

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155266	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/01/2012
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NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1649 SPY RUN AVENUE FORT WAYNE, IN 46805
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F0000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00116266 and IN00115404.</p> <p>Complaint IN00116266 - Substantiated. No deficiencies related to the allegation are cited.</p> <p>Complaint IN00115404 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: September 24, 25, 26, 27, 28, and October 1, 2012</p> <p>Facility number: 000167 Provider number: 155266 AIM number: 100273740</p> <p>Survey team: Sue Brooker RD TC Rick Blain RN Angie Strass RN Diane Nilson RN (September 24, 25, 26, 27, &amp; 28, 2012)</p> <p>Census bed type: SNF/NF: 68 Total: 68</p>	F0000	<p>This plan of correction is the facility's credible allegation of compliance. 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 forth in the statement of deficiencies. The plan of correction is prepared and/or executed because the provisions of federal and state law require it. The facility respectfully requests paper compliance be considered for this plan of correction.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>Census payor type: Medicare: 4 Medicaid: 56 Other: 8 Total: 68</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 10/05/12 by Suzanne Williams, RN</p>			
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F0166 SS=D	<p>483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>Based on interview and record review, the facility failed to document the resolution of a grievance for a resident who complained about the care she received, for 1 resident (Resident #67) of 2 residents who met the criteria for dignity.</p> <p>Findings include:</p> <p>During an interview with Resident #67, at 1:47 p.m., on 9/24/12, the resident indicated one week ago on Sunday night, staff left her lay in bed when she had been incontinent of bowel and bladder. She indicated this had occurred sometime in the evening, and she had turned her call light on, then waited one and one half hours until someone cleaned her. She indicated she "wadded up my diaper myself and tried to take it off." The resident indicated when the CNAs came in, they told her they had been busy. She further indicated she had reported this incident to one of the day shift CNAs.</p> <p>Resident #67 also indicated on Friday</p>			F0166	<p>Right to prompt efforts to resolve grievances:</p> <p>It is the policy of this facility that a resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>1. Corrective actions for residents affected: Resident #67 has documented resolution to previous concern in medical record and has had no further concerns reported to management about her care.</p> <p>2. Other residents having the potential to be affected and corrective actions: All other residents have the potential to be affected by this negative practice. Grievance log book was reviewed for any concerns lacking resolution documentation and follow up.</p>		10/23/2012

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	<p>night (September 21, 2012), of the past week, she had been incontinent in her brief, and she kept turning on her call light for assistance, and was hollering for the CNAs. She indicated she could hear them talking outside of her room. She indicated she waited and CNA #9 came in and told the resident he had been busy. She indicated one of the nurses, Nurse #10, came in her room 3 different times while she was waiting, and turned off her call light each time and told her the CNAs were busy and would be there in a few minutes, that they were putting residents to bed. When the CNAs came in, the resident indicated they told her the nurse could have assisted her, but the nurse didn't offer to help. The resident indicated CNA #9 was mad because the resident had asked him if he was drinking and he indicated he didn't drink. She indicated CNA #9 then told her he would not change her. She indicated CNA #9 assisted her roommate, then came back to her and told her he didn't like to be talked to in that manner, but then he cleaned her. The resident indicated she liked CNA #9 and he was a good CNA and that was the first time this had occurred. The resident further indicated she had not reported this incident to anyone.</p>		<p>3. Measures to ensure practice does not recur: Nurse management team and Social service staff were re-educated on 10/18/12 on following policy of resolving grievances. Grievance log book will be brought to morning meetings daily Monday thru Friday for review of concerns and resolutions of such concerns.</p> <p>4. Monitoring of grievance log book/resident concerns will be completed daily Monday thru Friday ongoing. Such auditing will be evidenced by the signature of the management team consisting of DON, Social Service designee and ED. Any non-compliance issues noted during auditing will be addressed at monthly meetings of the Performance Improvement meetings (PI, also known as Quality Assurance).</p>		

