

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155181	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/13/2013
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NAME OF PROVIDER OR SUPPLIER CARMEL HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 118 MEDICAL DR CARMEL, IN 46032
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F000000	<p>This visit was for the Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00131058.</p> <p>Complaint IN00131058-Unsubstantiated due to lack of evidence.</p> <p>Survey dates: August 5, 6, 7, 8, 9, 12, and 13, 2013</p> <p>Facility number : 000095 Provider number : 155181 AIM number : 100290490</p> <p>Survey team: Michelle Hosteter, RN-TC Janet Stanton, RN Gloria Bond, RN Sandra Nolder, RN (8/6, 8/7, 8/8, 8/9, 8/12, and 8/13, 2013)</p> <p>Census bed type: SNF : 20 SNF/NF : 127 Total : 147</p> <p>Census payor type: Medicare : 19 Medicaid : 109 Other : 19</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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	<p>Total :147</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review was completed by Tammy Alley RN on August 20, 2013.</p>				

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F000241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, record review and interview the facility failed to ensure dignity was maintained during personal care for 1 of 2 personal care observations (Resident # 38) and failed to ensure a urinary drainage bag was covered for 1 of 2 residents observed with catheters (Resident # 101).</p> <p>Findings include :</p> <p>1. The record for Resident # 38 was reviewed on 8/9/13 at 9 a.m.</p> <p>Current diagnoses included, but were not limited to, cognitive communication deficit and senile dementia.</p> <p>During an observation with LPN # 10 and Nurse Manager # 5 on 8/9/13 at 11:25 a.m., the following was observed. Resident # 38 was lying in bed sleeping then LPN # 10 came into the room to provide wound care. LPN # 10 pulled the pillow out from behind the resident's back, pulled the</p>	F000241	<p>F241 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>It is the practice of this provider to 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. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident 101 was not identified by the surveyors on the resident identifier list provided to the administrator at exit. However, all residents with indwelling catheters were provided dignity covers during the annual survey process, and their plans of care and assignment sheets were updated to reflect the use of the dignity cover. Resident 38 is provided dignity during dressing changes and staff request permission to enter her room. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. Residents with urinary</p>	09/03/2013			

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	<p>covers back and began turning the resident without waking or informing the resident of what she was doing. During this observation, the Wound Nurse knocked on the resident's door and the Unit Manager # 5 and LPN # 10 informed him resident care was being performed. The Wound Nurse then poked his head inside the door with the door cracked open and asked for a set of keys.</p> <p>During an observation on 8/9/13 at 2:25 p.m., Medical Records Clerk # 11 entered Resident # 38 ' s room to ask what she needed when the resident was yelling without knocking on the resident's door.</p> <p>During an interview with Unit Manager # 5 on 8/9/13 at 11:40 a.m., she indicated she would have expected the Wound Nurse to have waited until resident care was completed on Resident # 38 before he entered the room.</p> <p>During an interview with Unit Manager # 5 on 8/9/13 at 2:38 p.m., she indicated she would expect staff to knock on the door, have announced who they were, and have gotten permission to come into the resident's</p>		<p>catheters plans of care and aide assignment sheets were reviewed and updated to reflect the use of a catheter dignity cover. Staff knock and request permission prior to entering resident rooms. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>Re-education was provided to licensed nurses and certified nursing aides by 9/3/13, and ongoing, regarding the use of urinary catheter dignity covers by the Director of Nursing Services, or designee. Re-education was provided to all staff regarding resident dignity, including knocking on doors, and providing an introduction and reason for visit to all staff by 9/3/13, and ongoing, by the Director of Nursing, or designee. Licensed nurses were re-validated on dressing changes, including initial introduction to the resident, i.e. knocking on door, identifying self, and explaining task by the Wound Nurse, or designee, by 9/3/13, and ongoing. The systemic change includes a) Nurse managers review physician orders for urinary catheters, including new/readmission to ensure residents with urinary catheters have dignity covers provided; plans of care and assignment sheets are updated; b) Nurse managers round daily and monitor residents with urinary catheters for appropriate</p>		

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	<p>room before entering unless there was an emergency.</p> <p>During an interview with the Wound Nurse on 8/9/13 at 2:43 p.m., he indicated that before he would enter a closed door where resident care may be occurring, he would knock on the door and ask for permission to enter. Also, he indicated he would wait to enter the resident's room until resident care was completed.</p> <p>A policy titled "Resident Rights Guidelines for All Nursing Procedures" dated December 2007 was provided by the Director of Nursing on 8/9/13 at 3 p.m. The policy indicated staff should knock and gain permission before entering the resident's room, if the resident was sleeping and the procedure was not urgent or scheduled, the staff should return when the resident was awake, and the staff should explain the procedure to the resident and answer any questions she may have.</p>		<p>placement and use of dignity covers, and monitor for resident dignity. Identified areas are corrected immediately and reported to the administrator.d) The Department Heads (Caring Hearts) are assigned to specific residents and will observe for resident dignity, including knocking on doors and requesting entrance, explaining tasks, and observing for urinary catheter covers. Identified areas are corrected immediately and reported to the administrator. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? A Dignity CQI will be utilized to monitor resident dignity, including catheter dignity covers, and requesting entrance to resident room, daily x 30 days, weekly x 8 wks, and monthly x 9. Any identified concerns from audits will be addressed immediately. The results of these audits will be discussed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. Compliance Date: 9/3/13</p>		

