

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155656	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/18/2013
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NAME OF PROVIDER OR SUPPLIER CANTERBURY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2827 NORTHGATE BLVD FORT WAYNE, IN 46835
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: March 11, 12, 13, 14, 15 and 18, 2013</p> <p>Facility number: 000275 Provider number: 155656 AIM number: 100290930</p> <p>Survey team: Rick Blain, RN - TC Timothy Long, RN Carol Miller, RN Diane Nilson, RN</p> <p>Census bed type: SNF: 4 SNF/NF: 91 Total: 95</p> <p>Census payor type: Medicare: 12 Medicaid: 65 Other: 18 Total: 95</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on March 21, 2013 by Randy Fry RN.</p>	F000000	<p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set for the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</p> <p>The facility respectfully request that this plan of correction be accepted as the facility's compliance, effective April 17, 2013.</p> <p>The facility also request at this time that this plan of correction be considered for desk review compliance.</p>	

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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F000280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on record review and interview, the facility failed to ensure care plan meetings were conducted in a timely manner. This deficiency affected 1 of 1 residents reviewed for participation in care planning in the sample of 1 residents who met the criteria for participation in care planning (Resident #84).</p> <p>Finding include:</p> <p>On 3/12/13 at 11:14 a.m. Resident #84's Power of Attorney was interviewed and indicated she had never been invited to the residents care planning conferences.</p>	F000280	<p>It is the facility's policy that care plan meetings are conducted in a timely manner. Corrective Action of Alleged deficient practice: Care plan meeting is scheduled with Res #84's Power of Attorney on 4-5-13. Identification of others with potential to be affected by alleged deficient practice: 100% audit of current resident files completed. Care plan meetings scheduled to be completed within 30 days for any residents that did not have documented entries whereas POA/Families were invited to attend. Systematic change to ensure alleged deficient practice does not recur: Social Service will send out care plan notices 30 days in advance</p>	04/17/2013			

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	<p>Resident # 84's record was reviewed on 3/13/13 at 12:45 p.m., and indicated Resident # 84 was admitted to the facility on 12/2/09.</p> <p>The Social Service Notes did not indicate when the last care planning conference was done.</p> <p>Interview on 3/14/13 at 9:00 a.m. with the Social Service Designee (SSD) #1 indicated there was no formal care plan meeting done for the past year. The SSD #1 indicated the previous Program Director for the Memory Care Unit was employed from 6/26/12 through 10/15/12. The new Program Director started employment on 1/16/13 and there was no interim Program Director from 10/16/12 through 1/15/13. SSD #1 indicated the Program Director should have sent out a letter one month prior to each care plan meeting inviting the Power of Attorney of the resident and the resident to the care plan meetings that were held every 3 months. SSD #1 further indicated she made sure the care plans and Minimum Data Set Assessments from 10/15/12 - 1/15/13 were completed for the residents residing on the Memory Care Unit while there was no interim Program Director.</p>		<p>to responsible parties in coordination to the MDS schedule. Entries will be made in social service notes with date and contact information as to when the invitation was mailed. All responses will be recorded as well. Social service staff will be inserviced to regulation requirements and new system changes. Monitoring of system change to ensure alleged deficient practice does not recur: Social Service Director will provide the Administrator with a monthly schedule of all care plan meetings due for the month, The administrator/designee will audit social service notes wkly for 4 wks, then bi-wkly for 1 month, and then monthly for 4 months for evidence of family/POA involvement. Audit results will be discussed during the monthly CQI.</p>				

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	3.1-3(o) 3.1-35(d)(2)(B)				

