7/17/13 5:20 p.m., evening meal observation Resident # 35's tray was served however no one sat</p>	F000241	<p><u>F241</u></p> <p>It is the policy of this facility to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect, including when receiving assistance with meals.</p> <p>1. <u>What corrective action will be done by the facility?</u></p> <p>In addition to the hands-on re-training done by the DON and Nurse Consultant during survey, staff will be in-serviced by 8/18/13 regarding the need to allow residents choice regarding whether or not they wish to wear clothing protectors. In addition staff will also be in-serviced on the proper procedure to follow when assisting a resident to eat; for example, remaining with the resident until the meal is finished, not standing at the resident's, instead of sitting next to the resident while assisting them to eat, and talking to and with the resident, rather than others who are in the room, during the meal assistance.</p> <p>It is noted on page 15 of 49 that the facility policy "Meal Service" does not directly address the issue of staff</p>	08/18/2013			

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	<p>down to assist her. At 5:25 p.m. CNA # 6 sat down to assist Resident # 35 with the meal. During the meal observation CNA # 6 was observed to change places during the meal. CNA # 6 then was observed to stand next to the resident to assist her.</p> <p>During a 7/16/13 1:00 p.m. interview, the DON (Director of Nursing) indicated that staff should not get up from assisting a resident to eat until the resident was finished eating.</p> <p>Review of a current, facility policy titled "Meal Service," was provided by the Administrator on 7-19-13 at 2:30 p.m. indicating the following: "Purpose: ...To provide assistance for each residents as needed. Guidelines:..In order to maintain the resident's dignity while eating, staff assisting residents to eat will sit beside the resident. It is not acceptable to stand by the resident when assisting him or her to eat" The policy did not indicate that staff should not talk to other staff while assisting residents.</p>		<p>talking to other staff while assisting resident; there is an additional policy that was not shared with the surveyors titled, "Feeding the Resident", #N-F002. This policy does address the issue of staff talking over residents to other staff – page 2 of 3 (See attachment, F241-1). This policy will be shared with staff as part of the in-service done by 8/18/13.</p> <p>2. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></p> <p>- Residents who are assisted to eat have the potential to be affected; however, no other instances have been noted since survey. The DON and Nurse Consultant re-trained the staff during the survey when they realized that improper procedures were being followed regarding the placement of clothing protectors and the techniques being used while assisting residents to eat. However, if any issue is noted during meal service, the interdisciplinary team manager or nurse assigned to monitor and assist with the meal will stop the inappropriate practice immediately and re-instruct the staff involved on the facility policy. If non-compliance continues, progressive disciplinary action will be rendered.</p>		

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			<p>3. <u>What measures will be put into place to ensure this practice does not recur?</u></p> <p>One of the interdisciplinary team members is assigned to monitor each meal to assist with the meal service, but also to monitor staff performance during the meal. As indicated in question #2, if any concern or issue is identified the manager or nurse will address the staff immediately and re-train them in the acceptable procedure to follow. The meal manager will use a QA tool, "Meal Service" to document what he/she has observed, as well as any action taken to correct any concerns or issues that were observed. The meal manager will bring the completed QA tool to the next scheduled interdisciplinary morning manager meeting to review the results of his/her monitoring activities, as well as any action taken.</p> <p>4. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u></p> <p>The Administrator or designee will bring the results of the Meal Service audits to the monthly QA&A Committee meeting for further review and recommendations for process improvement. This will continue for the next 3 months – once 100% compliance has been</p>		

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	<p>2. During the dining observation on 7/17/13 at 5:44 p.m., a personal conversation between the Activities Director and CNA # 11 occurred while they were assisting the residents.</p> <p>During an Interview on 7/17/13 at 5:53 p.m., the CNA #11 indicated Resident #15, 16, 17 and 26 were seated at the table where the Activity Director and herself were assisting the residents.</p> <p>During an 7/19/2013 3:30 p.m., interview with LPN # 5 indicated staff was supposed to talk to the residents and not to each other during meal times.</p> <p>During an 7/19/2013 3:40 p.m., interview with Activities Director indicated that staff should be talking to the residents during meal times.</p> <p>3. The noon meal was observed on 7/15/13 at 12:00 p.m. The Activity Director was observed placing</p>		<p>reached, the Committee members may decide to stop the written audits. Even when the written audits are stopped, the process of monitoring the meals and reporting meal service issues will continue on an ongoing basis.</p> <p>Date of Compliance: 8/18/13</p>		

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	<p>clothing protectors on 6 of 6 residents in the small dining room without asking residents if they wanted them. The small dining room was reserved for independent residents. The residents dining in the small dining room included Residents # 1, 2, 13, 14, 31, & 33.</p> <p>Record review on 7/19/13 at 2:30 p.m., of the meal service nursing policy provided by the Administrator, did not address the use of clothing protectors.</p> <p>Review of a current, facility policy titled "Meal Service" , was provided by the Administrator on 7-19-13 at 2:30 p.m., indicating the following: "Purpose: ...To provide assistance for each residents as needed. Guidelines:...In order to maintain the resident's dignity while eating, staff assisting residents to eat will sit beside the resident. It is not acceptable to stand by the resident when assisting him or her to eat"</p> <p>The Policy did not indicate that staff should not talk to other staff while assisting residents.</p> <p>3.1-32 (a)</p>			

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F000242 SS=D	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on interview and record review, the facility failed to provide bathing choices for 2 of 3 residents reviewed in a sample of 4 who met the criteria for choices. (Resident # 18, # 25)</p> <p>Findings include:</p> <p>1. Interview with the Resident #18, on 7/15/13 at 2:32 p.m., indicated that she would have preferred baths to showers and was unable to take baths at this facility due to them not having a tub for bathing.</p> <p>Record review of the MDS (Minimum Data Set) assessment, dated 4/2013, on 7/18/13 at 2:30 p.m., Resident #18 indicated having a choice in bath or showers was very important to her.</p> <p>During an interview with the Administrator and Regional Director on 7/18/13 at 3 p.m., they indicated the tub for baths had been broken for</p>	F000242	<p>F242</p> <p>It is the policy of this facility to promote the residents' rights to choose activities, schedules, and health care, including his/her choice of bathing.</p> <p>1. <u>What corrective action will be done by the facility?</u></p> <p>The current tub is not able to be repaired and will be removed. A new tub has been ordered with an expected delivery date of 8/19/13. The Administrator has a confirmation receipt of this order and a method to track its delivery online. Once it is delivered, it will be installed as quickly as possible, and nursing staff will be trained in its operation and sanitation between residents, as outlined by the manufacturer's recommendations.</p> <p>2. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></p> <p>-</p> <p>All residents have the potential to be affected. Upon delivery of the new</p>	08/18/2013	

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	<p>4-5 months. They stated they had asked residents if they wanted to take a bath on multiple occasions and no resident voiced the desire to take a bath. The maintenance director had worked on it multiple times and the Regional Maintenance Director had been in twice to service the bath and parts were on order.</p> <p>During an interview with CNA # 9 on 7/18/13 at 2:48 p.m., she indicated the facility only had a shower option and the bath tub had been broken since before she began employment in December.</p>		<p>tub, the interdisciplinary team members will speak to residents who are able to make a choice of their preferred method of bathing. Those who choose tub baths will be bathed or assisted to be bathed in the tub once it is installed. The residents' choice of bathing will be reflected on the residents' care plans and the CNA assignment sheets at that time.</p> <p>3. <u>What measures will be put into place to ensure this practice does not recur?</u></p> <p>The Maintenance Director will in-service all staff by 8/18/13 on the procedure for reporting equipment that is in need of repair or replacement. The Administrator will meet with the Maintenance Director at least 5 days a week as part of the interdisciplinary team meeting to discuss any needed repairs or replacement of existing equipment.</p> <p>The Administrator and Maintenance Director will make joint rounds of all areas of the facility at least weekly to check on the repair and maintenance status of all equipment. Any identified issues will be followed up by the Maintenance Director who will report the status of the repair to the Administrator as outlined in question #3.</p> <p>4. <u>How will corrective action be</u></p>		

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	<p>2. During an interview with Resident #25 on 7/15/13 at 10:26 a.m., he indicated he would prefer a tub bath, but he indicated the tub bath had been broken for over a year and he wished it could be repaired. The MDS (Minimum Data Set) assessment, dated 6/13/13, was reviewed on 7/19/13 at 10:50 a.m. It indicated the resident was cognitively intact. It also indicated resident # 25 felt it was somewhat important to choose between a tub bath, a shower, bed bath or sponge bath.</p> <p>On 7/18/13 at 1:20 p.m., during an interview, the Maintenance Director indicated the tub was out of order. He indicated the tub had been broken for four to five months. He indicated he had repaired the tub twice, but it was not working at this time. He also indicated there was a</p>		<p><u>monitored to ensure the deficient practice does not recur and what QA will be put into place?</u></p> <p>The Maintenance Director will bring the reports and current status of any repairs or replacement of equipment to the monthly QA&A Committee meeting for review and further recommendations by the Committee members. This will continue on an ongoing basis.</p> <p>Date of Compliance: 8/18/13</p>		

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	<p>therapy tub available, but it was out of order at this time. He indicated due to the age of the tub, the Manufacturer had indicated the part needed to repair the tub was not available. He indicated the Regional Director of Operations would have to make the decision to replace the tub.</p> <p>During an observation on 7/18/13 at 1:00 p.m., there was a long white tub that was in a high position in restroom # 1.</p> <p>3.1-(u)(3) 3.1-(u)(1)</p>			

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F000250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>Based on record review and interview, the facility failed to monitor resident maladaptive behaviors for 2 of 6 residents reviewed for behaviors. (Resident # 5, 9, & 34)</p> <p>Findings include:</p> <p>During interview with Resident #5, on 7/15/13 at 2:39 p.m., Resident #5 stated that (Resident #9) "curses me....she uses curse words and calls me grandpa and I don't like it. I have told someone numerous times....I can't remember who.... it still continues."</p> <p>The Administrator, Consultant Nurse and RN #30 were notified 7/15/13 at 3:25 p.m. of the concern. No other information was provided previous to exit on 7/19/13 at 5:30 p.m.</p> <p>The clinical review for Resident #5 was reviewed on 7/18/13 at 10:03 a.m. The Minimum Data Set (MDS) Quarterly Review, dated 4/25/13, indicated the resident was not cognitively impaired.</p>	F000250	<p><u>F250</u></p> <p>It is the policy of this facility to provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, including monitoring of maladaptive behaviors.</p> <p>1. <u>What corrective action will be done by the facility?</u></p> <p>Resident #9 and Resident #5 have been separated from each other as much as possible within the facility. There have been no witnessed incidents of Resident #9 calling resident #5 Grandpa and Resident #9 has not been witnessed cursing. Care plans have been updated for both residents with specific interventions for each to reduce or eliminate these behaviors. The residents are now eating in different dining rooms in order to limit the interaction between them. A care plan meeting for Resident #5 was conducted on August 2 nd with Resident #5 attending. During the care plan meeting, he verbalized to the interdisciplinary team that he feels the dining room seating change has been effective.</p> <p>Resident #34 has been discharged to another setting to better meet her</p>	08/18/2013			