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	<p>2. Resident # 101's record was reviewed on 8/9/2013 at 9:45 A.M. Diagnoses included, but were not limited to, hypertension, end stage renal disease, anemia. Resident #101 had an indwelling urinary Foley catheter in place.</p> <p>During an observation on 8/9/2013 at 10:05 A.M., Resident # 101's catheter bag was observed to be uncovered and yellow/reddish urine was observed in the catheter bag. The resident was soon transported out of the building for an appointment.</p> <p>On 8/12/2013 at 9:30 A.M., the resident was observed being transported via wheel chair down the hall with his catheter bag clearly visible and no dignity bag over it.</p> <p>During an interview on 8/12/2013 at 10:20 A.M., with CNA # 14, she indicated leg bags are usually used during the day for active residents with urinary catheters and dignity</p>			
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	bags are available as well. Resident # 101 does not like the leg bags but has a dignity bag attached to his wheel chair that can be used. 3.1-3(t)				

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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 observation, interview and record review, the facility failed to ensure a tub bath was offered to 1 resident who desired to have a tub bath, in a sample of 5 residents reviewed for choices and preferences that were important to them. (Resident #241)</p> <p>Findings include:</p> <p>In an interview on 8/07/13 at 9:20 A.M., Resident #241 indicated he would like to take a tub bath because he didn't feel that he got some areas really clean when in the shower. He had not asked anyone because he didn't think there were any tubs available. None of the staff had ever asked him what his preference was, and if he would like to have a tub bath.</p> <p>The record for Resident #214 was reviewed on 8/13/13 at 3:40 P.M. Diagnoses included, but were not</p>	F000242	F242 483.15(b) SELF-DETERMINATION-RIGHT TO MAKE CHOICES It is the practice of this provider to ensure 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. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The facility is not able to utilize a hooyer lift to transfer residents to the tub as was previously stated to the surveyors during the annual survey. The current garden tub would only be accessible to independent residents and would require stand-by assistance to get in/out of the tub. Due to the inaccurate information provided to the surveyors related to the use of the tub, resident #241 is not able to be given a tub	09/03/2013			

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	<p>limited to, hypertension, orthostatic hypotension, cerebral vascular accident, arthritis, anxiety disorder, and depressive disorder.</p> <p>The admission MDS (Minimum Data Set) assessment, dated 6/20/13, indicated in Section F (Preferences for Customary Routines and Activities) that it was "Very important" to him to be able to choose between shower, tub bath or bed bath.</p> <p>During interviews on 8/12/13, nursing staff indicated the following: 2:40 P.M./300 Hall--LPN #6 indicated there was no tub in the 300 Hall shower room, and she did not know where there was a tub in the facility. The shower room was observed at that time, and there was no tub in the room. 2:43 P.M./200, 300 Hall--LPNs #2 and #9 indicated there was a tub in the facility but they were not sure where it might be. They knew there were no tubs on either the 200 or 300 Hall. They indicated they thought there might be a tub on the 400 and 500 wings. 2:45 P.M./200-300 Hall--LPN #5 indicated a resident's preference for a tub bath should be on the admission preference sheet, in the Care Plan and on the Nurse Aide assignment</p>		<p>bath safely. The resident was updated on this information and his personal requests were re-evaluated to determine how he wishes to be bathed. His plan of care and assignment sheet were updated, as needed. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Resident who request tub baths are potentially affected by the alleged deficient practice. The Guest Relations Coordinator reviewed the QIS Resident Survey Questionnaires from the previous 6 months to ensure their plans of care and assignment sheets are accurate in response to bathing questions. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? The Administrator and Director of Nursing met with Resident Council on 8/26/13, to discuss resident preferences, including the availability of tub baths. All staff were re-educated on resident rights, including resident preferences, by September 3, 2013, and ongoing, by the Director of Nursing, or designee. The systemic change includes: a) obtaining resident preferences regarding bathing upon admission. The residents' plan of care and assignment sheet will be updated at that time. b) Resident preferences will</p>				

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	<p>sheet. She indicated tubs were located on both the 400 and 500 Halls.</p> <p>2:47 P.M./400 Hall--LPN #4 indicated there was no tub in 400 Hall shower room. The only one that she knew of in the building was on the 500 Hall.</p> <p>2:50 P.M./500 Hall--LPN #8 and CNA #7 indicated there was a regular tub in the Spa shower room on that unit. LPN #8 indicated she had been in facility for many years, but had never seen the tub used. She indicated she had never had a resident ask to have a tub bath, and those that were disabled wouldn't be able to use this tub, anyway. The Spa shower room was observed at that time, and was observed to have a large regular tub with whirlpool jets. There was no lift seat or other handicap device to assist a resident with physical limitations to get into the tub.</p> <p>2:55 P.M.--the Clinical (Nurse) Consultant indicated a Hoyer (mechanical) lift sling could be used to transfer a resident into the tub. She later indicated a mesh lift sling, designed to be used in showers, could be used to transfer a resident into the tub.</p> <p>The resident's Care Plan, dated 6/24/13, had no entries addressing his preferences for a tub bath.</p>		<p>be discussed during MDS assessment periods and during resident Care Plans, updating their plan of care and assignment sheet as needed. c) MDS will monitor resident care plan for preferences during the completion of the MDS, c) Department Heads (Caring Hearts) will round daily and monitor resident preferences during resident interactions. Concerns will be addressed with the appropriate department head, as needed. d) Resident preferences will be discussed during Resident Council Meetings and the information will be presented to the appropriate Department for follow-up. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Residents will be interviewed by the Guest Relations Coordinator, or designee, no less than quarterly, utilizing the QIS Resident Questionnaire, to determine if individual preferences are met. If residents are unable to complete the questionnaire, the resident's responsible party will be interviewed. Any concerns will be forwarded to the appropriate department(s) for follow-up. The Administrator/designee will monitor the Guest Relations Coordinator spreadsheet weekly and follow-up with</p>		