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	<p>The Administrator and Regional Director of Clinical Services were interviewed, at 3:30 p.m., on 9/26/12 regarding the allegation and indicated this had not been reported to them.</p> <p>The resident record was reviewed, at 9:00 a.m., on 9/27/12.</p> <p>Diagnoses included, but were not limited to, cerebral vascular accident, hypertension, muscle weakness, chronic pain, anxiety, and depression.</p> <p>The Minimum Data Set assessment for Resident #67, dated 7/13/12, indicated a score of 10 out of 15 on the Brief Interview for Mental Status, indicating moderate cognitive impairment.</p> <p>Care plans indicated the resident had a potential for behaviors related to a history of being non-compliant, was at risk for injury related to consistent refusal of medical treatment, and had a potential for moods/behaviors related to the resident displayed verbally aggressive behavior.</p> <p>There was no documentation in the resident record regarding the concerns the resident had voiced regarding the long call light waits or</p>			

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	<p>the long wait regarding her incontinence care.</p> <p>The Director of Social Services was interviewed, at 9:47 a.m., on 9/27/12. She indicated she had interviewed Resident #67 on 9/26/12, and the resident told her sometimes she has to wait for her call light to be answered and recommended to the Director of Social Services that the staff come to her (the resident) before they lay any other residents down, to see if she needs anything. The Director of Social Services indicated the resident preferred that CNA #9 take care of her because she liked CNA #9. The Director of Social Services indicated the resident told her she didn't feel she had been abused by any staff and "if they tried she would let them have it." The Director of Social Services indicated on Friday, September 21, 2012, late in the evening, Resident #67 had requested to speak with her, and the Assistant Director of Nursing had been there as a witness. The Director of Social Services indicated the resident wanted to speak to them about incontinence care and having to wait for her call light to be answered. She indicated Resident #67 would call for her if she had any concerns. When she and the</p>			

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	<p>Assistant Director of Nursing entered the resident's room, she was laying in bed reading a magazine. The resident indicated on the previous Wednesday staff had taken "forever" to answer her call light, and indicated CNA #7 had taken 1 and 1/2 hours to answer the light. The resident then indicated she was not sure of the time, but she did end up removing her own brief because it was soiled. The resident also indicated Nurse #10, who was no longer employed at the facility, had answered her call light one time, and told the resident the CNAs were busy, but would be right in to assist her. The Director of Social Services indicated the resident did not seem upset and was smiling and giggling when they talked to her. She indicated the resident never mentioned the incident which happened on Sunday, and was not aware of it until the Regional Director of Clinical Services brought it to her attention on 9/26/12. She indicated she had documented the resident concerns in her personal notes, but had not written a concern form or documented the concerns in the resident record.</p> <p>The Assistant Director of Nursing was interviewed, at 2:16 p.m., on 9/27/12, and indicated the resident had voiced</p>			

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	<p>previous concerns about her call light not being answered timely, and about care issues, and an approach was added to the resident's care plan to have 2 staff in the room when providing care. She indicated on 9/21/12, the past Friday, she had gone into the resident's room with the Director of Social Services and the resident had complained that the CNAs took too long to answer her call light. The Assistant Director of Nursing indicated she did not document this concern, but the Director of Social Services had documented a concern form. She indicated she talked to staff on the evening shift on 9/21/12, after the resident had voiced her concerns. She indicated she was planning on talking to the resident prior to this concern because the resident had been using vulgarity with the staff and having increased behaviors. She indicated once in the room, the resident complained about waiting for her call light to be answered, and told them she had called for the bedpan, but now it was too late, she had been incontinent. The Assistant Director of Nursing indicated the resident had not waited for over an hour, as she had previously indicated, because the resident told her, it had just happened. She further indicated her</p>			

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	<p>office was on the same hall where the resident resided, and she listened for call lights, and if heard going off for any period of time, she would answer the call light herself.</p> <p>The Assistant Director of Nursing indicated on 9/21/12, after the concern was voiced, she talked to staff and none of them reported hearing the call light on for that length of time. She indicated she normally investigated resident concerns and tried to do immediate interventions to try to resolve the concerns. She further indicated this resident had a history of making allegations and had been care planned regarding this.</p> <p>At 3:00 p.m., on 9/27/12, the Assistant Director of Nursing presented additional care plans regarding behaviors. A care plan problem, dated as initiated on 5/12/12, indicated the resident had a history of singling out staff members and being verbally abusive towards them, threatening staff. Another problem indicated the resident displayed verbally aggressive behavior, i.e. yelling out, screaming instead of using the call light. Another care plan problem indicated the resident resisted care and could be uncooperative with care. Approaches included, but were not</p>			