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	<p>Clinical Review on 7/16/13 at 11:26 a.m., indicated Resident #5 had diagnoses which included, but were not limited to, chronic paranoid schizophrenia, hypertension, tardive dyskinesia, hypothyroidism, right foot partial amputation, peripheral neuropathy, mild chronic obstructive pulmonary disease, depression, bilateral edema, atrial fibrillation, and insulin dependent diabetes type II.</p> <p>Clinical Review, on 7/18/13 at 2:30 p.m., indicated Resident #5 was seen by the psychologist on 1/7/13 and again on 1/29/13. The psychologist indicated that the plan should be to ask the dietary department to get Resident #5's meal to him before resident #9 received her meal, likewise in activities to address Resident #5 first and alter medications as necessary. This would limit the interaction time between the two.</p> <p>The clinical record for Resident # 9 was reviewed on 7/18/13 at 3:00 p.m. There was not a care plan noted for the behavior of "calling other residents 'grandpa'."</p> <p>2. On the following dates and times Resident #34 was observed</p>		<p>needs.</p> <p>All staff will be in-serviced by 8/18/13 regarding the facility's abuse policy, including the need to monitor and react quickly to prevent resident to resident abuse and to accurately document and report all instances of abuse and other maladaptive behaviors that are ongoing, regardless of staff intervention. Nursing staff will also be in-serviced on the appropriate completion when documenting 15 minute checks for residents.</p> <p>The psychologist visited on August 5, 2013.</p> <p>2. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></p> <p>-</p> <p>All residents have the potential to be affected by this practice. The DON will review the 24 hour report, incident reports, and focus charting at least 5 days a week as part of her tour of duty. She will bring those items, plus new physician orders to the next scheduled morning management interdisciplinary meeting for further review and discussion. The social services director will bring the behavior logs and resident care plans for review of specific behaviors and the outcome of the interventions put into place by the staff. Results of Guardian Angel rounds will also be reviewed</p>	

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	<p>displaying behaviors: On 7/15/13 at 12:05 p.m., she was in the unassisted dining room and grabbed Resident #14's walker and tried to pull it away from the table. Resident #22 politely informed Resident #34 this was not her walker. Resident #34 then wandered into the assist dining room, and then back into the unassisted dining room, again to the table where Resident #14 and Resident #22 were seated.</p> <p>On 7/15/13 at 12:15 p.m., Resident #22 assisted Resident #34 into the assisted dining room. At that time, the Administrator indicated he would assist Resident #34.</p> <p>On 7/15/13 at 12:21 p.m., Resident #34 drank Resident #28's tea. She had been in the dining room unattended since 12:17 p.m.</p> <p>On 7/15/13 at 12:23 p.m., Resident #34 was taken out of the dining room.</p> <p>On 7/15/12 at 12:31 p.m., Resident #34 came into the unassisted dining room. At that time the Administrator assisted Resident #34 to the assist dining room.</p> <p>On 7/15/13 at 2:05 p.m., Resident #34 was in the assisted dining room</p>		<p>including those that demonstrate issues with resident behaviors that are affecting other residents.</p> <p>Recommendations made by the team will be followed up by the designated team member(s). Any changes to the behavior log and care plan will be made at the same time as the review, with the results of those recommendations brought back to the next scheduled morning meeting for further review and discussion. The DON will make sure that the CNA assignment sheet is updated as needed and will indicate a change in interventions or behavior plan on the 24 hour report form to make sure that communication is extended to other shifts.</p> <p>The Social Services Director is conducting a monthly Behavior Committee meeting comprised of the interdisciplinary team members and the consultant pharmacist – the psychologist will attend as needed or requested. All residents with maladaptive behaviors and all residents who are currently taking any type of psychoactive medication are reviewed. Recommendations are made by the team with the DON and/or Social Services Director following up accordingly and documenting that follow up in the residents' records. The interventions for behaviors on the logs and care</p>		

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	<p>and Resident #29 yelled at her "Shut the hell up." Resident #34 then hit Resident #29 on the arm.</p> <p>The record for resident #34 was reviewed on 7/18/13 at 11:31 a.m. Current diagnoses included, but were not limited to, dementia, Alzheimer's with psychosis.</p> <p>A physician order, dated 7/15/13, indicated the resident was placed on 15 minute checks for three days. The 15 minute checks began at 1:30 p.m. on this date.</p> <p>There was no documented 15 minute checks for 7/15/13 from 9:45 p.m., 11:45 p.m., 7/17/13 from 6 a.m. to 2:45 p.m., and on 7/17/13 from 7:15 p.m. to 8:30 p.m.</p> <p>Observation, on 7/17/13 at 9:50 a.m., during rounds, Resident #34 was not found in the room she was located in on 7/16/13. Resident #34 was found in another room on the opposite hall with her name tag changed and she was asleep in the bed.</p> <p>LPN #1 was interviewed on 7/17/13 at 9:50 a.m., and she indicated that Resident #34 was moved to her new room because she migrated down to the room with the stop sign on the</p>		<p>plans are reviewed and revised as indicated by the team, with revisions to the CNA assignment sheets as needed. Follow up to all recommendations is reviewed at the next scheduled monthly Behavior Committee meeting.</p> <p>3. <u>What measures will be put into place to ensure this practice does not recur?</u></p> <p>In addition to the process outlined in question #2, the Administrator, DON, and Social Services Director will monitor residents' environment and any indication of discomfort or unease with other residents as part of their frequent rounds that occur during each tour of duty. Any concern expressed by any resident regarding another resident will be documented on a resident concern form and will be brought to the attention of the Administrator immediately, if he is not the one who has received the concern first hand. Once the staff and the Administrator have made sure that safety is assured for all residents involved, the Administrator will bring the interdisciplinary team and related documentation together to discuss the concern expressed by the resident.</p> <p>The Administrator will also notify the Indiana State Board of Health if the concern meets the guidelines as</p>		

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	<p>door. She indicated that Resident #34 and Resident #29, who had the stop sign on his door, do not get along for some reason. So management thought the move would help the situation between the two residents. She indicated Resident #34 had been moved on dayshift yesterday sometime right before she started work.</p> <p>The DNS (Director of Nursing Services) was interviewed on 7/17/13 at 11:31 a.m., regarding Resident #34's move. She indicated the Administrator, Social Service Director and herself were investigating at this time if Resident #34 grabbed Resident #21's arm intentionally to harm her or to get her attention. DNS indicated Resident #21 was Resident #34's new roommate and Resident #21 had been the person who reported the resident to resident altercation. There were no witnesses to this incident.</p> <p>The clinical record was reviewed on 7/18/13 at 9:58 a.m., for Resident # 34. Nursing notes, dated 7/17/13 at 4:30 p.m., indicated LPN #5 witnessed Resident #34 in a verbal altercation with another resident and placed on one on one with staff.</p>		<p>a "reportable incident" and will begin an investigation. The attending physician and family/legal representative will be notified of the occurrence – if directed by the attending physician, the psychologist will also be notified. The facility will follow through on the physician's recommendations and will document the results. If necessary, the resident who is causing discomfort, fear, or intrusion with other residents may be transferred to acute care for further evaluation.</p> <p>4. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u></p> <p>-</p> <p>The Administrator and Social Services Director will report any occurrences of resident-to-resident abuse and other ongoing maladaptive behaviors, along with the results of specific interventions designed to prevent the abuse situation, to the monthly QA&A Committee meeting for further review and recommendations. Recommendations will be followed up by the designated person who will report the results of those recommendations at the next Committee meeting. This will continue on an ongoing basis.</p> <p>Date of Compliance: 8/18/13</p>				

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	<p>The clinical record indicated diagnoses which included, but was not limited to: dementia, Alzheimer's with psychosis, HTN, generalized osteoarthritis, hypothyroid, GERD, hyperlipidemia.</p> <p>According to the discharge summary by an attending psychiatrist, on 6/12/13, the resident was "agitated and combative with staff, refusing to eat and refusing to take meds. She had been verbally aggressive with staff, using curse words, threatened to 'cut' staff if they tried to bathe her again, kicked an aide when trying to dress her, spitting meds out and slapping meds out of nurses's hands, hitting staff, refusing to eat and throwing food in the dining room with rapid mood changes.</p> <p>The physician orders, since admission, were as follows: 7/16/13 Regular diet with thin liquids-may have finger foods 7/15/113 Paxil 20 milligrams one tablet by mouth daily started for depression 6/28/13 Order for Psychiatric services for evaluation and treatment 6/28/13 Order to change medication time from 8 a.m. to 10 a.m. 7/1/13 One day trial of full liquefied puree in cups secondary to resident</p>						

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	<p>not eating- she would not eat but she would per nurses notes 7-1-13 at 9 p.m. 7/3/13 Remeron 7.5 milligrams by mouth at bedtime started 6/26/13 Clozapine 25 milligrams three tablets by mouth at bedtime-hold until available from pharmacy</p> <p>A plan of care without a date, but presented on 7/17/13 at 11:31 a.m. by the DNS (Director of Nursing Services), indicated the resident was being tracked for the following behaviors and had interventions for the behaviors.</p> <p>#1 Behavior for refusal to eat and interventions included: "Gently ask me if I need help eating. Do not do so in a forceful manner); "Need help eating, Ask me if anything sounds good to eat and give me choices, and Offer me my nutritional shake supplement."</p> <p>#2 Behavior for going in and out of others rooms in w/c (wandering) and interventions included: "Gently ask me to come out of others room if I am in there or assist me w/ [sic] leaving the room, Gently re-direct me if you see me heading for another residents room, Help me find an activity of interest that I may enjoy."</p> <p>#3 Behavior for verbally/physically aggressive when asked to take</p>			