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	The CNA Assignment Sheet, updated 7/23/13, did not indicate the resident preferred to have a tub bath. 3.1-3(u)(3)		residents/families if concerns are noted. The Guest Relations Coordinator, or designee, will review the follow-up with the resident or responsible party to ensure preferences were met. Compliance Date: 9/3/13		

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F000257 SS=E	<p>483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F Based on observation and interview the facility failed to provide comfortable room temperature levels, related to being too cold, for 11 out of 24 residents interviewed in stage 1. (Hallway 800: Residents # 11, # 63, # 111, # 199. Hallway 700: Resident # 29. Hallway 500: Resident # 56. Hallway 400: Resident # 156. Hallway 300: Resident # 241. Hallway 200: Residents # 129, # 170, # 172).</p> <p>Findings include:</p> <p>During a resident observation and interview on 8/6/2013 at 10:15 A.M., Resident #11 was bundled up with a quilt and a towel stating she was cold. The vent over head was observed with aluminum foil covering it. Cold air was felt to be in the area of the resident.</p> <p>On 8/7/13 at 11:15 A.M., and at 1:45 P.M., Resident #29 was observed sitting in her room in her chair with a jacket on.</p>	F000257	257 483.15(h)(6) COMFORTABLE AND SAFE TEMPERATURE LEVELS It is the practice of this provider to provide comfortable and safe temperature levels. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Residents #11, 63, 111, 199, 156, 129, 170 and 172 were not identified by the surveyors on the resident identifier list provided to the administrator at exit. However, the Administrator met with Resident Council on 8/26/13 to review room temperatures. Resident #29 no longer resides in the facility Resident #56 was updated on the facility monitoring system for room temperatures. The Guest Relations Coordinator has met with the identified resident to determine if the resident has concerns related to room temperatures. The master thermostat for the affected area has been adjusted to the appropriate range of 71 to 81 degrees Fahrenheit. Resident #241 was updated on the facility monitoring system for room temperatures. The Guest Relations Coordinator has met	09/03/2013	

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	<p>During an interview on 8/7/2013 at 1:55 P.M., Resident #56 indicated the following: the 500 hallway shower room was cold no matter whether it was 80 degrees outside or not.</p> <p>Resident #56 continued, "This room is always cold ...There is no way to regulate your own heat because there are no thermostats in the rooms."</p> <p>On 8/7/2013 at 9:46 A.M., during an interview, Resident #63 indicated that it was freezing in her room. She indicated that it was cold in the winter and even colder in the summer.</p> <p>During an interview on 8/7/2013 at 10:24 A.M., Resident #111 indicated that it was cold in his room.</p> <p>During an interview on 8/6/2013 at 1:37 P.M., Resident #129 indicated that her previous room was cold and she could not adjust the temperature.</p> <p>On 8/6/2013 at 9:42 A.M., during an interview Resident #156 indicated it was a little chilly in her room.</p> <p>During an interview on 8/6/2013 at 3:02 P.M., Resident #170 indicated the room was hot and cold.</p> <p>On 8/7/2013 at 10:19 A.M., Resident</p>		<p>with the identified resident to determine if the resident has concerns related to room temperatures. The master thermostat for the affected area has been adjusted to the appropriate range of 71 to 81 degrees Fahrenheit. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Any residents in the affected areas have the potential to be affected by the alleged deficient practice. The master thermostat for the affected areas (800, 700, 500, 400, 300, and 200) has been set to the appropriate temperature range of 71 to 81 degrees Fahrenheit. The Guest Relations Coordinator reviewed the QIS Resident Survey Questionnaires from the previous 6 months to ensure their plans of care and assignment sheets are accurate in response to room temperatures. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? All staff were re-educated on the appropriate temperatures of resident rooms and the reporting of resident concerns related to room temperatures to maintenance, by the Administrator, Director of Nursing, or designee, by 9/3/13. The administrator met with Resident Council on 8/26/13, to</p>		

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	<p>#172 indicated his room was too hot but he has not told anyone.</p> <p>During an interview on 8/7/2013 at 9:20 A.M., Resident #199 indicated her room was cold and the vent was right over her dining table so it made her food cold.</p> <p>On 8/7/2013 at 9:31 A.M., during an interview Resident # 241 indicated his room gets too warm and too cold but it can't be adjusted in the room. He has had Maintenance come and check it out many times and they have indicated they are working on it. The resident's vents were observed with tape over them.</p> <p>A temperature check of the rooms on 8/6/2013 at 10:30 A.M., with the Maintenance Supervisor found the rooms for Resident's #11, # 199 and other randomly picked rooms to be 67 degrees Fahrenheit (F), 68 F, 69 F and briefly at 71 F. This temperature check was obtained after the Maintenance Supervisor checked the thermostat in the hall way and indicated that someone had turned it down because it should have been set higher. The Maintenance Supervisor indicated he would recheck the room temperatures. He indicated that he already checks the</p>		<p>discuss room temperatures and the corrective action of setting the master thermometer on affected units to 71 to 81 degrees Fahrenheit. The systematic change includes: a) The master thermostat has been set to the appropriate range of 71 to 81 degrees Fahrenheit. b) The master thermostats will be secured so that no one can adjust the master thermometer without the administrator's approval. c) Department Heads (Caring Hearts) will round daily and monitor resident room temperatures. Resident concerns will be forwarded to the maintenance department for follow-up. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Maintenance or designee will monitor and record the temperature daily for 4 weeks, then monthly. Results will be provided to the Administrator. Any identified concerns from audits will be addressed immediately. The results of these audits will be discussed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.</p> <p>Compliance Date: 9/3/13</p>				