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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 interview and record review, the facility failed to ensure a Physician's Order to obtain a laboratory test to monitor medication blood levels was followed for 1 of 10 residents reviewed for unnecessary medications (Resident #101). The facility also failed to ensure a medication was administered as ordered by the physician for 1 of 10 residents reviewed for unnecessary medications (Resident #7).</p> <p>Findings include:</p> <p>1. The record for Resident #101 was reviewed on 3/14/13 at 10:00 a.m., and indicated Resident #101'S diagnoses included, but were not limited to, atrial fibrillation (abnormal heart rhythm).</p> <p>Review of a Consultation Report from the pharmacy consultant, dated 2/18/13, indicated the pharmacist had made a recommendation for a serum digoxin (medication to used to treat abnormal heart rhythms) level due to</p>	F000282	<p>It is the policy of this facility to follow physician orders in accordance with the plan of care of a resident. Corrective Action for alleged deficient practice: Labs were drawn for res' #101. Res #7's MARS were compare to physician orders and has been getting medications administered as in the plan of care. Identification of others with potential to be affected by alleged deficient practice: All residents have potential to be affected. Facility completed 100 % audit of all lab orders received for the past 30 days for any new labs or orders for PRN psychotropic medications. Systematic changes to correct alleged deficient practice: Nurse managers will audit new orders and MARS/TARS?/ab TARS. New orders will be reviewed for accuracy and completion by off-going and on-coming nurses for verification on daily basis. Both nurses will initial orders. Nurses were re-educated on policy and procedure for obtaining/processing orders, including labs and medication policy and procedures. Monitoring of systematic change to ensure alleged</p>	04/17/2013			

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	<p>the resident receiving digoxin and not having a record of the digoxin level being drawn within the previous six months.</p> <p>A Physician's Order, dated 2/27/13, indicated to obtain a digoxin blood level for Resident #101.</p> <p>A Physician's Order, dated 3/15/13, indicated a stat (to be obtained immediately)digoxin level was ordered.</p> <p>A lab result for the digoxin level, dated 3/15/13, indicated the digoxin level was 0.20L (low).</p> <p>A Physician's Order, dated 3/15/13, indicated digoxin was to be increased from 0.125 milligrams every forty-eight hours to 0.25 milligrams daily. The order also indicated the digoxin level was to be rechecked in one month</p> <p>The Director of Nursing Services (DNS) was interviewed at 9:30 a.m. on 3/18/13. During the interview, the DNS indicated the digoxin level had not been obtained as ordered on 2/27/13. The DNS further indicated the physician had been contacted and a stat digoxin level had been ordered and obtained on 3/15/13.</p>		<p>deficient practice does not recur: The nurse managers will be responsible to review MARS/TARS daily for 4 wks, the bi-wkly for 4 wks, then wkly for 4 wks. The DON/Designee will monitor wkly audits once a wk for 30 days, then twice a month for 30 days and then monthly for 4 months. Audit results will be reviewed during CQI meetings monthly. Non-compliance issues will result in further education and/or termination,</p>				

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	<p>2. Resident # 7's clinical record was reviewed on 3/14/13 at 9:30 A.M.. The record indicated the resident was started on Xanax 0.125 milligrams (mg) PRN (as needed) daily for anxiety on 7/30/12.</p> <p>The MAR (medication administration record) indicated the resident had received the PRN Xanax 0.125 mg twice in one day on 12/19/12 at 1:30 A.M. and at 12:00 P.M..</p> <p>An interview with the Assistant Director of Nursing (ADN) on 3/15/13 at 9:55 A.M. indicated the resident should not have received Xanax PRN</p>			

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	twice in one day. 3.1-35(g)(2)				

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F000323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure a bed side rail was secured. This deficiency affected 1 of 4 residents reviewed for accidents in the sample of 6 residents who met the criteria for accidents (Resident # 101).</p> <p>Findings include:</p> <p>On 2/12/13 at 10:35 a.m., Resident #101's side rail was observed to be loose and moved easily back and forth. The Maintenance Assistant #2 was observed to tighten the knob on Resident #101's side rail, securing the side rail.</p> <p>The record of Resident #101 was reviewed on 3/14/13 at 10:00 a.m., and indicated Resident #101'S diagnoses included, but were not limited to, general debility and transischemic activity (mini strokes).</p> <p>A Nursing Comprehensive Admission Data Collection and Assessment,</p>	F000323	<p>It is the facility's policy to ensure that the resident's environment remains as free as possible of accident hazards. Corrective Action for alleged deficient practice: Res #101's side rails was immediately tightened when it was found by the surveyor by the maintenance assistant. Because of the surveyor's continued concerns with this issue, the bed was then replaced with a new bed. It was identified at that time that the bed in question was personal property belonging to res #101, and was not a facility-owned bed. Identification of other residents with potential to be affected by alleged deficient practice: All residents have potential to be at risk. The facility maintenance department completed a 100% audit on 3-12-13 of all beds in the facility to ensure that all side rails were secured. No other issues were identified at that time. Systematic changes to ensure alleged deficient practice does not recur: All bed frames and side rails will be inspected on a wklly basis during dly maintenance rounds by the maintenance</p>	04/17/2013