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	<p>limited to: 2 staff present when providing care.</p> <p>Review of policy "Grievance Procedures", provided by the Regional Director of Clinical Services, at 9:20 a.m., on 9/28/12, indicated social service staff were responsible for maintaining a system to keep records of all complaints reported, which contained the date of the report, circumstances, specifics of the investigation, actions taken, and follow-up with the complainant.</p> <p>3.1-7(a)(2)</p>			

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F0242 SS=D	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on interview and record review, the facility failed to honor a resident's choice to have more than 2 showers a week for 1 resident (Resident #53) of 7 who met the criteria for choices.</p> <p>Findings include:</p> <p>On 9/25/12 at 11:02 a.m. interview with Resident #53 indicated she takes a bath or a shower only two times a week. The resident went on to say she wished she could take a shower daily, like she did when she was at home.</p> <p>On 9/25/12 at 1:00 p.m. review of the clinical record for Resident #53 indicated she was alert and oriented.</p> <p>On 9/27/12 at 8:15 a.m. interview with the Regional Director of Clinical Services indicated the facility did not have any documentation that the residents are queried about how</p>	F0242	<p>Self –determination –Right to make choices: It is the policy of this facility that the resident has the right to choose activities, schedules and health care consistent with his/her interests, assessments and plans of care; and make choices about aspects of his/her life in the facility that are significant to the resident 1. Corrective action for residents affected: Resident # 53 was interviewed and questioned about her choices in regards to bathing. Resident is now being bathed per her choice. Care plan was updated with current schedule along with CNA care guides. 2. Other residents having the potential to be affected: All other residents have the potential to be affected. Residents identified as alert and able to make own decisions were also interviewed and questioned as to their bathing preference. Schedules were changed to fit residents' choices. 3. Measures to ensure practice does not recur: On 10/18/12 and 10/23/12 nursing staff/Social Service staff was in-serviced on</p>	10/23/2012			

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	<p>many times a week they would like a shower or bath.</p> <p>On 9/27/12 at 9:00 a.m. the Regional Director of Clinical Services provided the facility policy for "Bathing a Resident.", which was not dated. Review of the policy indicated the following:</p> <p>"Tub baths or showers will be given at least two (2) times per week to all residents and more frequently as needed. Staff will make every effort to encourage residents to bathe at least weekly."</p> <p>3.1-3(u)(1) 3.1-3(u)(3)</p>		<p>residents' right to choose. All newly admitted residents will be interviewed by Nursing staff and or Social service upon admission to ensure choices are being honored. DON will monitor charts for completion of the questionnaire weekly. 4. Corrective action to be monitored by: Monitoring of new resident choices will be completed weekly for 4 weeks, then monthly for 5 months, then quarterly thereafter ongoing. Any non-compliance issues noted during auditing will be addressed at monthly PI meetings.</p>		

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F0279 SS=E	<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 develop care plans for nausea, vomiting and loose stools, a tracheostomy and behaviors for the use of psychotropic medications, for 4 residents (Resident #21, Resident #14, Resident #63, Resident #62) of 41 sampled residents whose care plans were reviewed.</p> <p>Findings include:</p> <p>1. Review of the clinical record on 9/26/12 at 9:00 a.m. indicated</p>	F0279	<p>Develop Comprehensive care plans: It is the policy of this facility to develop, review and revise the residents' comprehensive plan of care 1. Corrective action taken for residents affected: Resident # 21 is no longer in the facility. Resident # 14 is no longer in the facility. Resident # 63 has updated care plans for behaviors/mental issues Resident # 62 has updated care plans for mental issues. 2. Other residents having the potential to be affected: All residents with trachs, behavior and/or mental issues, and nausea, vomiting, and diarrhea have the potential to be</p>	10/23/2012	