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	<p>thermostats out in the hall way daily but does not check the room temperatures daily.</p> <p>3.1-19(h)</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 interview and record review, the facility failed to implement a Care Plan addressing delusional behaviors or adverse side effects for an antidepressant medication, for 2 of 5 residents reviewed for Unnecessary Medication Use. (Residents #79 and #191)</p> <p>Findings include:</p> <p>1. The record for Resident #79 was reviewed on 8/8/13 at 2:12 P.M. Diagnoses included, but were not limited to, pre-senile dementia and</p>	F000279	F279 483.20(H), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS It is the practice of this provider to use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility develops 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. The care plan describes the services that are to be furnished to attain or maintain	09/03/2013	

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	<p>senile dementia--Alzheimer's type, encephalopathy, depressive disorder, headache syndrome, macular degeneration, generalized pain, and delusional disorder.</p> <p>Current physician orders included: 5/10/13--Olanzapine (Zyprexa--an anti-psychotic medication) 5 mg. (milligrams) 1 po (by mouth) every HS (bedtime).</p> <p>A Social Service progress note, dated 6/17/13, indicated "May Behavior Summary: Resident had no behaviors during the month of May. Resident is receiving Prozac 20 mg. po daily for depression and Zyprexa 5 mg. po q (every) HS for delusional behavior...." A progress note, dated 8/3/13, indicated "June Behavior Summary: Resident had no behaviors during the month of June. Resident is receiving Prozac 20 mg. po daily for depression and Zyprexa 5 mg. po q HS for delusional disorder...."</p> <p>The current Care Plan, dated 7/22/13, addressed issues that included, but were not limited to, the following: 7/22/13--At risk of falls due to use of daily Antidepressant (medication), as well as need for staff to assist with ambulation. 7/22/13--Receives Antidepressant</p>		<p>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). What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #79 – behavioral care plans were completed during the survey process. The interdisciplinary team has reviewed the resident's care plans and they were revised, as needed. Resident #191 – behavioral care plans were completed during the survey process. The interdisciplinary team has reviewed the resident's care plans and they were revised, as needed. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Residents who receive psychoactive medications related to behavioral symptoms have the potential to be affected by the alleged deficient practice. Residents on the behavioral program were reviewed for appropriate care plans for behaviors and psychoactive medication monitoring. Plans of care were revised, as needed. What</p>		

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	<p>medication related to diagnosis of depression; receives Prozac daily. 4/9/13-- Has history of depression. 7/22/13--At risk for adverse consequence related to receiving Anti-psychotic medication with diagnosis of dementia/Alzheimer's disease.</p> <p>A Care Plan addressing the resident's delusional behaviors, with the interventions to be used during these episodes, was not found.</p> <p>On 8/12/13 at 3:05 P.M., the Clinical (Nurse) Consultant and the Executive Director indicated they would need to review the Care Plan.</p> <p>On 8/13/13 at 9:00 A.M., a copy of a Care Plan addressing "Resident is currently prescribed Zyprexa due to history of delusions" was provided for review. This Care Plan entry was dated 8/12/13.</p>		<p>measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? All staff were re-educated on behavior monitoring and reporting behaviors to the charge nurse and/or social service by the Director of Nursing, or designee, by 9/3/13, and ongoing. Systemic changes include: a) Social Service collects Behavior Tracking Forms M-F and reviews with the Interdisciplinary Team. b) Social Service, or designee, initiates and/or reviews current care plans to ensure they accurately reflect the resident's individualized plan of care. c) Care plans are reviewed and revised, as needed, during Interdisciplinary Team At Risk Meetings, quarterly or with significant changes to ensure they reflect the resident's individualized plan of care. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Social Service Director/Designee will audit residents with new behaviors to determine care plans are updated as needed 5 x weekly x 2 weeks, then 3 x weekly x 2 weeks, then weekly x 2 months, then monthly x 9 months. Any identified concerns from audits will be addressed immediately. The results of these audits will be discussed at the</p>		

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	<p>2. Resident # 191's record was reviewed on 8/12/2013 at 9:26 A.M. Diagnoses included, but were were not limited to, diabetes, restless legs and periodic limb movements, atrial fibrillation, insomnia, and muscle weakness.</p> <p>Resident # 191's recapitulation of physician's orders indicated he had an order for the antidepressant Cymbalta 60 mg (milligrams) 2 capsules by mouth once a day, and the antidepressant Trazodone 50 mg 1 tablet by mouth at bedtime. No care plans were found regarding side effects of these medications.</p> <p>During an interview on 8/13/2013 at 1:40 P.M., with the Social Service Director, she indicated she completed the care plans for medications such as antidepressants and must have missed the care plans for Resident # 191.</p> <p>3.1-35(a)</p>		<p>monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. Compliance Date: 9/3/13</p>		

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F000281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.</p> <p>Based on observation, interview and record review, the facility failed to ensure a crushed pill medication was administered through a G-tube (gastrostomy tube) according to professional standards of quality, for 1 observation of a G-tube medication administration, for 1 resident during the Medication Pass observation task. (Resident #91 and LPN #2)</p> <p>Findings include:</p> <p>During the medication pass task done on 8/9/13, at 1:00 P.M., LPN #2 was observed to dispense and prepare liquid and pill-form medications to administer through a G-tube for Resident #91. Two of the medications ordered and dispensed, Amlodipine (Norvasc) and Carvedilol (Coreg), were in pill form. The nurse crushed each pill separately and placed in a 30 ml. (milliliter) graduated plastic medication cup.</p> <p>At 1:38 P.M., the nurse entered the resident's room to administer the two crushed pills and 3 liquid medications. After checking the patency of the</p>	F000281	<p>F281 483.20(k)(3)(i) SERVICES PROVIDED TO MEET PROFESSIONAL STANDARDS It is the practice of this provider to provide or arrange services to meet professional standards of quality. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #91 received G-tube medications per facility policy. Medications were reviewed by the pharmacy consultant for possible liquid form. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Residents who receive medications via G-tube have the potential to be affected by the alleged deficient practice. Their medications were reviewed by the pharmacy consultant to ensure medications were available in liquid form, when possible. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Licensed nurses were re-educated on the facility policy for administration of G-tube meds by the Director of Nursing, or designee, by 9/3/13,</p>	09/03/2013

