

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155245	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/16/2013
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NAME OF PROVIDER OR SUPPLIER CASTLETON HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7630 E 86TH ST INDIANAPOLIS, IN 46256
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F000000	<p>This visit was for a Recertification and State Licensure survey.</p> <p>Survey Date: July 9, 10, 11, 12, 15, 16, 2013.</p> <p>Facility number: 000149 Provider number: 155245 AIM number: 100266840</p> <p>Survey Team: Courtney Mujic, RN- TC Beth Walsh, RN (July 9, 10) Karina Gates, medical surveyor Suzanne Williams, RN (July 9, 10, 11, 12, 16) Tom Stauss, RN (July 9, 10, 11, 12)</p> <p>Census Bed Type: SNF: 7 SNF/NF: 44 Total: 51</p> <p>Census Payor Type: Medicaid: 35 Medicare: 9 Private: 4 Other: 3 Total: 51</p>	F000000	Submission of this Plan of Correction shall not constitute or be construed as an admission by Castleton Health Care Center that the allegations contained in the survey report are accurate or reflect accurately the provisions of Nursing Care and services to the residents of Castleton Health Care Center.	

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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	<p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on July 19, 2013 by Randy Fry RN.</p>			

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F000274 SS=D	<p>483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE</p> <p>A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)</p> <p>Based on interview and record review, the facility failed to ensure a resident had a significant change MDS (minimum data set) assessment completed timely after going on hospice for 1 of 20 residents reviewed for MDS assessments. (Resident #28)</p> <p>Findings include:</p> <p>The clinical record for Resident #28 was reviewed on 7/15/13 at 10:00 a.m.</p> <p>The diagnoses for Resident #28 included, but were not limited to: Alzheimer's disease and severe debility.</p>	F000274	<p>It is the intent of this facility to ensure each resident meeting the guidelines for Significant Change MDS, has an assessment completed within 14 days after the determination is made that there has been a significant change in the resident's physical or mental condition. I. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? Resident #28 had a significant change MDS Assessment completed on 7/15/13. II. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken? Any resident requiring a significant change MDS Assessment has the potential to</p>	08/15/2013	

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	<p>The clinical record indicated the last comprehensive MDS assessment was completed as an annual assessment on 3/20/12, and the last MDS assessment completed at all for Resident #28 was a quarterly assessment dated 2/28/13.</p> <p>The 6/20/13 physician's order for Resident #28 was for hospice to evaluate and treat.</p> <p>Resident #28 had a hospice care plan dated 6/24/13.</p> <p>During an interview with the MDS Coordinator on 7/15/13 at 10:43 a.m., she indicated, "It looks like something happened with the software and she was skipped. Her last comprehensive MDS was on 3/20/12 and her last quarterly was 2/28/13. I may need to start tracking this manually. I'm going to make sure these get done tomorrow."</p> <p>During another interview with the MDS Coordinator on 7/16/13 at 10:07 a.m. she indicated, "...Even the sig change (significant change MDS) should have been done by 7/8 (7/8/13) with her going on hospice on 6/24 (6/24/13).</p>		<p>be affected by the alleged finding. An audit was completed of all residents to ensure they had a current MDS Assessment completed. III. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur? The RAI guidelines for significant change MDS Assessments were reviewed with the MDS Coordinator by the facility D.O.N. Monthly audits will be completed by D.O.N./designee of all resident beginning Hospice care to ensure a significant change MDS Assessment was completed. IV. How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place? The D.O.N./designee will present the findings of the new Hospice care audits to the QA Committee during monthly meetings for six months to ensure compliance.</p>		

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	3.1-31(d)(1)			

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F000275 SS=D	<p>483.20(b)(2)(iii) COMPREHENSIVE ASSESS AT LEAST EVERY 12 MONTHS A facility must conduct a comprehensive assessment of a resident not less than once every 12 months.</p> <p>Based on interview and record review, the facility failed to ensure a resident had an annual MDS (minimum data set) assessment completed timely for 1 of 20 residents reviewed for MDS assessments. (Resident #28)</p> <p>Findings include:</p> <p>The clinical record for Resident #28 was reviewed on 7/15/13 at 10:00 a.m.</p> <p>The diagnoses for Resident #28 included, but were not limited to: Alzheimer's disease and severe debility.</p> <p>The clinical record indicated the last comprehensive MDS assessment was completed as an annual assessment on 3/20/12 and the last MDS assessment completed at all for Resident #28 was a quarterly assessment with a date of 2/28/13.</p> <p>During an interview with the MDS Coordinator on 7/15/13 at 10:43 a.m.,</p>	F000275	<p>It is the intent of this facility to ensure that each resident have an annual MDS Assessment completed not less than once every 12 months. I. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? Resident #28 had an MDS Assessment completed on 7/15/13. II. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected by the alleged finding. A audit of all residents last annual MDS Assessment was completed to ensure compliance. III. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur? The MDS Coordinator will keep a manual MDS Assessment calendar in addition to the computerized calendar. The MDS Coordinator will audit both tracking methods monthly to ensure all residents receive an annual MDS Assessment timely. IV. How the corrective action(s) will be monitored to ensure the</p>	08/15/2013