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	<p>dated 1/8/13, indicated the resident was alert and was oriented to self, with intermittent periods of confusion.</p> <p>A Safety Device Plan of Care, dated 1/9/13, indicated the resident used the side rails for repositioning.</p> <p>Interview on 3/15/13 at 8:15 a.m. with the Maintenance Director indicated three to four resident rooms were inspected every day at random, or if a resident was discharged from the room. He indicated the inspection included checking side rails. The Maintenance Director further indicated he also depended on the facility staff to submit work orders in regard to the side rails.</p> <p>A Resident Room Inspection Preventative Maintenance document, received from the Maintenance Director on 3/15/13 at 8:15 A.M., indicated Resident #101's room had been inspected on 1/30/13. The report indicated the inspection had included the side rails. The Maintenance Director indicated the side rail was checked after 1/30/13, but he was not sure of the date.</p> <p>CNA #3 was interviewed on 3/15/13 at 9:45 A.M. During the interview, CNA #3 indicated she routinely</p>		<p>department. Results of the rounds will be documented on a log that will be turned into the administrator. Maintenance Department will be inserviced on the new system change. Monitoring of the system change to ensure alleged deficient practice does not recur: The Maintenance Director will turn in wky audit results to the administrator for review for 4 wks, then 2 times for 1 month, then once a month for 1 time. The administrator will check side rails as part of the housekeeping rounds on a wky basis ongoing. Results will be documented utilizing the housekeeping rounds report. Any rails identified loose will be fixed immediately by the maintenance director. Results of the audits will be reviewed during monthly CQI.</p>				

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	<p>checked the residents' side rails in the morning when providing resident care. She indicated if the side rails were loose, she would complete a work order form and send one copy to maintenance and one copy to the Director of Nursing Services.</p> <p>The facility Administrator was interviewed on 3/15/13 at 10:45 A.M. During the interview, the Administrator indicated she and the Housekeeping Supervisor randomly checked resident rooms every week and Resident#101's side rail was last checked on 3/1/13.</p> <p>3.1-45(a)(1)</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 record review and interview, the facility failed to attempt non-pharmacological interventions before administration of as needed (PRN) psychotropic medications for 1 of 10 residents reviewed for unnecessary medication use (Resident #7).</p> <p>Findings include:</p> <p>Resident # 7's clinical record was reviewed on 3/14/13 at 9:30 A.M..</p>	F000329	It is the facility's policy to attempt non-pharmacological interventions before administration of PRN psychotropic medications. Corrective Action for alleged deficient practice: Res #7 was assessed for need of PRN Xanax. Order was d'cd on 3-14-13. Plan of care updated to include 5 non-pharmacological interventions for nursing to try prior to administration of any PRN psychotropic meds. Nursing staff inserviced on Res #7's POC. Identification of others with	04/17/2013			

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	<p>The record indicated the resident was started on Xanax 0.125 milligrams (mg) PRN daily for anxiety on 7/30/12.</p> <p>Review of resident #7's Medication Administration Record (MAR) indicated the resident received PRN Xanax 0.125 mg on 12/19/12 at 1:30 A.M. and at 12:00 P.M., 12/21/12 at 8:00 P.M., 12/23/12 at 8:00 P.M., and 2/12/13 at 2:30 P.M. On 12/19/12 at 1:30 A.M., several unsuccessful non-pharmacological interventions were attempted prior to administering the Xanax. Review of the MAR and nurse's progress notes indicated no non-pharmacological interventions were attempted before administration of the PRN Xanax 0.125 mg on 12/19/12 at 12:00 P.M., 12/21/12 at 8:00 P.M., 12/23/12 at 8:00 P.M., or 2/12/13 at 2:30 P.M.</p> <p>An interview with the Assistant Director of Nursing (ADN) on 3/15/13 at 9:55 A.M. indicated there was no documentation indicating non-pharmacological interventions had been attempted before administration of the PRN Ativan 0.125 mg on 12/19/12 at 12:00 P.M., 12/21/12 at 8:00 P.M., 12/23/12 at 8:00 P.M., or 2/12/13 at 2:30 P.M.</p>		<p>potential to be affected by alleged deficient practice:All residents with PRN psychotropic medications have potential to be affected: A 100 % audit completed on all residents who have PRN anti-psychotic medications.Systematic Changes to ensure alleged deficient practice does not recur: A non-pharmacological record will be placed in front of the MARS for any resident with PRN orders for antipsychotic medications with nurses to record 3-5 interventions that were tried before a PRN antipsychotic is administered. PRN antipsychotics will be reviewed with the on-shift supervisor prior to administration to ensure non-pharmacological interventions have been tried and noted in the resident's medical chart prior to administering the medication. Nursing staff have been in serviced regarding the facility's policies regarding procedure and protocol before administration of any PRN psychotropics.Monitoring of systematic changes to ensure alleged deficient practice does not recur: Any administration of PRN anti-psychotic medications will be recorded on the nursing 24 hour sheet. The 24 hours sheets will be reviewed daily at Clinical Triage meeting. Nurse managers will be responsible to audit the charts/MARS daily for confirmed documentation that non-pharmacological</p>				