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	<p>G-tube by instilling an air bolus and checking the residual, the nurse emptied each of the liquid medications, followed by a 5 cc. (cubic centimeter) water flush, into the barrel of a 60 cc. syringe. The syringe was connected to the distal end of the G-tube through a large bore tip.</p> <p>Each of the dry crushed pill medications were placed directly into syringe barrel, then water added to flush down tube. The medications were not dissolved in water before administration.</p> <p>In an interview on 8/12/13 at 9:37 A.M., LPN #2 indicated dry crushed pill medications should be dissolved in water or liquid before administering through a gastrostomy tube. She indicated the facility had a policy to do so; however, the resident, who was receiving hemodialysis, got very limited amounts of fluids. The nurse indicated the resident was not actually on a fluid restriction, but the Nursing and Dietary departments had discussed limiting the amounts of fluids and had arrived at the current level.</p> <p>The record for Resident #91 was reviewed on 8/12/13 at 10:14 A.M.</p>		<p>and ongoing. Skills validations were completed on licensed nurses to validate their understanding regarding dissolving crushed meds with warm water prior to administration. This was completed by the Nurse Managers by 9/3/13. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Skills validations will be completed on one G-tube medication administration 5 x weekly x 2 weeks, then 3 x weekly x 2 weeks, then weekly x 2 months, then monthly x 9. Identified concerns will be reviewed with the licensed nurse at that time and through progressive disciplinary action, as needed. The results of these audits will be discussed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. Compliance Date: 9/3/13</p>				

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	<p>Diagnoses included, but were not limited to, acute respiratory failure with tracheostomy, intracranial hemorrhage and cerebral vascular disease, aphasia, dysphagia, pressure ulcers, end-stage renal disease with hemodialysis, gastroesophageal reflux disease, generalize pain, anemia, hypertension, and depressive disorder.</p> <p>Physician orders, current as of 8/12/13, included the following pill or solid form medications: 7/6/13--Amlodipine (Norvasc) 10 mg. (milligrams) one per GT (gastrostomy tube) every A.M.; scheduled for 12:00 P.M. 7/1/13--Carvedilol (Coreg) 25 mg. one per GT twice a day; scheduled for 12:00 P.M. and 5:00 P.M.</p> <p>There were no physician orders for fluid restriction</p> <p>In an interview on 8/12/13 at 3:05 P.M., the Clinical (Nurse) Consultant indicated the nurse should have dissolved the crushed pills in some water before emptying into the syringe barrel.</p> <p>On 8/13/13 at 9:00 A.M., the Clinical Consultant provided an undated</p>				

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	<p>Policy/Procedure titled "Administration of Medication via Feeding Tubes." The Procedure included the following:</p> <p>"...6. Use liquid form of medication whenever possible...</p> <p>7. Pour and/or crush all medications separately. a) If a tablet must be crushed, be sure it is crushed finely and dispersed well in warm water...."</p> <p>The section for "Medication Administration Via Enteral Tubes" in the "Geriatric Medication Handbook, Eighth Edition," copyright 2007 by the American Society of Consultant Pharmacists, included the following instructions for the administration of pill-form medications through a G-tube:</p> <p>"...EQUIPMENT AND SUPPLIES: ...5. Warm water for dissolving medications...</p> <p>PROCEDURES: ...6.a. Crush immediate-release tablets into a fine powder then dissolve in 30 ml. of warm water, or the prescribed amount...."</p> <p>3.1-35(g)(1)</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 and interview, the facility failed to ensure a care plan was followed regarding having honey thickened fluids available for 1 of 1 resident in a sample of 22 reviewed for care plans. (Resident #19)</p> <p>Findings include:</p> <p>The record review for Resident #19 was completed on 8/8/13 at 2 P.M. Diagnoses included, but were not limited to, Alzheimer's, depression, dysphagia, anxiety, abnormal posture, anxiety, anemia, and stroke.</p> <p>The physician's orders dated 5/6/13, indicated the resident was on a Pureed diet with honey thick liquids with all meals. The documentation for care plans and CNA (Certified Nursing Aide) assignment sheets indicated resident on nectar thickened liquids, this was incorrect.</p> <p>The care plan origin date of 7/27/12 with revision date 6/19/13 indicated, "...Provide honey thick fluids at all times. Staff will observe for and</p>	F000282	<p>F282 483.20 (k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN It is the practice of this provider to provide or arrange services by qualified persons in accordance with each resident's plan of care.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident # 19 no longer resides at the facility. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Residents with physician orders for thickened liquids have the potential to be affected by the alleged deficient practice. These residents were reviewed by the interdisciplinary team and their plan of care and assignment sheets were revised, as needed. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Re-education was provided to all staff on residents who have orders for thickened liquids by the Director of Nursing Services, or designee, by 9/3/13, and ongoing. The systemic</p>	09/03/2013	