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	<p>Resident #21 was admitted to the facility on 6/28/12 with diagnoses including, but not limited to, fractured femur, aplastic anemia, diabetes, and chronic kidney disease with a kidney transplant.</p> <p>Review of the resident's admission MDS (minimum data set assessment) dated 7/5/12, indicated the resident was alert and oriented and able to feed herself.</p> <p>Review of the nursing notes indicated the resident was having diarrhea and emesis from 7/20/12 through 8/25/12..</p> <p>Interview on 9/27/12 at 2:30 p.m. with LPN # 6 indicated the resident had stomach problems and had been seen by a specialist. She indicated the resident was on Nexium (used to treat stomach acid) 40 milligrams per mouth every morning.</p> <p>Review of the clinical record indicated the resident had received an order on 7/23/12 for Immodium ( for loose stools) 2 milligram caplets, give 2 caplets initially then give 1 caplet there after per mouth for loose stools, not to exceed 6 caplets in 24 hours. The resident also had an order for Zofran (to prevent nausea and</p>		<p>affected, and their care plans have been reviewed and updated to reflect current status and risk factors. 3. Measures to ensure practice does not recur: On 10/18/12 and 10/23/12 licensed nursing staff was in-serviced/re-educated regarding care plan development and implementation of care issues. DON/designee will monitor for completeness and accuracy of resident care plans weekly during care plan meetings by comparing new physician orders to the care plans for completeness. 4. Corrective action to be monitored by: Monitoring of complete and accurate care plans will be completed weekly for 3 months, then monthly thereafter ongoing. All non-compliance issues noted during auditing will be addressed in monthly PI meetings.</p>		

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	<p>vomiting) dated 6/29/12, 4 milligrams tablet orally every 6 hours as needed.</p> <p>Review of the clinical record on 9/28/12 at 10:00 a.m. indicated there was no documentation in the clinical record of the facility tracking the resident's loose stools and emesis other than the nursing notes and the times the staff gave the resident Immodium for loose stools.</p> <p>Review of the resident's "Care Plans" on 9/28/12 at 10:15 a.m. indicated there was no written plan of care addressing the resident's loose stools or emesis which had been an ongoing problem for the resident.</p> <p>2. The record for Resident #14 was reviewed on 9/27/12 at 10:00 A.M. Diagnoses included, but were not limited to, morbid obesity, pulmonary insufficiency, respiratory failure, and severe hypoxic encephalopathy.</p> <p>A nursing note, dated 6/6/12 at 12:30 P.M., indicated "Res (resident) arrived at facility per (name of ambulance provider) from (name of local hospital) at 12:25 P.M. ...Res arrived on O2 (oxygen) per trach (tracheostomy) et (and) was placed on O2 per concentrator at 28%."</p>			

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	<p>A review of the care plans dated 6/6/12 for Resident #14 did not indicate a care plan addressing the tracheostomy was in the record.</p> <p>An Admission Minimum Data Set Assessment dated 6/13/12 indicated in the Special Treatment section the resident received tracheostomy care.</p> <p>The facility Assistant Director of Nursing (ADON) was interviewed on 9/27/12 at 3:15 P.M. During the interview, the ADON indicated any resident newly admitted to the facility with a tracheostomy should have an interim care plan to address the tracheostomy. The ADON reviewed the resident's record and also checked the facility computer system, but could not locate a care plan for the tracheostomy. The ADON indicated an interim care plan for the tracheostomy should have been initiated by the nurse at the time of the resident's admission to the facility.</p> <p>3. Review of the clinical record for Resident #63 on 9/26/12 at 2:42 p.m., indicated the following: diagnoses included, but were not limited to, presenile delirium, intellectual disability, Down's syndrome, anxiety, depression, psychosis, delusional thinking, and agitation.</p>			