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	<p>she indicated, "It looks like something happened with the software and she was skipped. Her last comprehensive MDS was on 3/20/12 and her last quarterly was 2/28/13. I may need to start tracking this manually. I'm going to make sure these get done tomorrow."</p> <p>During another interview with the MDS Coordinator on 7/16/13 at 10:07 a.m. she indicated, "She should have had an annual (annual MDS) done in March (2013). The 2/28 (2/28/13) quarterly (quarterly MDS) should have been an annual (annual MDS) and then triggered again for one in May (2013)."</p> <p>3.1-31(d)(2)</p>		<p>alleged deficient practice will not recur, i.e., what quality assurance program will be put into place? The MDS Coordinator will present the results of the MDS Assessment calendar audits to the QA Committee during monthly QA Meetings to ensure compliance.</p>		

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident received the appropriate wound care as ordered, and policy and procedures for re-weighing a resident were followed, for 2 of 6 residents reviewed for pressure ulcers and for nutrition. (Resident #'s 28 and 44)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #28 was reviewed on 7/15/13 at 10:00 a.m.</p> <p>The diagnoses for Resident #28 included, but were not limited to: Alzheimer's disease and severe debility.</p> <p>A 6/12/13 physician's order indicated, "...sacral ulcer. Start cleanse area (symbol for "with") sterile water, pat dry..."</p> <p>The 7/10/13 (name of wound care center) progress note indicated the plan for this wound was, "Cleanse</p>	F000282	<p>It is the intent of this facility that services provided or arranged by the facility be provided by qualified persons in accordance with each resident's written plan of care. I. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? Resident #28 no longer resides in the facility. Resident #44 received a re-weight on 7/16/13. II. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken? Any resident requiring wound care and/or re-weighing have the potential to be affected by the alleged finding. Physician orders for all residents receiving wound care were reviewed to ensure physician orders were being followed. No resident receiving wound care was found to be affected by the alleged deficient finding. All resident weights for August were reviewed, any resident with a 5 pound weight loss or gain were re-weighed. 7 residents were found to need re-weights and those re-weights were completed and appropriate</p>	08/15/2013

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	<p>wound with sterile water. Pat dry..."</p> <p>An observation of Resident #28's dressing change to her sacral ulcer was made on 7/16/13 at 11:55 a.m. with the DON (Director of Nursing) and LPN #5. LPN #5 indicated she was using normal saline, Risamine and silver alginate for the dressing change. LPN #5 opened small, pink colored tubes ("bullets") of normal saline and cleansed the wound with the saline.</p> <p>During an interview with LPN #5 following the dressing change at 12:05 p.m. on 7/16/13, she confirmed she used normal saline to cleanse the wound. At this time, the 6/12/13 physician order to use sterile water to cleanse the wound was reviewed with LPN #5. LPN #5 indicated she was unaware sterile water was supposed to be used.</p> <p>2. Resident #44's clinical record was reviewed on 7/12/13 at 1:25 p.m. Diagnoses included, but were not limited to; dementia, insomnia, depression, anxiety, dysphagia (difficulty in swallowing), glaucoma, constipation.</p>		<p>individuals were notified. Licensed nursing staff will be in-serviced on following physician orders on 8/6/13. Licensed nursing staff and C.N.A.s will be in-serviced on weighing residents on 8/6/13. III. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur? The D.O.N./designee will audit all weights by the 15th of each month to ensure any needed re-weights are completed and appropriate parties are notified. The D.O.N./designee will complete random audits of wound care being performed on not less than 10% of residents requiring wound care twice weekly for 6 months. IV. How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place? The D.O.N./designee will present results of audits to the QA Committee during monthly QA Meetings to ensure compliance.</p>		