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	<p>meds-eat etc. and interventions included: "Use dementia protocol, Re-focus my attention to approach me c (with) a smilest [sic] soft tone, Provide personal space and reapproach later, and Change staff member"</p> <p>#4 Behavior for using other res walker/assistance-no interventions in place for this behavior.</p> <p>No entries in behavior book for 7-15-13 for mealtime when Edna was in the nonassisted DR and she drank another res tea.</p> <p>Social Services Director (SSD) was observed on 7/17/13 at 5:30 p.m., pushing Resident #34 in her wheelchair into the unassisted dining room. then she had her in the unassisted dining room sitting with her one on one. At 5:25 p.m., the Nurse Consultant came into the unassisted dining room and asked the SSD "Are you going to sit with her in here?" The SSD answered "Yes." Resident # 34 was calmly sitting holding the SSD's hand.</p> <p>A nursing note dated 7/17/13 at 5 p.m., indicated an order was received to send the resident to the hospital for behavioral health treatment. A subsequent note, at 8:30 p.m.,</p>			

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	<p>indicated the resident was transported to the hospital.</p> <p>3. Review of the "Behavior Management and Monitoring Program," dated 1/15/01, on 7/19/13 at 4:00 p.m., indicated "It is the policy of this facility that residents who exhibit behavior problems will be included in the behavior management and monitoring program. This program is designed to accommodate individual needs and maintain resident's dignity, while managing behavioral symptoms....</p> <p>In addition, this facility reserves the right to include residents who exhibit:...Behaviors which violate the rights of others;....</p> <p>The behavior monitoring records will be initiated at the beginning of each month for each resident who requires behavior monitoring as designated by the behavior committee. A behavior monitoring record will be filled out and/or revised at any time that a new or worsening behavior is observed....</p> <p>Behavior monitoring records for the current month will be maintained in a log at the nurses' station. At the end of each month, the behavior monitoring records will be filed in the</p>				

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	residents' medical record...." 3.1-34(a)(1)			

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F000258 SS=D	<p>483.15(h)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS The facility must provide for the maintenance of comfortable sound levels. Based on observation and interview, the facility failed to provide a quiet dining experience during 1 of 2 meal observations. This affected 1 of 11 residents interviewed for noise in the facility. It had the potential to effect 31 to 31 residents who ate in the dining rooms. (Resident # 25)</p> <p>Findings include:</p> <p>1. During a 7/15/13 11:45 a.m. lunch meal observation, Resident # 35 and Resident # 6 were yelling out for 10 minutes prior to being served. At 11:55 a.m., LPN # 3 began feeding Resident # 35. Resident # 6 quit yelling when she was served. LPN # 3 stopped assisting Resident #35, to assist other residents. Resident # 35 began to yell out again. LPN # 3 returned to assist the resident to eat. Resident # 35 then became quiet. During the observation other residents were yelling to shut up at the residents who were yelling.</p> <p>During an 7/16/13 1:00 p.m. interview, the DON indicated that staff should not get up from assisting a resident to eat until the resident was</p>	F000258	<p><u>F258</u> It is the policy of this facility to provide for the maintenance of comfortable sound levels, including during meal times. 1. <u>What corrective action will be done by the facility?</u> In addition to the hands-on re-training done by the DON and Nurse Consultant during survey, staff will be in-serviced by 8/18/13 on the proper procedure to follow when assisting a resident to eat; for example, remaining with the resident until the meal is finished, not standing at the resident's side, instead of sitting next to the resident while assisting them to eat, and talking to and with the resident, rather than others who are in the room, during the meal assistance. It is noted on page 15 of 49 that the facility policy "Meal Service" does not directly address the issue of staff talking to other staff while assisting resident; there is an additional policy that was not shared with the surveyors titled, "Feeding the Resident", #N-F002. This policy does address the issue of staff talking over residents to other staff – page 2 of 3 (See attachment, F241-1). This policy will be shared with staff as part of the in-service done by 8/18/13.</p>	08/18/2013			

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	<p>finished eating.</p> <p>Review of a current, facility policy titled "Meal Service," was provided by the Administrator on 7-19-13 at 2:30 p.m. and indicated the following: "Purpose: ... To provide assistance for each residents as needed. Guidelines:...In order to maintain the resident's dignity while eating, staff assisting residents to eat will sit beside the resident. It is not acceptable to stand by the resident when assisting him or her to eat...."</p>		<p>As of the lunch service on 8/1/13 the dining room seating was adjusted by moving residents who require more assistance during meal time to the smaller dining room. This allows for a quieter atmosphere with less stimulation. The residents who require little to no assistance with meals are now seated in the larger dining room. Since there is less staff and resident activity this gives them a quieter dining experience as well. Resident #35 has been moved to the smaller dining room, so that Resident #35 and #6 are now at separate tables.</p> <p>2. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></p> <p>-</p> <p>All residents have the potential to be affected; however, no other instances have been noted since the rearrangement of the dining rooms. The DON and Nurse Consultant re-trained the staff during the survey when they realized that improper procedures were being followed regarding the techniques being used while assisting residents to eat.</p> <p>However, if any issue is noted during meal service with the noise level or staff practice, the interdisciplinary team manager or nurse assigned to monitor and assist with the meal will</p>		

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			<p>intervene to lessen the noise or stop the inappropriate practice immediately and re-instruct the staff involved on the facility policy. If non-compliance continues with staff performance, progressive disciplinary action will be rendered.</p> <p>3. <u>What measures will be put into place to ensure this practice does not recur?</u></p> <p>One of the interdisciplinary team members is assigned to monitor each meal to assist with the meal service, but also to monitor staff performance during the meal. As indicated in question #2, if any concern or issue is identified the manager or nurse will address the situation immediately. Re-training of staff or redirection of the resident(s) involved will occur at that time. The meal manager will use a QA tool, "Meal Service" to document what he/she has observed, as well as any action taken to correct any concerns or issues that were observed. The meal manager will bring the completed QA tool to the next scheduled interdisciplinary morning manager meeting to review the results of his/her monitoring activities, as well as any action taken. If the noise level was observed to be too loud, the interdisciplinary team will review the circumstances of the situation and recommend changes to the dining</p>	

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	<p>2. During the interview with Resident #25, on 7/15/13 at 10:38 a.m., he indicated the dining room was noisy while he is eating.</p> <p>According to the MDS (Minimum Data Set) assessment reviewed on 7/19/13 at 10:50 a.m., Resident #25 was cognitively intact.</p> <p>3.1-19(f)</p>		<p>service as needed to maintain more comfortable sound levels during the meals.</p> <p>4. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The Administrator or designee will bring the results of the Meal Service audits to the monthly QA&A Committee meeting for further review and recommendations for process improvement. This will continue for the next 3 months – once 100% compliance has been reached, the Committee members may decide to stop the written audits. Even when the written audits are stopped, the process of monitoring the meals and reporting meal service issues will continue on an ongoing basis.</p> <p>Date of Compliance: 8/18/13</p>		

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F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to initiate a care plan for maladaptive behaviors for 1 of 19 residents reviewed for care plans. (Resident # 9)</p> <p>Findings include:</p> <p>During interview with Resident #5, on 7/15/13 at 2:39 p.m., Resident #5 stated that (Resident #9) "curses me....she uses curse words and calls me grandpa and I don't like it. I have told someone numerous times....I can't remember who.... it still</p>	F000279	<p><u>F279</u></p> <p>It is the policy of this facility to develop a comprehensive care plan for each resident, including for those residents who demonstrate maladaptive behaviors.</p> <p>1. <u>What corrective action will be done by the facility?</u></p> <p>Resident #9 and Resident #5 have been separated from each other as much as possible within the facility.</p> <p>In an attempt to clarify the concern that Resident #5 seems to have regarding Resident #9, the team found documentation from 2006 when Resident #5 was at Bowen Center where it was noted that, "he</p>	08/18/2013
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	<p>continues."</p> <p>The Administrator, Consultant Nurse and RN #30 were notified 7/15/13 at 3:25 p.m. of the concern. No other information was provided prior to exit on 7/19/13 at 5:30 p.m.</p> <p>The clinical review for Resident #5 was reviewed on 7/18/13 at 10:03 a.m. The Minimum Data Set (MDS) Quarterly Review, dated 4/25/13, indicated the resident was not cognitively impaired.</p> <p>Clinical Review on 7/16/13 at 11:26 a.m., indicated Resident #5 had diagnoses which included, but were not limited to, chronic paranoid schizophrenia, hypertension, tardive dyskinesia, hypothyroidism, right foot partial amputation, peripheral neuropathy, mild chronic obstructive pulmonary disease, depression, bilateral edema, atrial fibrillation, and insulin dependent diabetes type II.</p> <p>Clinical Review on 7/18/13 at 2:30 p.m. indicated Resident #5 was seen by the psychologist on 1/7/13 and again on 1/29/13. The psychologist indicated that the plan should be to ask the dietary department to get Resident #5's meal to him before resident #9 received her meal,</p>		<p>(Resident #5) has had times when he thought people were making fun of him at the facility and his feelings were very hurt by this..." The Administrator has indicated that earlier this week he was present in the dining room when Resident #9 walked into the room and passed by Resident #5 at a distance of several feet away. She did not notice him nor make an attempt to speak to him, but Resident #5 remarked to the Administrator that Resident #5 called him "Grandpa". Administrator told him that Resident #9 did not speak to him at all. He then redirected Resident #5 by asking what he wanted to drink for lunch. Care plans have been updated for both residents with specific interventions for each to reduce or eliminate these behaviors. The residents are now eating in different dining rooms in order to limit the interaction between them. The Nurse Consultant will in-service the interdisciplinary team by 8/18/13 regarding the development of comprehensive care plans for all residents and the need to address maladaptive behaviors where indicated.</p> <p>2. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></p> <p>- All residents have the potential to be</p>		