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	<p>report any signs and symptoms of dehydration such as poor skin turgor, dry lips/mucus (SIC) membranes, foul smelling or discolored urine to MD/daughter. Staff will offer as well as encourage nectar thick fluids when providing care or when attending activities..." The resident was on honey thick fluids not nectar thick fluids.</p> <p>In an observation of the resident on 8/12/13 at 10:30 A.M., there was a 20 ounce foam cup of water at the bedside. The cup had no date on it and had approximately 4 ounces of water missing from it. The water inside the foam cup was not thickened.</p> <p>During an observation with LPN #5 on 8/12/13 at 10:30 A.M., she checked the water at the beside and indicated the resident should have thickened water. She indicated she was not sure if the resident had free (unthickened) water orders. At 10:45 A.M., LPN #5 checked the physician's orders and indicated the resident is only to have honey thickened water.</p> <p>At that time, LPN #5 checked the undated CNA (Certified Nursing Aide) assignment sheet and indicated for Resident #19 was to receive</p>		<p>change includes a) Residents with orders for thickened liquids have signage at their door indicating the type of liquid they are to receive so that all staff are aware of their order.b)Nurse managers review readmission/admission hospital transfer orders to ensure physician orders for thickened liquids are implemented appropriately and the plan of care and assignment sheet are updated, as needed.c)Nurse managers will review new orders daily to ensure physician orders for thickened liquids are implemented appropriately and the plan of care and assignment sheet are updated as needed. d) Resident rooms will be monitored by nurse managers during daily rounds to ensure appropriate fluids are at resident bedside. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? A CQI will be completed on residents on thickened liquids, 5 x weekly x 4 weeks, weekly x 2 months, and monthly x 9 months.Any identified concerns from audits will be addressed immediately.The results of these audits will be discussed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. Compliance Date: 9/3/13</p>		

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	<p>thickened liquids.</p> <p>In an interview with LPN #5 at 10:47 A.M., she indicated she did not have any reason as to why there was regular water at the resident's bedside. LPN #5 indicated the night staff must have provided it during the ice water pass. She indicated the CNA assignment sheet had documentation regarding the need for nectar thickened liquids so there is no reason for there to be regular water. The physician order was for honey thick liquids.</p> <p>3.1-35(g)(2)</p>				

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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 interview and record review the facility failed to monitor residents on psychotropic medications for adverse side effects of these medications for 3 of 5 residents reviewed for Unnecessary Medications. (Residents # 191, # 23 and #79).</p> <p>Findings include:</p> <p>1. Resident # 191's record was reviewed on 8/12/2013 at 9:26 A.M.</p>	F000329	F329 483.25(i) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS It is the practice of this provider to ensure 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	09/03/2013			

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	<p>Diagnoses included but were were not limited to, diabetes, restless legs and periodic limb movements, atrial fibrillation, insomnia, and muscle weakness.</p> <p>The recapitulation of the physician's order for July and August 2013 indicated the resident had an order for the antidepressant Cymbalta 60 mg(milligrams) 2 capsules by mouth once a day, and the antidepressant Trazodone 50 mg 1 tablet by mouth at bedtime.</p> <p>Resident # 191's nursing progress notes dated 7/9/2013 at 2:00 A.M., indicated the following: " Resident had used call light to alert staff he was on the floor. He was sitting on his buttocks with his back leaning on the bed. Said he hit his right shoulder and head. Received a small (0.5 cm diameter) abrasion on right hand, 3 rd knuckle...."</p> <p>Nursing progress notes dated 7/9/2013 at 10:20 A.M., indicated the following: "Bedside interview with resident related to fall from bed last night. Resident had discussion with MD yesterday about insomnia and MD increased his Gabapentin resident stated in interview that this dose</p>		<p>combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility ensures 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>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #23's psychoactive medications are monitored for adverse reactions by licensed nursing staff each shift.Abnormals are reported to the attending physician and the resident's plan of care is updated, as needed.Resident #79's psychoactive medications are monitored for adverse reactions by licensed nursing staff each shift.Abnormals are reported to the attending physician and the resident's plan of care is updated, as needed.Resident #191's psychoactive medications are monitored for adverse reactions by licensed nursing staff each shift.Abnormals are reported to the attending physician and the resident's plan of care is updated, as needed. How will you identify</p>		

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	<p>increase did help him get to sleep better last night but made him a bit groggy...."</p> <p>The Physician's orders and medication administration record indicated Resident # 191 had his anticonvulsant Gabapentin medication increased on 7/8/2013 and the antidepressant Trazodone started for insomnia on 7/8/2013.</p> <p>According to Nursing Spectrum Drug Handbook, 2010 edition Trazodone has the following side effects or adverse reactions: "drowsiness, dizziness...."</p> <p>Documentation for monitoring of adverse side effects for the antidepressants the resident was taking was lacking. During an interview on 8/9/2013 at 2 :30 P.M., the DON indicated she did not know where it was. During an interview on 8/12/2013 at 3:05 P.M., the Clinical (Nurse) Consultant indicated that there was no monitoring of side effects.</p>		<p>other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Residents with physician orders for psychoactive medications have the potential to be affected by the alleged deficient practice. These residents were reviewed by the social service and their care plans were updated, as needed. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Licensed nurses were educated on the monitoring of adverse side effects of psychoactive medications by the Director of Nursing Services, or designee, by 9/3/13, and ongoing. Systemic changes include: a) Residents with orders for psychoactive medications will have an order in Matrix to monitor for adverse reactions to these medications and the nurse will sign off every shift. If the resident is experiencing possible adverse reactions, the physician will be notified and the resident's plan of care will be updated, as needed. b) The pharmacy consultant will review residents on psychoactive drugs during monthly consultations and provide recommendations to the facility and attending physician. c) The Interdisciplinary Team will review residents on psychoactive medications during At Risk Meetings, for possible side</p>		