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	<p>The resident's clinical record indicated the following body weights in 2013, "January: 119.2 lbs, February: 119.4 lbs, March: 119.2, April: 119.8, May: 117.8, June: 117.2, July: 111.4".</p> <p>A "Nutrition" care plan indicated, "Goal: Resident's weight will remain +/- 5 lbs of current weight through next review. Approaches; Weigh and monitor results monthly and PRN (as needed)."</p> <p>An interview with the Dietary Manager (DM) on 7/16/2013 at 10 am indicated she wasn't aware of a weight loss for Resident #44. She indicated weights are tracked in the weight book and then re-written in the resident's chart. She indicated the July weight of 111 must be wrong, and she would immediately re-weigh the resident.</p> <p>An interview with the Dietary Manager, on 7/16/2013 at 10:10 am, indicated, the resident was re-weighed, and she currently weighed 117.2 lbs. The Dietary Manager indicated she reviewed all the weights within a week or two after they were taken, which is supposed to be completed by the 7th of each month. The DM indicated Resident</p>			

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	<p>#44 had been doing really well, and had a stable weight since coming off of hospice in end of December 2012.</p> <p>A document from the Dietary Manager's weight book, provided by the Dietary Manager on 7/16/2013 at 3:50 pm, indicated, "Month: July. Monthly Weight and Vital Signs. Must be done between July 1st and July 7th." Resident #44's row indicated, "Wt (weight) last month: 117.2. Resident weight: 111.4. If more than 5 lb from Resident's last month weight do a re-weight: Reweigh 7/16/2013, 117.2".</p> <p>A "Weight measurement/variance" policy, provided by the D.O.N. on 7/16/2013 at 10:53 am, indicated, "Policy:...Discrepancies in monthly weights will be monitored and reported to appropriate parties. Procedure: 2. ...All residents will be weighed by the 7th of each month. 4. By the 10th of each month, the Charge Nurse will review the "weight log", identify problems, and direct the Nursing Assistants to reweigh residents as necessary. The reweigh results will be recorded on the weight log."</p>				

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	3.1-35(g)(2)			

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F000314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident wore her prevalon boot in bed as a means of offloading pressure to her right heel with a stage 3 pressure ulcer for 1 of 3 residents reviewed of 8 who met the criteria for pressure sores. (Resident # 33)</p> <p>Findings include:</p> <p>The clinical record for Resident #33 was reviewed on 7/16/13 at 10:30 a.m.</p> <p>The diagnoses for Resident #33 included, but were not limited to: dementia and right side hemiparesis.</p> <p>The June, 2013 physician's orders for Resident #33 indicated, "Keep Prevalon boots on in bed & chair. Pressure relieving mattress on bed;</p>	F000314	<p>It is the intent of this facility to ensure that residents entering the facility without pressure sores do not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. I. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? Resident #33 wears her prevalon boots while in bed. II. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken? Any resident wearing prevalon boots have the potential to be affected by the alleged finding. Nursing staff will be in-serviced on offloading pressure devices on 8/6/13. III. What</p>	08/15/2013

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	<p>check every shift."</p> <p>The 2/11/13 pressure ulcer care plan, last updated 7/10/13, for Resident #33 indicated the goal was for her pressure ulcer(s) to exhibit signs of healing evidenced by decrease in size, improved appearance, and free from signs & symptoms of infection. Approaches indicated on the care plan were as follows:</p> <p>"Prevalon boot Rt (right) heel Float heals when in bed Wound care as ordered by physician."</p> <p>An observation was made on 7/16/13 at 1:39 p.m. of Resident #33 lying in bed with her heels not floated and not wearing her prevalon boot.</p> <p>During an interview with LPN #6 on 7/16/13 at 1:45 p.m. regarding whether anything specific should be done to Resident #33's heels while lying in bed, she responded, "Does she not have her boot on? That's not good." LPN #6 walked quickly to Resident #33's room and put Resident #33's prevalon boot on her right foot. LPN #6 stated "The CNA (Certified Nursing Assistant) just layed (sic) her down. She should have her boot on or her heels floated.</p>		<p>measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur? The D.O.N./designee will complete random audits of not less than 5 residents 3 times per week for 6 months to ensure proper offloading devices are in place. IV. How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place? The D.O.N./designee will present the findings of the audits to the QA Committee during monthly QA Meetings.</p>		