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	<p>likewise in activities to address Resident #5 first and alter meds as necessary. This would limit the interaction time between the two.</p> <p>The clinical record for Resident # 9 was reviewed on 7/18/13 at 3:00 p.m. There was not a care plan noted for the behavior of "calling other residents 'grandpa'."</p> <p>Review of the "Behavior Management and Monitoring Program," dated 1/15/01, on 7/19/13 at 4:00 p.m., indicated "It is the policy of this facility that residents who exhibit behavior problems will be included in the behavior management and monitoring program. This program is designed to accommodate individual needs and maintain resident's dignity, while managing behavioral symptoms....</p> <p>In addition, this facility reserves the right to include residents who exhibit:...Behaviors which violate the rights of others;....</p> <p>The behavior monitoring records will be initiated at the beginning of each month for each resident who requires behavior monitoring as designated by the behavior committee. A behavior monitoring record will be filled out and/or revised at any time that a new</p>		<p>affected by this practice. All care plans of residents who have maladaptive behavior will be reviewed by 8/18/13 to make sure that they are current and have appropriate interventions in place.</p> <p>The DON will review the 24 hour report, incident reports, and focus charting at least 5 days a week as part of her tour of duty. She will bring those items, plus new physician orders to the next scheduled morning management interdisciplinary meeting for further review and discussion. The social services director will bring the behavior logs and resident care plans for review of specific behaviors and the outcome of the interventions put into place by the staff. Results of Guardian Angel rounds will also be reviewed including those that demonstrate issues with resident behaviors that are affecting other residents.</p> <p>Recommendations made by the team will be followed up by the designated team member(s). Any changes in interventions to the behavior log and care plan will be made at the same time as the review, with the results of those recommendations brought back to the next scheduled morning meeting for further review and discussion. The DON will make sure that the CNA assignment sheet is updated as</p>				

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	<p>or worsening behavior is observed....</p> <p>Behavior monitoring records for the current month will be maintained in a log at the nurses' station. At the end of each month, the behavior monitoring records will be filed in the residents' medical record...."</p> <p>3.1-35(a)</p>		<p>needed and will indicate a change in interventions or behavior plan on the 24 hour report form to make sure that communication is extended to other shifts.</p> <p>The Social Services Director is conducting a monthly Behavior Committee meeting comprised of the interdisciplinary team members and the consultant pharmacist – the psychologist will attend as needed or requested. All residents with maladaptive behaviors and all residents who are currently taking any type of psychoactive medication are reviewed. Recommendations are made by the team with the DON and/or Social Services Director following up accordingly and documenting that follow up in the residents' records. The interventions for behaviors on the behavior logs and care plans are reviewed and revised as indicated by the team, with revisions to the CNA assignment sheets as needed. Follow up to all recommendations is reviewed at the next scheduled monthly Behavior Committee meeting.</p> <p>3. <u>What measures will be put into place to ensure this practice does not recur?</u></p> <p>In addition to the process outlined in question #2, the Administrator, DON, and Social Services Director</p>		

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			<p>will monitor residents' environment and any indication of discomfort or unease with other residents as part of their frequent rounds that occur during each tour of duty. Any concern expressed by any resident regarding another resident will be documented on a resident concern form and will be brought to the attention of the Administrator immediately, if he is not the one who has received the concern first hand. Once the staff and the Administrator have made sure that safety is assured for all residents involved, the Administrator will bring the interdisciplinary team and related documentation together to discuss the concern expressed by the resident.</p> <p>4. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u></p> <p>- The Administrator and Social Services Director will report any occurrences of ongoing maladaptive behaviors, along with the results of specific interventions designed to lessen or prevent the situation from occurring to the monthly QA&A Committee meeting for further review and recommendations for new or revised interventions which will be placed on the involved residents' care plans. These will be followed up by the designated</p>		

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			<p>person who will report the results of those recommendations at the next Committee meeting. This will continue on an ongoing basis.</p> <p>Date of Compliance: 8/18/13</p>	

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F000319 SS=D	<p>483.25(f)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem.</p> <p>Based on observation, record review and interview the facility failed to provide care and services for 1 of 1 residents who displayed psychological and mental adjustment difficulty after admission identified. (Resident #34)</p> <p>Findings including:</p> <p>On the following dates and times Resident #34 was observed displaying behaviors: 7/15/13 at 12:05 p.m., she was in the unassisted dining room and grabbed Resident #14's walker and tried to pull it away from the table. Resident #22 politely informed Resident #34 this was not her walker. Resident #34 then wandered into the assist dining room, and then back into the unassisted dining room, again to the table where Resident #14 and Resident #22 were seated.</p> <p>On 7/15/13 at 12:15 p.m., Resident</p>	F000319	<p><u>F319</u></p> <p>It is the policy of this facility to ensure that residents who display mental or psychosocial adjustment difficulties receive appropriate treatment and services.</p> <p>1. <u>What corrective action will be done by the facility?</u> Resident #34 has been discharged to another setting to better meet her needs. All staff will be in-serviced by 8/18/13 regarding the facility's abuse policy, including the need to monitor and react quickly to prevent resident to resident abuse and to accurately document and report all instances of abuse and other maladaptive behaviors that are ongoing, regardless of staff intervention. Nursing staff will also be in-serviced on the appropriate completion when documenting 15 minute checks for residents. The psychologist visited 8/05/2013</p> <p>2. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></p>	08/18/2013			

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	<p>#22 assisted Resident #34 into the assisted dining room. At that time, the Administrator indicated he would assist Resident #34.</p> <p>On 7/15/13 at 12:21 p.m., Resident #34 drank Resident #28's tea. She had been in the dining room unattended since 12:17 p.m.</p> <p>On 7/15/13 at 12:23 p.m., Resident #34 was taken out of the dining room.</p> <p>On 7/15/12 at 12:31 p.m., Resident #34 came into the unassisted dining room. At that time the Administrator assisted Resident #34 to the assist dining room.</p> <p>On 7/15/13 at 2:05 p.m., Resident #34 was in the assisted dining room and Resident #29 yelled at her "Shut the hell up." Resident #34 then hit Resident #29 on the arm.</p> <p>The record for resident #34 was reviewed on 7/18/13 at 11:31 a.m. Current diagnoses included, but were not limited to, dementia, Alzheimer's with psychosis.</p> <p>According to the discharge summary by an attending psychiatrist, on 6/12/13, the resident was "agitated and combative with staff, refusing to</p>		<p>All residents have the potential to be affected by this practice. The DON will review the 24 hour report, incident reports, and focus charting at least 5 days a week as part of her tour of duty. She will bring those items, plus new physician orders to the next scheduled morning management interdisciplinary meeting for further review and discussion. The social services director will bring the behavior logs and resident care plans for review of specific behaviors and the outcome of the interventions put into place by the staff. Results of Guardian Angel rounds will also be reviewed including those that demonstrate issues with resident behaviors that are affecting other residents.</p> <p>Recommendations made by the team will be followed up by the designated team member(s). Any changes to the behavior log and care plan will be made at the same time as the review, with the results of those recommendations brought back to the next scheduled morning meeting for further review and discussion. The DON will make sure that the CNA assignment sheet is updated as needed and will indicate a change in interventions or behavior plan on the 24 hour report form to make sure that communication is extended to other shifts.</p>	
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	<p>eat and refusing to take meds. She had been verbally aggressive with staff, using curse words, threatened to 'cut' staff if they tried to bathe her again, kicked an aide when trying to dress her, spitting meds out and slapping meds out of nurses's hands, hitting staff refusing to eat and throwing food in the dining room with rapid mood changes.</p> <p>The clinical record indicated diagnoses which included, but were not limited to: dementia, Alzheimer's with psychosis, HTN, generalized osteoarthritis, hypothyroid, GERD, hyperlipidemia</p> <p>The physician orders since admission on 6/24/13, were as follows: 7/16/13 Regular diet with thin liquids-may have finger foods 7/15/113 Paxil 20 milligrams one tablet by mouth daily started for depression 6/28/13 Order for Psychiatric services for evaluation and treatment 6/28/13 Order to change medication time from 8 a.m. to 10 a.m. 7/1/13 One day trial of full liquefied puree in cups secondary to resident not eating- she would not eat but she would per nurses notes 7-1-13 at 9 p.m. 7/3/13 Remeron 7.5 milligrams by</p>		<p>The Social Services Director is conducting a monthly Behavior Committee meeting comprised of the interdisciplinary team members and the consultant pharmacist – the psychologist will attend as needed or requested. All residents with maladaptive behaviors and all residents who are currently taking any type of psychoactive medication are reviewed. Recommendations are made by the team with the DON and/or Social Services Director following up accordingly and documenting that follow up in the residents' records. The interventions for behaviors on the logs and care plans are reviewed and revised as indicated by the team, with revisions to the CNA assignment sheets as needed. Follow up to all recommendations is reviewed at the next scheduled monthly Behavior Committee meeting.</p> <p>3. <u>What measures will be put into place to ensure this practice does not recur?</u></p> <p>In addition to the process outlined in question #2, the Administrator, DON, and Social Services Director will monitor residents' environment and any indication of discomfort or unease with other residents as part of their frequent rounds that occur during each tour of duty. Any concern expressed by any resident regarding another resident will be</p>		

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	<p>mouth at bedtime started 6/26/13 Clozapine 25 milligrams three tablets by mouth at bedtime-hold until available from pharmacy.</p> <p>Observation on 7/17/13 at 9:50 a.m., during rounds, Resident #34 was not found in the room she was located in on 7/16/13. Resident #34 was found in another room on the opposite hall with her name tag changed and she was asleep in the bed.</p> <p>LPN #1 was interviewed on 7/17/13 at 9:50 a.m., and she indicated that Resident #34 was moved to her new room because she migrated down to the room with the stop sign on the door. She indicated that Resident #34 and Resident #29, who had the stop sign on his door, do not get along for some reason. So management thought the move would help the situation between the two residents. She indicated Resident #34 had been moved on dayshift yesterday sometime right before she started work.</p> <p>The DNS (Director of Nursing Services) was interviewed on 7/17/13 at 11:31 a.m., regarding Resident #34's move. She indicated the Administrator, Social Service Director and herself were investigating at this</p>		<p>documented on a resident concern form and will be brought to the attention of the Administrator immediately, if he is not the one who has received the concern first hand. Once the staff and the Administrator have made sure that safety is assured for all residents involved, the Administrator will bring the interdisciplinary team and related documentation together to discuss the concern expressed by the resident.</p> <p>The Administrator will also notify the Indiana State Board of Health if the concern meets the guidelines as a "reportable incident" and will begin an investigation. The attending physician and family/legal representative will be notified of the occurrence – referrals to the psychologist will be done as ordered by the physician. The facility will follow through on the physician's and psychologist's recommendations and will document the results. If necessary, the resident who is causing discomfort, fear, or intrusion with other residents will be transferred to acute care for further evaluation.</p> <p>4. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u></p> <p>- The Administrator and Social</p>		