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	<p>2. The record for Resident #23 was reviewed 8/9/13 at 12:44 P.M. Diagnoses included, but were not limited to, multiple sclerosis, muscle weakness and disuse atrophy, dysphagia, rheumatoid arthritis, anxiety state, depressive disorder, idiopathic neuropathy, atrial fibrillation, insomnia, hypertension, chronic respiratory failure, generalized pain, and Type 1 diabetes with ketoacidosis.</p> <p>Current medications included the following:</p>		<p>effects and dosage reduction, as needed. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The DON/Designee will audit residents with new orders for psychotropic meds to determine side effects are monitored and care plans are updated as needed 5 x weekly x 2 weeks, then 3 x weekly x 2 weeks, then weekly x 2 months, then monthly x 9 months. Any identified concerns from audits will be addressed immediately. The results of these audits will be discussed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.</p> <p>Compliance Date: 9/3/13</p>		

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	<p>5/25/13--Alprazolam (Xanax--an anti-anxiety medication) 0.5 mg. (milligrams) 1 tab po (by mouth) q (every) 4 hours PRN (as needed)</p> <p>6/24/13--Ativan (Lorazepam--an anti-anxiety medication) 1 mg. 1 po BID (twice a day)</p> <p>4/22/13--Cymbalta (an antidepressant medication) 60 mg. 1 po BID</p> <p>7/18/13--Remeron (an antidepressant medication) 7.5 mg. 1 po at HS (at bedtime)</p> <p>7/15/13--Wellbutrin XL (an antidepressant) 150 mg. 1 po qd (every day)</p> <p>Physician's progress notes indicated the following: 5/23/13--"...Went to ER on 5/21 for complaints of increased pain, and at request of family. In ER evaluation was negative. ...Recently had her ...Xanax 0.5 mg. [increased to] qid [four time daily] PRN. Continues to call out for medication." 6/20/13--"Presently on Rx [prescription] for UTI. She was calling out continuously, so was given around the clock analgesics and Xanax for a few days while waiting for IV [intravenous] ATB [antibiotic] to work, but she actually became oversedated and stopped eating. Given IVF [intravenous fluids] and oxycodone changed back to PRN...."</p>						

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	<p>7/11/13--"... 3. Increased fatigue... [will check multiple labs]. She has multiple reasons for fatigue including MS, fibromyalgia, and current UTI. [Family member] and patient feel it is not related to analgesics or anxiolytics. [Family member] feels her mother is depressed; she was started on Wellbutrin yesterday. Resident denies depressive symptoms, but says she has taken antidepressants in the past...."</p> <p>Nursing Progress notes included the following: 7/10/13--"Resident's [family member] spoke with writer regarding effectiveness of resident's antidepressant, and questioned if adjustments could be made as she felt [the resident] may be more depressed recently. Writer spoke with [physician's name] and consulting psychiatrist. Received new order for additional antidepressant Remeron, in adjunct to current therapy of Cymbalta, of which resident is receiving optimum dose." 7/12/13--"...slow to respond, eyes glazed over.... Spoke at length with [family member] about resident's condition, and notified her of new orders to hold Wellbutrin...."</p> <p>Care Plan entries addressed issues</p>						

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	<p>which included the following: 7/11/13--"Problem: Displays signs/symptoms of depression as evidenced by trouble sleeping and feeling tired. Approaches: Continue to monitor medications for side effects and report any changes...." 5/15/13--"Problem: Receives anti-anxiety medication related to diagnosis of anxiety. Approaches: Monitor for drug use effectiveness and adverse consequences...." 4/3/13--"Problem: Has verbal behavioral symptoms directed toward staff (e.g. threatening others, screaming at others, cursing at others) and persistent anger toward others. Approaches: Report adverse Side Effects...." 5/15/13--"Problem: At risk for adverse consequences related to antidepressant medication for treatment of Depression. Approaches: Monitor and report signs of sedation, hypotension, or anticholinergic symptoms.; monitor resident's mood and response to medication...."</p> <p>Documentation of adverse side effects monitoring was not found.</p> <p>In an interview on 8/9/13 at 2:30 P.M., the Director of Nursing indicated she would have to check the electronic</p>				

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	<p>health records in the computer for any documentation of monitoring for adverse side effects. She indicated paper documentation was no longer done.</p> <p>In an interview on 8/12/13 at 3:05 P.M., the Clinical (Nurse) Consultant indicated documentation of the monitoring of adverse side effects had not been done.</p> <p>3. The record for Resident #79 was reviewed on 8/8/13 at 2:12 P.M. Diagnoses included, but were not limited to, pre-senile dementia and senile dementia--Alzheimer's type, encephalopathy, depressive disorder, headache syndromes, macular degeneration, backache, shortness of breath, generalized pain, congestive heart failure, and delusional disorder</p> <p>Current physician orders included: 5/10/13--Fluoxetine (Prozac) 20 mg. (milligrams) 1 po (by mouth) qd (every day). 5/10/13--Olanzapine (Zyprexa) 5 mg. 1 po q HS (at bedtime).</p> <p>Social Service progress notes indicated the following: 4/9/13--"Resident is currently taking Prozac 20 mg. for depression and Zyprexa 5 mg. for dementia."</p>				

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	<p>6/17/13--"May Behavior Summary: Resident had no behaviors during the month of May. Resident is receiving Prozac 20 mg. po daily for depression and Zyprexa 5 mg. po q HS for delusional behavior. Resident is receiving no psych services at this time."</p> <p>7/2/13--"Quarterly MDS interviews... Scored 8/15 on BIMS... No behaviors documented during the observation period. Resident stated he had been depressed several days of the last two weeks."</p> <p>8/3/13--"June Behavior Summary: Resident had no behaviors during the month of June. Resident is receiving Prozac 20 mg. po daily for depression and Zyprexa 5 mg. po q HS for delusional disorder. Resident is receiving no psych services at this time."</p> <p>Care Plan entries addressed issues including the following: 7/22/13--"Problem: Receives antidepressant medication related to diagnosis of Depression. Receives Prozac daily. Approaches: monitor resident's mood and response to medication." 7/22/13--"Problem: At risk for adverse consequence related to receiving antipsychotic with diagnosis of dementia/Alzheimer's disease.</p>				