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	<p>Honestly, they were not floated before I put the boot on." LPN #6 indicated CNA #7 put Resident #33 to bed.</p> <p>During an interview with CNA #7 on 7/16/13 at 1:56 p.m., she indicated she was the one who put Resident #33 to bed and stated, "I was told she's not to have the boot on in bed. It's not on my assignment sheet." CNA #7 handed her assignment sheet to the ADON.</p> <p>Review of CNA #7's assignment sheet did not indicate any information about her prevalon boot. At this time, the ADON updated CNA #7's assignment sheet to read "add prevalon boots @ all times to Rt foot." The ADON stated, "It should be on there. It's on the orders."</p> <p>During another interview with CNA #7 on 7/16/13 at 1:59 p.m., she indicated she was under the impression that with an air mattress, Resident #33's boots weren't necessary. She indicated whenever she put Resident #33 to bed, she left her prevalon boot off because she had an air mattress.</p> <p>The 7/10/13 wound specialist progress note indicated, "Musculoskeletal: Contracted; poor range of motion making offloading</p>			

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	<p>and positioning difficult...Wound # 1 Right Heel is a Stage 3 pressure ulcer and has received a status of not healed. Measurements are 1 cm length x 2 cm width x 0.3 cm depth, with an area of 2 sq cm and a volume of 0.6 cubic cm. There is a moderate amount of sero-sanguineous drainage noted which has a mild odor. The patient reports a wound pain of level 0. The wound margin is undefined. Wound bed is 76-100% pink granulation; no eschar present. There is no change noted in the wound progression. The periwound skin texture is normal. The periwound skin moisture is normal. The periwound skin color is normal. Periwound skin does not exhibit signs or symptoms of infection. Local pulse is weak. General Notes: only tiny area of increased (0.3) depth to center. Otherwise wound unchanged...Educated nursing staff at bedside regarding proper wound offloading/pressure relief: Yes."</p> <p>During another interview with the ADON on 7/17/13 at 2:40 p.m. she indicated she was the nurse at bedside who would have received the education on proper offloading/pressure relief indicated in the above mentioned wound specialist progress note.</p>			

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	3.1-40(a)(1) 3.1-40(a)(2)			

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F000315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident received the appropriate catheter care, as ordered, for 1 of 2 residents reviewed for catheter care of 2 who met the criteria for catheter use. (Resident #79)</p> <p>Findings include:</p> <p>The clinical record for Resident #79 was reviewed on 7/16/13 at 11:30 a.m. He was admitted on 7/8/13.</p> <p>The diagnoses for Resident #79 included, but were not limited to: atrial fibrillation, chronic renal insufficiency, and chronic left ventricular diastolic dysfunction.</p> <p>The 7/11/13 physician's order for Resident #79 indicated, "F/C (foley catheter) 18 FR/5cc may (symbol for</p>	F000315	<p>It is the intent of this facility to ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. I. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? Resident #79 receives catheter care every shift and PRN, and catheter care is addressed on resident's Care Plan. Residents catheter drainage bag was changed on 7/16/13. II. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken?</p>	08/15/2013

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	<p>"change") PRN (as needed) occlusion/leakage per resident request chronic use F/C care q (every) shift."</p> <p>In the hallway, prior to entering Resident #79's room on 7/16/13 at 9:30 a.m., a strong urine odor was observed. After entrance into the room, a slow drip with a delay of 10 seconds between drips was observed coming from Resident #79's catheter bag onto the floor. A yellow puddle of urine covering an area of 7 square feet was underneath Resident #79's bed. A strong urine odor permeated the entire room. Resident #79 indicated he was put in bed last night by an aide, and staff were in his room this day, and someone brought him his breakfast tray a half hour ago.</p> <p>During an interview with CNA #7 on 7/16/13 at 9:36 a.m., she indicated she was in Resident #79's room this morning, about halfway into the room. When informed of Resident #79's leaking catheter bag, she indicated Resident #79 mentioned 2 days earlier that "it was leaking." She indicated she was unaware of the current leak.</p> <p>Review of the Resident #79's July, 2013 MAR (medication administration</p>		<p>Any resident with a catheter has the potential to be affected by the alleged finding. Nursing staff will be in-serviced on catheter care on 8/6/13. Licensed nurses will be in-serviced on Care Planning catheters. III. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur? The D.O.N./designee will audit catheter care twice per week for 6 months to ensure compliance. Interim admission care plans will be reviewed by IDT during Morning Clinical Meeting to ensure proper completion on ongoing basis. IV. How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place? The D.O.N./designee will present findings of audits to the QA Committee during monthly QA Meetings to ensure compliance.</p>				