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	<p>time if Resident #34 grabbed Resident #21's arm intentionally to harm her or to get her attention. DNS indicated Resident #21 was Resident #34's new roommate and Resident #21 had been the person who reported the resident to resident altercation. There were no witnesses to this incident.</p> <p>The clinical record was reviewed on 7/18/13 at 9:58 a.m., for Resident # 34. Nursing notes, dated 7/17/13 at 4:30 p.m., indicated LPN #5 witnessed Resident #34 in a verbal altercation with another resident and placed on one on one with staff.</p> <p>A physician order dated 7/15/13 indicated the resident was placed on 15 minute checks for three days. The 15 minute checks began at 1:30 p.m. on this date.</p> <p>There were no documented 15 minute checks for 7/15/13 from 9:45 p.m. to 11:45 p.m., 7/17/13 from 6 a.m. to 2:45 p.m., and on 7/17/13 from 7:15 p.m. to 8:30 p.m.</p> <p>A plan of care without a date, but presented on 7/17/13 at 11:31 a.m., by the DNS (Director of Nursing Services). indicated the resident was being tracked for the following</p>		<p>Services Director will report any occurrences of resident-to-resident abuse and other ongoing maladaptive behaviors, along with the results of specific interventions designed to prevent the abuse situation, to the monthly QA&A Committee meeting for further review and recommendations. Recommendations will be followed up by the designated person who will report the results at the next Committee meeting. This will continue on an ongoing basis.</p> <p>Date of Compliance: 8/18/13</p>		

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	<p>behaviors and had interventions for the behaviors.</p> <p>#1 Behavior for refusal to eat and interventions included: "Gently ask me if I need help eating. Do not do so in a forceful manner); "Need help eating, Ask me if anything sounds good to eat and give me choices, Offer me my nutritional shake supplement."</p> <p>#2 Behavior for going in and out of others rooms in w/c (wandering) and interventions included: "Gently ask me to come out of others room if I am in there or assist me w/ [sic] leaving the room, Gently re-direct me if you see me heading for another residents room, Help me find an activity of interest that I may enjoy."</p> <p>#3 Behavior for verbally/physically aggressive when asked to take meds-eat etc. and interventions included: "Use dementia protocol, Re-focus my attention to approach me c (with) a smilest [sic] soft tone, Provide personal space and reapproach later, and Change staff member."</p> <p>#4 Behavior for using other res walker/assistance-no interventions in place for this behavior.</p> <p>No entries in behavior book for 7-15-13 for mealtime when Edna was in the nonassisted DR and she drank</p>			

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	<p>another res tea.</p> <p>Social Services Director (SSD) was observed on 7/17/13 at 5:30 p.m., pushing Resident #34 in her wheelchair into the unassisted dining room. then she had her in the unassisted dining room sitting with her one on one. At 5:25 p.m., the Nurse Consultant came into the unassisted dining room and asked the SSD "Are you going to sit with her in here?" The SSD answered "Yes." Resident # 34 was calmly sitting holding the SSD's hand.</p> <p>A nursing note, dated 7/17/13 at 5 p.m., indicated an order was received to send the resident to the hospital for behavioral health treatment. A subsequent note at 8:30 p.m., indicated the resident was transported to the hospital.</p> <p>3.1-43(a)(1)</p>				

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F000323 SS=D	<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. Based on observation and record review, the facility failed to provide supervision to prevent choking for 1 of 18 residents eating in the assist dining room during 2 of 2 meal observations. (Resident # 9)</p> <p>Findings include:</p> <p>During the lunch meal observation, on 7/15/13 at 12 noon, Resident # 9 was served her meal. She began to eat using utensils. There were staff in the area but not monitoring her closely. Then she picked up her breadstick and bit a piece off of it. Without chewing, she bit another piece of bread off and then another. Her mouth was so full of bread that her cheeks puffed out. CNA # 12 was called to prevent the resident from choking.</p> <p>During the evening meal observation, on 7/17/13 at 5:45 p.m., Resident # 9 was served her meal. She began eating a sandwich that had been cut in fourths. She stuffed three of the</p>	F000323	<p><u>F323</u> It is the policy of this facility to ensure that each resident receives adequate supervision and assistance to prevent accidents, including provision of supervision to prevent choking during meal time.</p> <p>1. <u>What corrective action will be done by the facility?</u></p> <p>In addition to the hands-on re-training done by the DON and Nurse Consultant during survey, staff will be in-serviced by 8/18/13 on the proper procedure to follow when assisting a resident to eat; for example, remaining with the resident until the meal is finished, not standing at the resident's side, instead of sitting next to the resident while assisting them to eat, talking to and with the resident, rather than others who are in the room, during the meal assistance, and supervising residents who have been identified as being at risk for choking during meal times.</p> <p>It is noted on page 15 of 49 that the facility policy "Meal Service" does not directly address the issue of staff talking to other staff while assisting</p>	08/18/2013			

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	<p>four sections into her mouth without chewing. Staff were in the dining room but not monitoring her closely. The nurse consultant was called to attend to the resident to prevent her from choking.</p> <p>The record for Resident #9 was reviewed on 7/19/13 at 4:10 p.m. The care plan, dated 9/26/13, indicated: "I do not have any teeth. I will eat very fast and put too much food in my mouth at times. Because of this, I am at risk for choking or aspiration."</p> <p>The care plan interventions were updated 7/2013 and indicated: "I need staff to monitor me while I am eating and I need staff to encourage me to eat slowly."</p> <p>3.1-45(a)(2)</p>		<p>resident; there is an additional policy that was not shared with the surveyors titled, "Feeding the Resident", #N-F002. This policy does address the issue of staff talking over residents to other staff – page 2 of 3 (See attachment, F241-1). This policy will be shared with staff as part of the in-service done by 8/18/13.</p> <p>As of the lunch service on 8/1/13 the dining room seating was adjusted by moving residents who require more assistance during meal time to the smaller dining room. This allows for a quieter atmosphere with less stimulation. The residents who require little to no assistance with meals are now seated in the larger dining room. Since there is less staff and resident activity this gives them a quieter dining experience as well. Resident #9 has been moved to the smaller dining room to provide for closer supervision and subsequent redirection when needed. A speech therapy evaluation to assess Resident #9's eating behaviors was done on 8/7/13, and the resident is currently being seen for modification of her method of eating. Staff will integrate the speech therapist's recommendations into the resident's plan of care as they are determined.</p> <p>2. <u>How will the facility identify other residents having the potential</u></p>		

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			<p><u>to be affected by the same practice and what corrective action will be taken?</u></p> <p>-</p> <p>All residents have the potential to be affected; however, no other instances have been noted since the rearrangement of the dining rooms. The DON and Nurse Consultant re-trained the staff during the survey when they realized that improper procedures were being followed regarding the techniques being used while assisting residents to eat.</p> <p>However, if any issue is noted during meal service with the staff practice in supervising residents to make sure that they are eating safely, the interdisciplinary team manager or nurse assigned to monitor and assist with the meal will intervene to stop the inappropriate practice immediately. Once the resident has been cared for and is safe, the manager will re-train the staff involved on appropriate procedure for monitoring and redirecting at risk residents while eating. If non-compliance continues with staff performance, progressive disciplinary action will be rendered, up to and including termination of employment.</p> <p>3. <u>What measures will be put into place to ensure this practice does not recur?</u></p>	

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			<p>One of the interdisciplinary team members is assigned to monitor each meal to assist with the meal service, but also to monitor staff performance during the meal. As indicated in question #2, if any concern or issue is identified the manager or nurse will address the staff immediately and re-train them in the acceptable procedure to follow. The meal manager will use a QA tool, "Meal Service" to document what he/she has observed, as well as any action taken to correct any concerns or issues that were observed. The meal manager will bring the completed QA tool to the next scheduled interdisciplinary morning manager meeting to review the results of his/her monitoring activities, as well as any action taken.</p> <p>The interdisciplinary team will provide further recommendations, if appropriate, for revised interventions in redirecting residents to eat safely. The resident's care plan and behavior log will be revised to reflect those interventions, and the CNA assignment sheet will also be updated. The DON will add the changed interventions to the 24 hour report sheet to make sure that those changes are communicated to other shifts.</p> <p>4. <u>How will corrective action be</u></p>	

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			<p><u>monitored to ensure the deficient practice does not recur and what QA will be put into place?</u></p> <p>The Administrator or designee will bring the results of the Meal Service audits to the monthly QA&A Committee meeting for further review and recommendations for process improvement. This will continue for the next 3 months – once 100% compliance has been reached, the Committee members may decide to stop the written audits. Even when the written audits are stopped, the process of monitoring the meals and reporting meal service issues will continue on an ongoing basis.</p> <p>Date of Compliance: 8/18/13</p>		

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F000329 SS=E	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 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 interview, and record review, the facility failed to ensure that psychotropic medications (medications used to manage behaviors) were reviewed for gradual dose reductions, for 8 of 10 residents reviewed for unnecessary drugs. (Residents # 14,13,16,18, 27,9, 22,and 5)</p> <p>Findings include:</p> <p>1. Resident # 14's record was</p>	F000329	<p><u>F329</u> It is the policy of this facility to ensure that each resident's drug regimen is free from unnecessary drugs, including gradual dose reductions for residents who use psychotropic medications.</p> <p>1. <u>What corrective action will be done by the facility?</u> The facility held a comprehensive behavior committee meeting on 8/5/13 to review all residents who are receiving psychotropic drugs. <u>For Resident #13</u>, his Seroquel was reduced to 100 mg. BID on August</p>	08/18/2013			

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	<p>reviewed 7/17/13 at 1:30 p.m..</p> <p>Resident # 14's current diagnoses included, but were not limited to, Bipolar Type Schizophrenia with psychosis, depression, diabetes, and borderline personality disorder.</p> <p>Resident # 14 had a current, 6/2013, physician's order for the following Psychotropic medications: Valium 5 mg one half of a tablet, twice a day. Seroquel 200 mg take 2 tablets at hour of sleep, Seroquel 50 mg at 8:00 a.m. and 2:00 p.m., Effexor ER 75 mg every a.m., Depakote 250 mg three times a day, Remeron 15 mg at hour of sleep.</p> <p>Review of Resident # 14's record indicated that there had not been a gradual dose reduction for any of the medications since 5/2012.</p> <p>2. Resident #13 record was reviewed on 7/19/13 at 12:45 p.m.</p> <p>Resident # 13 had a current 6/2013, physician's order for the following psychotropic medications: Seroquel 200 mg twice a day, Lexapro 20 mg every a.m..</p> <p>Resident #13 current diagnoses, included but were not limited to,</p>		<p>12, 2013.</p> <p><u>For Resident #14</u> , On August 8, 2013, the attending physician declined a request for a dose reduction of Remeron, a contraindication statement has been requested from the Physician.</p> <p><u>For Resident #22</u>, his Xanax was reduced to 0.25mg BID on August 6, 2013. It is true that this resident is on Fluoxetine, too, but the physician agreed with the pharmacist's recommendations to start with reduction of one of the several psychoactive medications that he takes, and gradually move to each one as other medication reductions are attempted and completed. The physician has been contacted regarding whether or not he believes that the Depakote is still contraindicated for reduction – an updated clinically contraindicated letter has been requested.</p> <p><u>For Resident #5</u>, the committee recommended in June and July 2013 that no reduction be attempted because of his continued paranoia toward others. In fact, his concerns over Resident #9 are outlined elsewhere in the CMS-2567. At this 8/5/13 meeting, reduction was again delayed and the psychologist did visit him with some recommendations for non-drug interventions. His behavior will be monitored throughout August and</p>				