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	3.1-48(a)(4)		interventions have been documented prior to administratorm of the medication. The nurses will audit daily for 4 wks for compliance. Audit results will be reviewed wkly by the DON/ADON for 4 wks, then 2 time a month for 4 wks, then 1once a month for 4 months. Audit results will be discussed during monthly CQI. Identified non-compliance issues will result in additional education and/or termination.		

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F000428 SS=D	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on record review and interview the facility failed to ensure a Pharmacy Consult Report was acted upon in a timely manner for 1 resident in a sample of 10 residents reviewed for unnecessary medications (Resident #84).</p> <p>Findings include:</p> <p>The clinical record of Resident #84 was reviewed on 3/13/13 at 12:45 p.m., and indicated Resident #84's diagnoses included, but were not limited to, anxiety and depression.</p> <p>The Change Of Condition Medication Regimen Review Report, dated 2/20/13, indicated the Facility Nurse Practitioner had signed and dated the report on 3/1/13 without indicating any recommendations on the form. The facility had requested The Change Of Condition Medication Regimen Review Report due to the resident having had a new onset or</p>	F000428	<p>It is the facility's policy to ensure pharmacy consulting reports are addressed in a timely manner. Corrective action for alleged deficient practice: The pharmacy recommendation for res #84 was reviewed by the nurse practitioner and no changes were made. Identification of other residents with potential to be affected by alleged deficient practice: All residents who receive pharmacy recommendations have the potential to be affected. A 100% audit of all pharmacy recommendation reports within past 30 days completed. Systematic change to ensure alleged deficient practice does not recur: A pharmacy recommendation log will be implemented for the nurse managers to track follow-up on any pharmacy recommendations as they are received. The log will be brought to daily clinical triage daily and reviewed to determine status of recommendation follow-up. Once recommendations have been followed through, the</p>	04/17/2013			

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	<p>worsening of falls, dizziness, and impaired coordination. The Change Of Condition Medication Regimen Review Report indicated the resident had been prescribed buspar (antianxiety medication) 10 milligrams (mg) two times a day on 1/16/13, Xanax (anxiety) 0.25 mg 2 times a day, and Celexa (antidepressant) 10 mg one time daily on 4/20/12. The Change Of Condition Medication Regimen Review Report further indicated "...all cause sedation, increased confusion and cause unsteady gait...."</p> <p>Interview on 3/14/13 at 1:30 p.m. with the facility Nurse Practitioner (NP) indicated the The Change Of Condition Medication Regimen Review Report, signed and dated 3/1/13, was incomplete. The NP further indicated she had signed and dated the form and had put it aside for further review. The NP indicated she did not get back to the form to document the changes she had wanted to implement. The NP further indicated the pharmacy consult had gotten missed and had not been completed.</p> <p>Interview on 3/15/13 at 10:00 a.m. with the Director Nursing Service (DNS) indicated she had asked for</p>		<p>recomendation will be removed from the log by the ADON/DON. Monitoring of systematic change to ensure alleged deficient practice does not recur: The unit managers will audit the log 2 times a wk for complianc and will record results on the audit tool. The ADON/DON will monitor the audit tool once a wk for 4 wks, then 2 times a month for 4 wks, then 1 time a month for 4 months to ensure compliance. Any trends or issues will be addressed as they occur with the staff through individual education and disciplinary action including termination as appropriate. Audit results will be reviewed during monthly CQI.</p>		

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	<p>the pharmacy to review Resident #84's medications because the resident was having falls and dizziness.</p> <p>3.1-25(j)</p>			