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	<p>record) and TAR (treatment administration record) did not indicate foley catheter care.</p> <p>During an interview with the ADON (Assistant Director of Nursing) on 7/16/13 at 10:00 a.m., she indicated the 7/12/13 order for catheter care every shift did not get transcribed onto the TAR. She stated, "I flagged the page, but it didn't happen." At this time, the ADON transcribed the 7/12/13 order onto the TAR</p> <p>Review of Resident #79's 7/8/13 Interim Admission Care Plan did not indicate he had a urinary catheter. There was a section on the interim care plan to address it, but it was blank.</p> <p>During an interview with Resident #79 on 7/16/13 at 10:46 a.m. he indicated, "Today is the first time my catheter has been changed. They thought it was leaking a couple days ago and said something about the bag being upside down. I dont know which staff. They did not change it at that time."</p> <p>During another interview with Resident #79 on 7/16/13 at 11:06 a.m. regarding whether his catheter was being cared for every shift (3 times a day), he indicated, "They are</p>				

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	cleaning it twice a day, in the morning and at night." 3.1-41(a)(2)				

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F000329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review, observations and interview, the facility failed to ensure residents were free from unnecessary medications, related to lack of documentation of non pharmacological interventions attempted and lack of indications for the use of an antianxiety medication, and free from discontinued cough medicine, for 3 of 10 residents reviewed for unnecessary medications (Residents #77, #44, and #30).</p>	F000329	<p>It is the intent of this facility that each resident's drug regimen be free from unnecessary drugs. I. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? Resident #77 no longer resides in facility. Resident #44's Lorazepam was discontinued. Resident #30's Robafen DM was discontinued. II. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will</p>	08/15/2013

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	<p>Findings include:</p> <p>1. Review of Resident #77's record on 7/12/13 at 3:25 p.m. indicated the resident was admitted on 6/13/13. Diagnoses included, but were not limited to, status post gastrointestinal bleed with transfusion, chronic renal failure, anemia, cerebrovascular accident (stroke), hypertension, dysphagia, bilateral renal cysts, glaucoma, muscle spasms, constipation, and arthritis.</p> <p>Review of physician orders indicated on 6/20/13, Buspar (antianxiety medication) 5 mg was ordered twice a day for one week, then change to 10 mg twice a day. Review of medication administration records indicated the resident received the Buspar as ordered since 6/20/13.</p> <p>Review of nurse practitioner progress notes, from visits dated 6/20/13 and 6/24/13, indicated no mention of anxiety or use of the antianxiety medication, Buspar.</p> <p>A 7/09/13 neuropsychological screening report indicated depression and did not mention anxiety. The resident was also receiving the antidepressant medication, Celexa,</p>		<p>be taken? All residents have the potential to be affected by the alleged finding. All residents receiving PRN anti-anxiolytics were reviewed, no resident was found to be affected by the alleged finding. All physician orders were reviewed for accuracy and current. No residents were found to be affected by the alleged finding. Nursing staff will be in-serviced on non-pharmalogical interventions prior to the use of antianxiety medication on 8/6/13. Licensed nursing staff will be in-serviced on following physician orders on 8/6/13. III. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur? The D.O.N./designee will audit 3 charts per week for 6 months for proper following of physician orders. The D.O.N./designee will monitor residents with PRN antianxiety medications weekly for 6 months for the use of non-pharmalogical interventions prior to medication use. IV. How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place? The D.O.N./designee will present the results of the audits to the QA Committee during monthly QA Meetings to ensure compliance.</p>		

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	<p>during this time.</p> <p>Behavior monitoring forms in the medication administration record for July 2013, and in the resident's record for June 2013, indicated monitoring for anxiety and depressed mood. No anxiety was documented on this form; depressed mood was documented.</p> <p>Review of a care plan, dated 6/06/13, with a goal date of 9/06/13, indicated a problem of "alteration in mood state," with the following checkmarked on the pre-printed care plan: verbal expressions of distress, sad, apathetic, anxious appearance, and other, "wishes for death" written in.</p> <p>The goal was "Resident will demonstrate an improved mood as evidenced by improved mood by seeing psychologist provided et SSD (and Social Service Director)."</p> <p>All the following approaches were pre-printed and checkmarked: Report to the physician changes in mood status. Support resident's strengths and coping skills. Encourage and allow open expression of feelings. Discuss with resident ways to utilize present coping skills to deal with situations that arise. Provide regular</p>						