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	<p>Dementia, Alzheimer's with depression, sexually inappropriate behavior to men, and acute psychotic episodes.</p> <p>Resident 13's record indicated no gradual dose reduction been tried for any of the medications since 5/2012.</p> <p>During an interview with the nurse consultant on 7/18/13 at 10:30 a.m., she indicated there was not an attempted G.D.R. (gradual dose reduction) since 5/2012 for Resident # 13 and Resident # 14.</p>		<p>the committee will review him in September for possible drug reduction. If that does not occur, the physician will be contacted for medication adjustment and/or clinical contraindication documentation.</p> <p>For <u>Resident #9</u>, her Seroquel was reduced July 9, 2013 to 75mg. There is a need to consider a reduction of her Lexapro as indicated in the survey deficiencies; however, the committee chose to try reducing the antipsychotic medication first.</p> <p><u>For Resident #18</u>, the physician has been contacted as to whether or not he believes that her psychotropic medication is still contraindicated for reduction – an updated clinically contraindicated letter has been requested.</p> <p><u>For Resident #27</u>, her Risperdal was reduced on July 9, 2013 to 0.5mg daily and the committee recommended that it be decreased again in August. This was done on August 12, 2013 to 0.25mg.. The physician has been contacted regarding whether or not he believes that the Cymbalta or Remeron are still contraindicated for reduction – an updated clinically contraindicated letter has been requested. <u>For Resident #16</u>, his Seroquel was reduced on July 8, 2013 to 25mg.</p>		

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			<p>daily. The physician has been contacted regarding whether or not he believes that the Celexa or Depakote are still contraindicated for reduction – an updated clinically contraindicated letter has been requested.</p> <p>Other reductions include: <u>Resident #2</u> Lexapro was discontinued August 8, 2013. <u>Resident #7</u> had Risperdal reduced to 0.5mg twice daily on August 13, 2013. <u>Resident #1</u> had Buspar discontinued on August 12, 2013. <u>Resident #17</u> had Seroquel reduced on August 12, 2013 to 25mg in the am and 50 mg at hs. <u>Resident #33</u> had Trazadone reduced to 100mg at HS on August 12, 2013.</p> <p>2. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></p> <p>- Residents receiving psychoactive medications have the potential to be affected by this practice. The Social Services Director is conducting a monthly Behavior Committee meeting comprised of the interdisciplinary team members and the consultant pharmacist – the psychologist will attend as needed or requested. All residents with maladaptive behaviors and all residents who are currently taking</p>		

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			<p>any type of psychoactive medication are reviewed. Recommendations for reductions are made by the team with the DON and/or Social Services Director following up accordingly and documenting that follow up in the residents' records. If clinically contraindicated letters are needed, the DON and/or Social Services Director will follow up with the physician to make sure that the appropriate documentation is obtained. The interventions for behaviors on the logs and care plans are reviewed and revised as indicated by the team, with revisions to the CNA assignment sheets as needed. Follow up to all recommendations is reviewed at the next scheduled monthly Behavior Committee meeting.</p> <p>3. <u>What measures will be put into place to ensure this practice does not recur?</u></p> <p>The DON and Social Services Director have set up a system of tracking psychoactive drug order changes and gradual reduction attempts for all residents who receive psychoactive medications. They will review this with the consultant pharmacist during her drug regimen reviews and will use this as a guide during the Behavior committee meetings to make sure that requests for drug reductions are occurring as required.</p>	

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	3. The clinical record for Resident		<p>The Nurse Consultant will continue to attend the behavior committee meetings for the next 3 months to make sure that the committee is addressing behavior needs and drug reductions appropriately. If she finds any issues, she will re-train the committee members on the facility policy and will monitor the results of that re-training at subsequent committee meetings. Once the 3 months has elapsed, the Nurse Consultant will schedule her visits to coincide with the behavior committee meeting at least quarterly. That will continue on an ongoing basis.</p> <p>4. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u></p> <p>-</p> <p>The Social Services Director will report the results of the behavior committee review, including the status of drug reductions to the monthly QA&A Committee meeting for further review and recommendations. Recommendations will be followed up by the Social Services Director who will report the results at the next Committee meeting. This will continue on an ongoing basis.</p> <p>Date of Compliance: 8/18/13</p>	

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	<p>#22 was reviewed on 7/16/13 at 2:44 p.m. Current diagnoses included, but were not limited to, vascular dementia with depression, left cerebrovascular accident with hemiplegia, hyperlipidemia, aphasia, anemia and chronic kidney disease.</p> <p>The resident was currently receiving the following medications, on a daily basis, Divalproex (Mood Stabilizer) originally ordered on 9/18/2008 and Fluoxetine (Antidepressant) originally ordered on 8/20/2008.</p> <p>The chart indicated a GDR (Gradual Dose Reduction) had a last Contraindicated Letter (CL) dated 5/2012 for Depakote, being used as a mood stabilizer.</p> <p>There was no GDR noted for Fluoxetine, originally ordered 8/20/2008. The Nurse Consultant was asked twice to provide any further information concerning the GDR for Fluoxetine. No other information was provided as of exit on 7/19/13.</p> <p>4. The clinical record for Resident #5 was reviewed on 7/16/13 at 11:26 a.m. Current diagnoses included, but were not limited to, chronic paranoid schizophrenia, hypertension, tardive</p>			

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	<p>dyskinesia, hypothyroidism, right foot partial amputation, peripheral neuropathy, mild chronic obstruction pulmonary disease, depression, bilateral edema, atrial fibrillation and insulin dependent diabetes type II.</p> <p>The resident was currently receiving the following medications, on a daily basis, Citalopram (Anti-depressant) originally ordered on 6/5/2012, Clonazepam (Antianxiety) originally ordered on 11/10/2012, and Divalproex (Mood Stabilizer) originally ordered on 1/20/2013.</p> <p>The chart indicated a GDR (Gradual Dose Reduction) on Depakote, being used as a mood stabilizer was last completed on 1/2012. The GDR on Citalopram, being used as a antidepressant was last completed 5/2012. There was no GDR noted for Clonazepam, originally ordered 11/10/12.</p> <p>Nurse Consultant was asked twice to provide any further information concerning the GDR for Clonazepam. No other information was provided as of exit on 7/19/13.</p> <p>5. The clinical record for Resident #9 was reviewed on 7/16/13 at 9:16 a.m. Current diagnoses included, but were</p>			

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	<p>not limited to, erosive esophagitis, status post cholecystectomy, hypothyroidism, cataracts, gastroesophageal reflux disease, constipation and bipolar II.</p> <p>The resident was currently receiving the following medication, on a daily basis, Lexapro (Antidepressant) originally ordered on 8/11/2007.</p> <p>The chart indicated a GDR (Gradual Dose Reduction) on Lexapro, being used as a Antidepressant was last completed on 7/2011.</p> <p>Nurse Consultant was asked twice to provide any further information concerning the GDR for Lexapro. No other information was provided as of exit on 7/19/13.</p> <p>6. Resident # 18's clinical record was reviewed on 7/17/13 at 4 p.m.</p> <p>Current diagnoses included, but were not limited to, bipolar disorder, depression, paranoid schizophrenia, and mental retardation.</p> <p>Resident # 18 had current orders for Depakote (a mood stabilizing medication) 250 milligrams, one tablet by mouth twice daily for bipolar disorder. This order originated on 6/19/08. Risperdal (an antipsychotic</p>			

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	<p>medication) 1.5 milligrams, one tablet by mouth twice daily for schizophrenia. This order originated on 8/6/2008. Zoloft 100 milligrams (an antidepressant medication), one tablet by mouth at bedtime for depression. This order originated on 6/19/2008. Zyprexa (an antipsychotic medication) 5 milligrams in the morning and 15 milligrams at bedtime for paranoid schizophrenia. This order originated on 8/24/2009.</p> <p>Resident # 18's record lacked any documentation of a GDR (Gradual Dose Reduction) for Depakote since the Clinical Contraindication Letter from the physician on 4/2011. The order for Risperdal showed no GDR since the increase of dosage on 11/2011. The order for Zoloft showed no GDR since the increase of dosage on 5/2012 and the order for Zyprexa showed no GDR since the decrease of dosage on 5/2012.</p> <p>During an interview with the Nurse Consultant on 7/17/13 at 4 p.m., she indicated that the May of 2012 Contraindication Letter from the physician was the last letter that could be found for the GDR.</p> <p>7. Resident # 27's clinical record was reviewed on 7/17/13 1:20 p.m.</p>			

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	<p>Resident # 27's current diagnoses included, but were not limited to, depression and vascular dementia with behavioral disturbance.</p> <p>Resident #27 had current orders for Cymbalta (an antidepressant medication) 60 milligrams, one capsule by mouth daily with food for vascular dementia with depression. This order originated on 1/17/2012. Remeron (an antidepressant medication) 30 milligrams, one tablet by mouth at bedtime for depression. This order originated on 1/27/2012.</p> <p>Resident # 27's record lacked any documentation of a GDR (Gradual Dose Reduction) for Cymbalta or Remeron since the Clinical Contraindication letter from the physician on 5/2012.</p> <p>During an interview with the Nurse Consultant on 7/17/13 at 4:00 p.m., she indicated that the May of 2012 Contraindication Letter from the physician was the last letter that could be found for the GDR.</p> <p>8. Resident #16's clinical record was reviewed on 7/17/13 at 10:22 a.m.</p> <p>Resident #16's current diagnoses</p>			