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	<p>Approaches: AIMS quarterly...."</p> <p>Documentation of adverse side effects monitoring was not found.</p> <p>In an interview on 8/9/13 at 2:30 P.M., the Director of Nursing indicated she would have to check the electronic health records in the computer for any documentation of monitoring for adverse side effects. She indicated paper documentation was no longer done.</p> <p>In an interview on 8/12/13 at 3:05 P.M., the Clinical (Nurse) Consultant indicated documentation of the monitoring of adverse side effects had not been done.</p> <p>3.1-48(a)(3) 3.1-48(a)(5)</p>				

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F000371 SS=C	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview the facility failed to maintain counters, floors and equipment in a clean and sanitary manner, failed to dispose of expired food or maintain proper holding temperatures. This deficient practice had the potential to affect 145 of 147 residents at the facility who were served food from the kitchen.</p> <p>Findings include:</p> <p>During an initial tour with the Dietary Manager on 8/5/2013 at 10:00 A.M., the first refrigerator checked was found to have a box of sour cream packages with an expiration date of 7/31/13.</p> <p>A meat slicer was unattended and had a piece of white meat hanging from one corner of it.</p> <p>A pureed food container on the counter, containing food identified by the kitchen staff as peach cobbler,</p>	F000371	F371 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE – SANITARY It is the practice of this provider to (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were identified as having been affected. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents who receive food from the kitchen have the potential to be affected by the alleged deficient practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Education will be offered to all dietary staff regarding cleaning floors, cleaning/sanitizing counters,	09/03/2013	

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	<p>was left uncovered.</p> <p>On 8/5/2013 after all the residents in the main dining area were served lunch, Serving Assistant # 12 found the brussel sprouts to be at 120 degrees Fahrenheit (F) for their holding temperature and indicated he did not know why that was and that it should be higher than 135 F.</p> <p>During a test tray temperature check on 8/9/2013 at 12:30 P.M., the Dietary Manager measured the temperature for the cheese cake being served to be above 50 F. The Dietary Manager indicated a cold food should be held at no more than 41 F and a dessert like this would be replaced with fruit or cookies if it was out of range.</p> <p>On 8/12/2013 at 11:15 A.M., during a random observation of the kitchen, serving cups were found to have water condensation saturating the bottom of them and upside down on a serving tray. The Dietary Manager returned them to the cleaning area and indicated they needed to go back to the drying rack.</p> <p>3.1-21(i)(3)</p>		<p>labeling foods and checking for expiration dates and temperature monitoring by 9-3-13. This education will also be offered upon hire for new staff. Systemic changes include: a) the kitchen floors will be cleaned after each meal. They will be industrial/deep cleaned once per week. B) All counters will be cleaned/sanitized after each use c) All refrigerators will be checked daily for expired/outdated foods by the Dietary Manager/Designee d) Temperature logs will be checked daily by the Dietary Manager/Designee. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Dietary Manager will audit the cleanliness/sanitation of counters and floors, refrigerators for outdated foods and temperature logs 2 x daily x 2 weeks, daily x 2 weeks, weekly x 2 months, and monthly x 9 months. Any identified concerns from audits will be addressed immediately. The results of these audits will be discussed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.</p> <p>Compliance Date: 9/3/13</p>		

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NAME OF PROVIDER OR SUPPLIER CARMEL HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 118 MEDICAL DR CARMEL, IN 46032
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F000441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, and interview, the facility failed to ensure proper</p>	F000441	F441 483.65 INFECTION CONTROL, PREVENT SPREAD,	09/03/2013			

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	infection control techniques to prevent cross contamination during a wound care observation for 1 of 1 resident observed for wound care in a sample of 1. (Residents # 38) Findings include:		LINENS It is the practice of this provider to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident 38 receives dressing changes by licensed nurses maintaining a sanitary environment. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Residents who have physician's orders for dressing changes have the potential to be affected by the alleged deficient practice. Those residents receive dressing changes by licensed nurses maintaining a sanitary environment. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Licensed nurses were re-educated on maintaining a sanitary environment and infection control practices during dressing changes by the Director of Nursing Services, or designee, by 9/3/13, and ongoing. Dressing change skills validations were completed on licensed nurses to validate their knowledge of maintaining a sanitary		

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	<p>During an observation with LPN # 10 on 8/9/13 at 11:25 a.m., the following was observed. LPN # 10 was observed doing a dressing change to Resident # 38's coccyx. She removed a pair of bandage scissors from her scrub jacket pocket and used them to cut a piece of silver alginate dressing and applied the alginate to the resident's wound. After the dressing change was completed she replaced the bandage scissors to her pocket. During an interview with LPN # 10 on</p>		<p>environment by the Wound Nurse, or designee, by 9/3/13. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Dressing change validations will be completed 2 x weekly x 2 weeks, once a week x 2 weeks, monthly x 2 months and quarterly x 3, to monitor infection control and sanitary environment. Any identified concerns from audits will be addressed immediately. The results of these audits will be discussed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. Compliance Date: 9/3/13</p>		

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	8/9/13 at 11:50 a.m., she indicated she would clean her scissors with bleach wipes from the medication cart after a dressing change before she put them back in her pocket. 3.1-18(l)			