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	<p>opportunities for physical activity, daily decision making, stimulation, socialization, leisure activities consistent with interests.</p> <p>Monitor effectiveness/side effects of medications as ordered - see current physician orders.</p> <p>Consultation with psychological/psychiatric. Provide services based upon resident/responsible party approval and physician's order.</p> <p>Encourage frequent contact with family and friends, if desired by resident.</p> <p>Promote homelike environment, when possible use familiar objects from home, or objects with sentimental value, family pictures, etc.</p> <p>There was no documentation to indicate the care plan was updated since 6/06/13, and after the Buspar was ordered on 6/20/13.</p> <p>Review of Social Services notes since admission indicated they addressed the resident's depressed mood. The note dated 6/27/13 indicated the resident had a depressed mood and had a BIMS (Brief Interview for Mental Status) score of 5, indicating cognitive impairment. The notes indicated the resident was on Celexa and Buspar, but did not indicate the resident was demonstrating any</p>			

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	<p>symptoms of anxiety or address nonpharmacological interventions for anxiety.</p> <p>The resident was observed on 7/10/13 at 10:55 a.m. in bed listening to music on a CD player, on 7/11/13 at 4:00 p.m. and 7/12/13 at 10:00 a.m. in bed with TV on, on 7/12/13 at 3:00 p.m. with family in the room, on 7/16/13 in bed watching TV, and at 10:55 a.m. in bed with TV on and resident's eyes closed. The resident was lying quietly in bed during all of the above observations. The resident was interviewed on 7/10/13 at 10:55 a.m. and said he was "doing fine" and listening to music, as he looked over at the CD player. When asked further questions, the resident did not respond.</p> <p>A Nursing Home Psychiatric Initial Assessment Form, dated 6/20/13, indicated "Appreciate (psychologist's name) help in this resident's case. Reviewed his note and agree with his assessment. Will hold off starting a psychostimulant medication since resident has elaborated more on anxiety sx's (symptoms) than depression. Psychostimulants can aggravate anxiety sx's.</p> <p>1. Trial with Buspar 5 mg [twice daily] x 1 wk (for one week) than [sic] 10 mg</p>						

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	<p>[twice daily] for anxiety.</p> <p>2. Continue individual and family therapy by (psychologist).</p> <p>3. f/u (follow up) at next visit."</p> <p>On 7/12/13 at 3:00 p.m., interview with DON (Director of Nursing) indicated she had just talked to the psychiatrist, and he said the resident had made comments to him and his nurse regarding feeling anxious on 6/20/13. And, the psychiatrist indicated even if it's transitional anxiety, he would treat it even if short term. She said he did not say anything about nonpharmacological interventions. The DON indicated she reviewed the resident's record and confirmed the only documentation in the resident's record regarding the resident experiencing anxiety was the 6/20/13 psychiatric note. When interviewed regarding nonpharmacological interventions, the DON indicated the resident receives visits from activities, and the resident's wife is involved.</p> <p>On 7/12/13 at 3:30 p.m. the psychiatrist was interviewed. He said he thinks the Buspar is an appropriate medication for the resident with his adjustment to his living situation. When asked about the increase in dose from 5 mg to 10 mg twice a day</p>						

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	<p>after one week, the psychiatrist indicated he wanted to trial the medication and see how the resident tolerated it before going to the 10 mg dose, which was the dose he wanted the resident to be on.</p> <p>2. Resident #44's clinical record was on 7/12/13 at 1:25 p.m. Diagnoses included, but were not limited to; dementia, insomnia, depression, anxiety, dysphagia (difficulty in swallowing), glaucoma, constipation.</p> <p>An interview with the D.O.N. (Director of Nursing), on 7/15/2013 at 10:49 am, indicated, Resident #44 "has not had any behaviors for the month of July" because her "medications are working."</p> <p>A "Behavior Monitoring Record" for the month of July indicated none of the following, "Behavioral symptoms; anxiety. medication: Lorazepam."</p> <p>A "Medication Record" for 6/1/2013 - 6/30/2013 indicated, "Lorazepam tab 0.5 mg one tablet by mouth every 4 hours as needed for anxiety PRN (as needed)". The medication was initialed as given on June 5th at "0600" (6 am). The back of the record indicated, "reason: anxiety/repetitive leg movement. Result: good." There</p>			