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	<p>included, but were not limited to, dementia due to head injury, psychosis with delusion, and depression.</p> <p>Resident #16 had current orders for Celexa 10 milligrams (an antidepressant medication) one tablet by mouth daily for depression. This order originated on 3/28/2011.</p> <p>Depakote (an antiseizure medication used as a mood stabilizer 250 milligrams/5 milliliters, 12.5 milliliters (625 milligrams) by mouth twice daily for psychosis w/delusions. This order originated on 12/5/2007.</p> <p>Resident #16's record lacked any documentation of a GDR (Gradual Dose Reduction) for Celexa or Depakote, since Clinical Contraindication Letter from the physician on 5/2012.</p> <p>During an interview with the Nurse Consultant on 7/17/13 at 4:00 p.m., she indicated that the May of 2012 Contraindication Letter from the physician was the last letter that could be found for the GDR.</p> <p>9. Review of current facility policy titled "Psychoactive Drug Monitoring," which was provided by the Director of Nursing on 7/19/13 at 12:54 p.m.,</p>			

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	<p>indicated the following:</p> <p>"Residents who receive antidepressant, hypnotic, antianxiety, or antipsychotic medications are monitored to evaluate the effectiveness of the medication. Every effort is made to ensure that residents receiving these medications obtain the maximum benefit with the minimum of untoward effects.</p> <p>The continued need for the psychoactive medication is reassessed regularly by the prescriber and the care planning team. If continuation is deemed necessary, this is indicated in the medical record. Effects of the medications are documented as a part of the care planning process. Unless medically contraindicated, periodic dosage reductions are attempted and the results documented.</p> <p>For deviation from the recommended dosage and dosage reduction criteria, the clinical record contains evidence to support justification for use of a drug not meeting the dosage criteria, but considered clinically appropriate by the physician."</p> <p>3.1-48(b)(2)</p>						

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F000356 SS=C	<p>483.30(e) POSTED NURSE STAFFING INFORMATION</p> <p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation, and record review, the facility failed to post staffing information that contained the actual hours worked for 3 of 5 days of the survey. This practice has the potential to effect 31 of 31 residents.</p>	F000356	<p><u>F356</u></p> <p>It is the policy of this facility to post nurse staffing data as required, including the actual hours worked for RNs, LPNs, and CNAs.</p> <p>1. <u>What corrective action will be done by the facility?</u></p>	08/18/2013

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	<p>Findings include:</p> <p>During initial tour observation on 7/15/13, at 9:00 a.m., the posted staffing was dated 7/14/2013. Review of the posted staffing indicated it did not contain the actual hours worked.</p> <p>During an observation on 7/16/13 at 3:00 p.m., the posted staffing did not contain the actual hours worked for 7/16/13.</p> <p>During an observation on 7/17/13 at 8:00 a.m., the posting was blank except for the date and the census. It did not contain the number of staff or the actual hours that were to be worked on 7/17/13.</p> <p>During a 7/17/13, 8:05 a.m., interview with the Director of Nursing, she indicated that the night shift nursing staff was responsible for filling out the posting for staffing.</p> <p>Review of a current policy titled "Nursing Staffing," received from the Director of Nursing at 7/19/13 at 9:30 a.m., indicated the following: "Policy: the nursing home will post the following information in a daily basisThe total number and the</p>		<p>The DON and charge nurses will be in-serviced by the Nurse Consultant by 8/18/13 regarding posting the nursing staffing and indicating actual hours worked for each shift.</p> <p>2. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></p> <p>While the posting of actual nursing staffing hours did not meet regulations, there were no residents affected by this practice.</p> <p>3. <u>What measures will be put into place to ensure this practice does not recur?</u></p> <p>The night shift charge nurse will post the projected nursing staffing hours for the next day. The DON or designated charge nurse will check the projected staffing hours and amend them to show actual hours worked each shift.</p> <p>The Administrator or designated manager will check the posted hours each day during rounds throughout the building to make sure that the hours have been amended to show actual hours worked. If he finds that this has not been done, he will re-train the charge nurse on duty at the time and will bring the concern to the DON who will follow up with the nurse to make sure that she clearly understands the process. Completed nursing staffing forms</p>				

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	actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift...."		will be retained for 18 months as per facility policy. 4. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The Administrator will bring the completed staffing reports for the prior month to the monthly QA&A Committee meeting for review for the next 3 months. At the end of that time, if 100% compliance is reached, the Committee may decide to stop their monthly review. Date of Compliance: 8/18/13	

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F000428 SS=E	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on observation and interview, the facility failed to ensure the pharmacy reviewed the medication regimen and reported gradual dose reductions for 4 of 10 residents reviewed for unnecessary medications. (Residents #'s 13,14, 33, and 22)</p> <p>Findings include:</p> <p>1. Resident # 14's record was reviewed 7/17/13 at 1:30 p.m..</p> <p>Resident # 14's current diagnoses included, but were not limited to, Bipolar Type Schizophrenia with psychosis depression diabetes, and borderline personality disorder.</p> <p>Review of Resident # 14's record indicated there had not been a recommendation from the pharmacy for any gradual dose reduction since 1/2013.</p>	F000428	<p>F428</p> <p>It is the policy of this facility to ensure that each resident's drug regimen has been reviewed by the consultant pharmacist including the need for gradual dose reductions for residents who use psychotropic medications.</p> <p>1. <u>What corrective action will be done by the facility?</u></p> <p>The facility held a comprehensive behavior committee meeting with the pharmacist in attendance on 8/5/13 to review all residents who are receiving psychotropic drugs. <u>For Resident #14</u>, On August 8,2013 the attending Physician declined a request for a dose reduction of Remeron, a contraindication statement has been requested from the Physician.</p> <p style="text-align: right;">E</p> <p><u>or Resident #13</u>, his Seroquel was reduced to 100 mg. BID on August 12, 2013.</p> <p><u>For Resident #33</u>, her Trazodone has been decreased again on August 12, 2013. The committee noted that it had been increased when she was</p>	08/18/2013

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	<p>Resident # 14 had a current, 6/2013, physician's order for the following Psychotropic medications: Valium 5 mg one half of a tablet, twice a day. Seroquel 200 mg take 2 tablets at hour of sleep, Seroquel 50 mg at 8:00 a.m. and 2:00 p.m., Effexor ER 75 mg every a.m., Depakote 250 mg three times a day, Remeron 15 mg at hour of sleep.</p> <p>2. Resident #13 record was reviewed on 7/19/13 at 12:45 p.m.</p> <p>Resident #13's current diagnoses, included but were not limited to, Dementia Alzheimer's with depression sexually inappropriate behavior to men, acute psychotic episodes.</p> <p>Resident # 13 had a current, 6/2013, physician's order for the following psychotropic medications: Seroquel 200 mg twice a day, Lexapro 20 mg every a.m.</p> <p>Review of Resident # 13's record indicated there had not been a recommendation from the pharmacy for a gradual dose reduction since 8/23/12.</p> <p>During an interview with the nurse consultant on 7/19/13 at 2:30 a.m.,</p>		<p>staying at an inpatient psych unit recently and staff had observed that she seemed to be overly sedated.</p> <p><u>For Resident #22,</u> his Xanax was reduced to 0.25mg BID on August 6, 2013. It is true that this resident is on Fluoxetine, too, but the physician agreed with the pharmacist's recommendations to start with reduction of one of the several psychoactive medications that he takes, and gradually move to each one as other medication reductions are attempted and completed. The physician has been contacted regarding whether or not he believes that the Depakote is still contraindicated for reduction – an updated clinically contraindicated letter has been requested. While it is not clear why the pharmacist's attendance was not requested by the former Administrator and interdisciplinary team members, the current Administrator and team have made sure that the pharmacist is involved in every behavior committee meeting. The consultant pharmacist has been in attendance for all behavior committee meetings since June 2013 and will continue to attend.</p> <p>We could not find a regulation that requires a pharmacy review for every new admission beyond what is done at the pharmacy itself when the admission/readmission orders</p>				

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	she indicated there was not a GDR (gradual dose reduction) since 5/2012 for Resident # 13 and Resident # 14 and that the pharmacy had not recommended a gradual dose reduction. She also indicated that pharmacy had only started attending the Psychotropic drug meetings until last month.		are conveyed to them for ordering of the needed medications. However, in order to establish a best practice approach to the unique needs of the residents we serve at this facility, the DON will contact the consultant pharmacist when a resident is admitted/readmitted from an inpatient psychiatric stay to assess the admission orders for any psychoactive drugs and to advise the facility of any recommendations for changes in these drugs. If recommendations are received, the attending physician will be notified of those recommendations. The DON's contact with the pharmacist and any subsequent recommendations will be documented in the nurses' progress notes in the resident's medical record. 2. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> - Residents receiving psychoactive medications have the potential to be affected by this practice. The Social Services Director is conducting a monthly Behavior Committee meeting comprised of the interdisciplinary team members and the consultant pharmacist – the psychologist will attend as needed or requested. All residents with maladaptive behaviors and all		

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			<p>residents who are currently taking any type of psychoactive medication are reviewed. Recommendations for reductions are made by the team with the DON and/or Social Services Director following up accordingly and documenting that follow up in the residents' records. If clinically contraindicated letters are needed, the DON and/or Social Services Director will follow up with the physician to make sure that the appropriate documentation is obtained. The interventions for behaviors on the logs and care plans are reviewed and revised as indicated by the team, with revisions to the CNA assignment sheets as needed. Follow up to all recommendations is reviewed at the next scheduled monthly Behavior Committee meeting.</p> <p>3. <u>What measures will be put into place to ensure this practice does not recur?</u></p> <p>The DON and Social Services Director have set up a system of tracking psychoactive drug order changes and gradual reduction attempts for all residents who receive psychoactive medications. They will review this with the consultant pharmacist during her drug regimen reviews and will use this as a guide during the Behavior committee meetings to make sure that requests for drug reductions are</p>		

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			<p>occurring as required.</p> <p>The Nurse Consultant will continue to attend the behavior committee meetings for the next 3 months to make sure that the committee is addressing behavior needs and drug reductions appropriately. If she finds any issues, she will re-train the committee members on the facility policy and will monitor the results of that re-training at subsequent committee meetings. Once the 3 months has elapsed, the Nurse Consultant will schedule her visits to coincide with the behavior committee meeting at least quarterly. That will continue on an ongoing basis.</p> <p>4. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u></p> <p>-</p> <p>The Social Services Director will report the results of the behavior committee review, including the status of drug reductions to the monthly QA&A Committee meeting for further review and recommendations. Recommendations will be followed up by the Social Services Director who will report the results at the next Committee meeting. This will continue on an ongoing basis.</p> <p>Date of Compliance: 8/18/13</p>		