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	<p>was no documentation of non-pharmacological interventions attempted prior to the medication administration.</p> <p>An interview with the D.O.N., on 7/15/2013 at 2:05 pm, indicated Resident #44 went off hospice sometime around Christmas, and the daughter was not happy about it. The D.O.N. thinks the hospice company didn't do a good job of explaining why the resident was coming off hospice. She says the resident's daughter is "very reluctant to stop any of her mother's meds." The Psychiatric MD just deleted the PRN ativan order today because she hasn't used this since the beginning of June. The D.O.N. indicated she thought the PRN (as needed) Ativan shouldn't have been discontinued when she came off hospice because the daughter "wouldn't have gone for that, she wants her mother to be comfortable." The Psychiatric MD kept her on the scheduled Ativan so she stays comfortable.</p> <p>A "Physician recommendations" note from a pharmacist, dated 4/18/2013, indicated, "...lorazepam 0.5 mg BID (twice a day) and PRN (as needed). Both of these therapies are due for dosage evaluation per state operation</p>			

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	<p>manual...Physician/Prescriber response: Defer to hospice on above medications, 5/13/2013".</p> <p>A MD order, dated 7/15/2013, indicated, "DC (discontinue) Ativan 0.5mg po (by mouth) q (every) 4 hours prn (as needed) keep scheduled Ativan".</p> <p>3. Resident #30's clinical record was reviewed on 7/12/13 at 3:00 p.m. Diagnoses included, but were not limited to; hypertension, schizophrenia, chronic right hip/leg pain, depression.</p> <p>A care plan labeled "Potential for opportunistic infection related to medical condition", with the most recent date of 4/25/2013, indicated, "Problem, Need, Strength, Potential Concern: Resident has potential to develop infection related to medical condition. Approach: Administer medications as ordered."</p> <p>A MD order, dated 5/25/2013, indicated, "DM 10/Guaifensesn 100mg/5 mL syr (syrup) 2 teaspoons PO (by mouth) Q (every) 6hrs for cough".</p>			

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	<p>A "Medication Record" for 6/1/2013 - 6/30/2013 indicated, "Guaifensen 10mg/5mL 2 Tsp (teaspoonfuls) PO (by mouth) q (every) 6 hours cough" The following times listed indicated the medication was scheduled at, "8 a, 2 p, 8 p". On June 1 - 10th all days were initialed as given for each time space. On June 11th and 12th only the "8 a" and "2 p" time spaces were initialed. Handwritten on the record was, "Order to stop".</p> <p>A "Medication Record" for 7/1/2013 - 7/31/2013 indicated, "Robafen DM SYP (syrup) 100-10/5 (For: Robitussin DM) Two teaspoonfuls by mouth every 6 hours for cough" The following times listed indicated the medication was scheduled at, "6 am, 12 pm, 6 pm, 12 am". On July 1, the, "12 pm" and "6 pm" time spaces were initialed as given.</p> <p>An interview with the A.D.O.N., on 7/15/2013 at 3:10 pm, indicated, "someone (a nurse) probably noticed it was still being given on July 2nd, and got a verbal order from the NP(Nurse Practitioner) to end it and then forgot to write it. We try to do everything but sometimes we just miss one thing." At 3:15 pm, the A.D.O.N. indicated, "I clarified it with Nurse Practitioner's nurse that it was</p>						

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	<p>a verbal order to discontinue it (the Robitussin)."</p> <p>A MD order, dated 7/15/2013, indicated, "DC (discontinue) Robafen 2 tsps (teaspoons) PO (by mouth) Q (every) 6hrs routine on 7/2/2013".</p> <p>3.1-48(a)(1) 3.1-48(a)(2) 3.1-48(a)(4)</p>			

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F000465 SS=C	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observations and interviews, the facility failed to ensure the residents' environment was maintained, related to chipped and scraped paint on walls, trim, doors and furniture throughout 2 of 2 units and in all common areas of the facility, window blinds in the beauty shop in disrepair, a nourishment room refrigerator in need of cleaning, and a wall in the food storage room with a black substance on its surface. This deficient practice had the potential to affect all 51 of 51 residents in the facility.</p> <p>Findings include:</p> <p>1. The environmental tour was conducted on 7/12/13 at 10:30 a.m. with the Administrator, Maintenance Supervisor and Housekeeping Supervisor. The following was observed:</p> <p>a. The paint was chipped, scraped and/or marred on the trim and baseboards throughout the hallways and dining rooms, and the doors to resident rooms, on the Rehab and</p>	F000465	<p>It is the intent of this facility to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. I. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? A Preventive Maintenance schedule has been written to address the routine touch-up painting of trim, baseboards and furniture throughout the facility. The wall and cove base were repaired in room 226. The tile in the bathroom of room 121 was repaired. The blinds in the beauty shop were replaced. The refrigerator in the long term care nourishment room was cleaned. The baseboard in the dry storage room was repaired and the wall was cleaned. The wall in the main dining room will be repaired by 8/15/13. II. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken? All residents were found to be affected by the alleged finding. A Preventive Maintenance schedule has been written to address the routine touch-up painting of trim,</p>	08/15/2013	