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	<p>3. The clinical record for resident #33 was reviewed on 7-19-13 at 12:26 p.m., and indicated no pharmacy review had been completed. The resident was admitted on 6/24/13.</p> <p>Interview with Nurse Consultant, on 7/19/13 at 1:35 p.m., indicated that "no pharmacy review was in the chart due to the resident was a new admit."</p> <p>4. The clinical record for resident #22 was reviewed on 7-19-13 at 2:26 p.m., and indicated that the last pharmacy review was on 6/25/13 and currently had not been acted on.</p> <p>3.1-25(h) 3.1-25(i)</p>	F000428	<p><u>F428</u></p> <p>It is the policy of this facility to ensure that each resident's drug regimen has been reviewed by the consultant pharmacist including the need for gradual dose reductions for residents who use psychotropic medications.</p> <p>1. <u>What corrective action will be done by the facility?</u></p> <p>The facility held a comprehensive behavior committee meeting with the pharmacist in attendance on 8/5/13 to review all residents who are receiving psychotropic drugs. <u>For Resident #14</u>, On August 8,2013 the attending Physician declined a request for a dose reduction of Remeron, a contraindication statement has been requested from the Physician.</p> <p style="text-align: right;">E</p> <p><u>or Resident #13</u>, his Seroquel was reduced to 100 mg. BID on August 12, 2013.</p> <p><u>For Resident #33</u>, her Trazodone has been decreased again on August 12, 2013. The committee noted that it had been increased when she was staying at an inpatient psych unit recently and staff had observed that she seemed to be overly sedated.</p> <p style="text-align: right;"><u>For Resident #22</u>,</p> <p>his Xanax was reduced to 0.25mg BID on August 6, 2013It is true that this resident is on Fluoxetine, too, but the physician agreed with the pharmacist's recommendations to</p>	08/18/2013	

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			<p>start with reduction of one of the several psychoactive medications that he takes, and gradually move to each one as other medication reductions are attempted and completed. The physician has been contacted regarding whether or not he believes that the Depakote is still contraindicated for reduction – an updated clinically contraindicated letter has been requested.</p> <p>While it is not clear why the pharmacist's attendance was not requested by the former Administrator and interdisciplinary team members, the current Administrator and team have made sure that the pharmacist is involved in every behavior committee meeting. The consultant pharmacist has been in attendance for all behavior committee meetings since June 2013 and will continue to attend.</p> <p>We could not find a regulation that requires a pharmacy review for every new admission beyond what is done at the pharmacy itself when the admission/readmission orders are conveyed to them for ordering of the needed medications.</p> <p>However, in order to establish a best practice approach to the unique needs of the residents we serve at this facility, the DON will contact the consultant pharmacist when a resident is admitted/readmitted from an inpatient psychiatric stay to assess the admission orders for any</p>		

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			<p>psychoactive drugs and to advise the facility of any recommendations for changes in these drugs. If recommendations are received, the attending physician will be notified of those recommendations. The DON's contact with the pharmacist and any subsequent recommendations will be documented in the nurses' progress notes in the resident's medical record.</p> <p>2. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></p> <p>- Residents receiving psychoactive medications have the potential to be affected by this practice. The Social Services Director is conducting a monthly Behavior Committee meeting comprised of the interdisciplinary team members and the consultant pharmacist – the psychologist will attend as needed or requested. All residents with maladaptive behaviors and all residents who are currently taking any type of psychoactive medication are reviewed. Recommendations for reductions are made by the team with the DON and/or Social Services Director following up accordingly and documenting that follow up in the residents' records. If clinically contraindicated letters are needed, the DON and/or Social Services</p>		

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			<p>Director will follow up with the physician to make sure that the appropriate documentation is obtained. The interventions for behaviors on the logs and care plans are reviewed and revised as indicated by the team, with revisions to the CNA assignment sheets as needed. Follow up to all recommendations is reviewed at the next scheduled monthly Behavior Committee meeting.</p> <p>3. <u>What measures will be put into place to ensure this practice does not recur?</u></p> <p>The DON and Social Services Director have set up a system of tracking psychoactive drug order changes and gradual reduction attempts for all residents who receive psychoactive medications. They will review this with the consultant pharmacist during her drug regimen reviews and will use this as a guide during the Behavior committee meetings to make sure that requests for drug reductions are occurring as required.</p> <p>The Nurse Consultant will continue to attend the behavior committee meetings for the next 3 months to make sure that the committee is addressing behavior needs and drug reductions appropriately. If she finds any issues, she will re-train the committee members on the facility</p>		

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			<p>policy and will monitor the results of that re-training at subsequent committee meetings. Once the 3 months has elapsed, the Nurse Consultant will schedule her visits to coincide with the behavior committee meeting at least quarterly. That will continue on an ongoing basis.</p> <p>4. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u></p> <p>-</p> <p>The Social Services Director will report the results of the behavior committee review, including the status of drug reductions to the monthly QA&A Committee meeting for further review and recommendations. Recommendations will be followed up by the Social Services Director who will report the results at the next Committee meeting. This will continue on an ongoing basis.</p> <p>Date of Compliance: 8/18/13</p>		

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F000520 SS=E	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on observations, record review, and interview, the facility failed to develop and implement appropriate plans of action to address how staff treated residents in the dining room, that residents' choices were honored for use of a tub for bathing, that gradual dose reductions were implemented for 8 of 10 residents reviewed for unnecessary medications, and that the pharmacy reviewed and recommended gradual</p>	F000520	<p><u>F520</u></p> <p>It is the policy of this facility to maintain a quality assessment and assurance committee to develop and implement plans of action to address identified concerns and issues within the facility.</p> <p>1. <u>What corrective action will be done by the facility?</u></p> <p>-</p> <p>The Administrator and the interdisciplinary team will be re-trained by the Nurse Consultant on the facility policy for quality</p>	08/18/2013

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	<p>dose reductions for 4 of 10 residents as identified during the Annual Recertification and State Licensure survey. (Residents # 1, 2, 5, 9, 13, 14,16, 18, 22, 25, 27, 31, 33, 34, and 35)</p> <p>Findings include:</p> <p>During a 7/19/2013 at 2:30 p.m. interview with the Administrator and Regional Director of Operations, the administrator was queried regarding QAA (Quality Assurance and Assessment) and the identified concerns of the annual survey as follows:</p> <ol style="list-style-type: none"> 1. Dignity in the dining room regarding staff standing to feed residents for Resident # 35, interrupting resident assistance by leaving the table for Resident # 35, and placing clothing protectors on residents without asking permission for Residents # 1, 2, 13, 14, 31, & 33. 2. Choices related to use of a tub for bathing for Residents # 18 & 25. 3. Behavior Management in place for Residents # 9 and 34. 4. Gradual dose reduction of psychotropic drugs on Residents # 5, 9, 13, 14, 16, 18, 22, & 27. 5. Pharmacy recommendations for dose reduction for psychotropic drugs not being followed for Residents # 13, 		<p>assurance and assessment meetings, including the function and need for continuous assessment, review, planning, and development of action plans to address identified concerns and issues within the facility, including dignity in the dining room, residents' choices for bathing, behavior management of maladaptive behaviors, gradual dose reductions for residents receiving psychotropic drugs, and follow up to pharmacy recommendations for dose reductions by 8/18/13.</p> <p>2. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></p> <p>All residents have the potential to be affected by this practice. On an ongoing basis identified concerns or issues in any area that affect the residents' care or environment will be brought to the interdisciplinary team meeting at the next scheduled morning meeting which occurs at least 5 days a week. The more severe issues will be immediately addressed by the Administrator or other member of management staff to make sure that the resident is safe and comfortable. Those situations will also be brought to the interdisciplinary team to review and discuss what interventions or other action is needed to make sure that process</p>	

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	<p>14, 22, & 33.</p> <p>The Administrator indicated none of these concerns had been included in the facility qaa program. He also indicated no action plan or evaluation of the concerns had been included in the qaa program.</p> <p>3.1-52(b)(2)</p>		<p>improvement is in place and being monitored so that it continues to occur as planned, or so that the need for more revision is identified as necessary to correct the situation until compliance is in place and the residents' care and services is appropriate.</p> <p>3. <u>What measures will be put into place to ensure this practice does not recur?</u></p> <p>In addition to the review of the 24 hour report, focus charting, incident reports, new physician orders, behavior logs and results of the Guardian Angel rounds which occurs at least 5 days a week as part of the interdisciplinary morning management meeting, the interdisciplinary team meets weekly for Standards of Care which analyzes ongoing trends or patterns within the facility requiring problem-solving or some type of intervention. Any additional needs for process improvement are discussed and approaches are developed for correction.</p> <p>The monthly QA&A Committee meets to review the results of all prior problem identification and the interventions that have been put into place to provide improvement in the services and care of the residents. This Committee will continue the review and oversight of all facility processes until ongoing compliance is demonstrated on a consistent basis.</p>		

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			<p>The Nurse Consultant or the Regional Director of Operations will review the minutes of the morning management meetings, weekly Standards of Care, and monthly QA&A Committee at least weekly for the next 90 days. They will indicate their review by their signature and date of review on each committee's minutes. Any identified concerns will be discussed with the Administrator and interdisciplinary team members at the time of the review, with training and direction for improvement provided for the committee members.</p> <p>4. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u></p> <p>The QA&A Committee will meet at least monthly to review and provide recommendations as needed for all areas identified as needs improvement, including those identified in the survey and written on the CMS-2567. Action plans for newly identified issues will be developed with interventions and documentation of progress or lack of progress noted on each as the improvement activities are integrated into the facility services. As interventions are added or changed, they will be documented on the action plan. The Administrator and interdisciplinary</p>		

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			<p>team will use these as a point of reference as they work on each of the identified areas throughout the month. The action plans for areas already identified as needing improvement will be reviewed at each QA&A Committee meeting to assess progress in the correction efforts. The results will be analyzed by the Committee members and recommendations made as needed to continue the improvement process.</p> <p>After 90 days, the Nurse Consultant and Regional Director of Operations may decide to stop the documentation of their weekly review of the committees' minutes; however, the reviews and related action done by each of the committees including the QA&A Committee will continue on an ongoing basis.</p> <p>Date of Compliance: 8/18/13</p>		