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	<p>Long Term Care units and in the main dining room.</p> <p>b. The paint was chipped all over the surfaces of the wooden chairs in the main dining room, and the dining rooms on the Rehab and Long Term Care units.</p> <p>c. In room 226, on the Rehab unit, a 12 inch section of paint on the wall above the resident's bed was deeply scraped with paint missing. A 4 inch section of cove base to the left of the bathroom door in this room was coming away from the wall.</p> <p>d. In room 121, in the bathroom a 6 inch by 2 inch section of tile was missing, and the perimeter of the room along the floor had a rust-colored stain.</p> <p>e. The window blinds in the beauty shop were crooked and bent.</p> <p>f. There was sticky, brown-colored spillage in the freezer section of the refrigerator in the Long Term Care nourishment room.</p> <p>During the environmental tour, the Administrator and Maintenance Supervisor indicated the observed areas were in need of painting, repair</p>		<p>baseboards and furniture throughout the facility. The wall and cove base were repaired in room 226. The tile in the bathroom of room 121 was repaired. The blinds in the beauty shop were replaced. The refrigerator in the long term care nourishment room was cleaned. The baseboard in the dry storage room was repaired and the wall was cleaned. The wall in the main dining room will be repaired by 8/15/13. III. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur? The Administrator will complete weekly Environmental Rounds to ensure routine touch-up painting is being completed and facility blinds, walls and base trim are clean and in good repair. IV. How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place? The Administrator will report the results of the weekly Environmental Rounds to the QA Committee during monthly QA Meetings to ensure compliance.</p>				

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	<p>or cleaning. The Administrator also indicated the facility is scheduled to be remodeled very soon.</p> <p>2. A tour of the kitchen was conducted on 7/9/13 at 10:00 a.m.</p> <p>In the dry storage room, a baseboard area along the back wall 2 1/2 feet across was broken and crumbling. Pieces of baseboard were lying on the floor. A black, wet, gunk like substance was observed in the corner of the dry storage area along the front wall.</p> <p>During interview with the DM (Dietary Manager) regarding the black, wet, gunk like substance in the corner, she indicated, "I think it's moisture associated." The DM proceeded to move a box of dry food on a rack to the side. Behind the box, on the wall, was the same black substance covering an area of 1 square foot of wall space with black up and down streaks. The DM stated, "It's along the wall shared with the air conditioner." The DM then proceeded to show the air conditioner unit in a closet immediately behind the blackened, streaked area on the</p>			

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	<p>wall. The air conditioner was pressed against the wall, immediately opposite the blackened area on dry storage wall. The DM stated, "I talked to the Maintenance Director in late June and he said he'd look into it. He said he was going to clean it with bleach. I think he did because this area on the wall was much darker than it is now."</p> <p>An interview was conducted with the Maintenance Director on 7/9/13 at 12:10 p.m. He indicated the AC (air conditioner) was frozen in June and there was a puddle on the floor leading out of the closet. "I recharged the AC and let the area dry out, and cleaned the spot on the wall with bleach because that is what I was taught to do in that situation."</p> <p>An observation of the main dining room was made with the Maintenance Director at this time. Water damage was observed on the right side wall behind a table. The wall was wavy and looked painted over. The Maintenance Director stated, "See this. We're going to remodel and the company said they were going to replace this whole area." In regards to whether the dry storage wall with the streaked blackened area would be replaced, the Maintenance Director stated, "They didn't look at</p>						

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	<p>that area."</p> <p>Then an observation of the dry storage area of the kitchen was made with the Maintenance Director. The wall in the dry storage area now smelled of bleach and the blackened streaked substance was no longer quite visible to the eye. The dry storage racks with food were now removed from this wall. The Maintenance Director stated, "I just thought it was moisture when dietary told me about it a few weeks ago. This whole area was wet with moisture." At this time the Maintenance Director spread his hand over an area covering 4 feet across and 1 foot high immediately above the previously observed blackened area. He stated, "I didn't see anything black (a few weeks ago)."</p> <p>Regarding what "black in color" could indicate the substance to be, the Maintenance Director stated, "It could be mold." Regarding why he hadn't continued to check on this wall area since he'd known about the moisture problem since late June, he indicated Dietary did not tell him there were any more problems.</p>				

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	3.1-19(f)				