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	<p>A Behavioral Medicine Evaluation &amp; Management Note for Resident #63, dated 5/19/12, indicated she received Risperdal (medication to treat psychiatric conditions) 0.5 mg (milligrams) BID (twice a day). The note also indicated Resident #63 had a diagnosis of senile dementia with delusional features.</p> <p>A Behavioral Medicine Evaluation &amp; Management Note for Resident #63, dated 6/4/12, indicated Risperdal 0.5 mg BID. The note also indicated Resident #63 was more delusional. The note further indicated to increase Risperdal to 1 mg BID for agitated psychosis/delusional thinking.</p> <p>A physician's order for Resident #63, dated 6/4/12, indicated to increase Risperdal to 1 mg BID for agitated psychosis and delusional thinking.</p> <p>A Minimum Data Set (MDS) assessment for Resident #63, dated 7/27/12, indicated active diagnoses of dementia and depression. The MDS also indicated Resident #63 had not displayed any behaviors, including hallucinations and delusions.</p> <p>A physician's order for Resident #63, dated for the month of September</p>				

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	<p>2012, indicated Risperidone 1 mg BID for agitation/psychosis/delusional thinking.</p> <p>Facility care plans for Resident #63 included the areas of: at risk for decline in upper extremity strength and mobility, at risk for contractures to bilateral upper extremities, at risk for developing pressures ulcers, behaviors of restless agitation, yelling out and non-compliant with care and combative towards staff, wandering, cries/yells out, abrasions, falls, seizure activity, at risk for aspiration, at risk for abuse, activities, pain, at risk for choking, at risk for bleeding, communication, at risk for hearing difficulty, nutrition, psychotropic medication, and passive range of motion. There was no care plan for delusional thinking.</p> <p>4. Review of the clinical record for Resident #62 on 9/26/12 at 8:45 a.m., indicated the following: diagnoses included, but were not limited to, depressive disorder, Alzheimer's disease, dementia with behavioral disturbances, presenile dementia, and altered mental state.</p> <p>A Behavioral Medicine Evaluation &amp; Management Note for Resident #62, dated 5/7/12, indicated to start</p>				

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	<p>Risperdal 0.5 mg HS (hour of sleep) for delusional thinking.</p> <p>A Minimum Data Set (MDS) assessment for Resident #62, dated 8/23/12, indicated active diagnoses of Alzheimer's disease, dementia and depression. The MDS also indicated Resident #62 had not displayed any behaviors, including hallucinations and delusions.</p> <p>A physician's order for Resident #62, dated for the month of September 2012, indicated she received Risperdal 0.5 mg HS for delusional thinking.</p> <p>Facility care plans for Resident #62 included the areas of: depression, at risk for bleeding, non-compliant with showering, self-isolates herself in her room, active range of motion to bilateral lower and upper extremities, activities of daily living assistance, at risk for break in skin integrity, at risk for falls, at risk for pain, hypertension, at risk for psychotropic drug induced side effects related to antidepressant medication and psychotropic med, diagnosis of insomnia, nutrition, and activities. There was no care plan for delusional thinking.</p> <p>The Assistant Director of Nursing was</p>			

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	<p>interviewed on 10/1/12 at 10:45 a.m. During the interview she indicated a care plan should be in place for any resident who receives a psychotropic medication for delusional thinking.</p> <p>A undated facility policy "Care Plan," from the AIT Manual and provided by the Regional Director of Clinical Services on 9/27/12 at 11:00 a.m., indicated "...A written nursing care plan will be initiated and maintained for each resident based on the nature of the illness, treatment prescribed, long- and short-term goals, and other pertinent information. The nursing care plan will be a personalized plan for individual residents...."</p> <p>3.1-35(a)</p>				

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F0327 SS=D	<p>483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION</p> <p>The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.</p> <p>Based on interview and record review, the facility failed to monitor the fluid intake to ensure adequate hydration of 2 of 2 residents reviewed for hydration (Resident #21 and Resident #88) of 2 residents who met the criteria for hydration.</p> <p>Findings include:</p> <p>1. Review of the clinical record on 9/26/12 at 9:00 a.m. indicated Resident #21 was admitted to the facility on 6/28/12 with diagnoses including, but not limited to, fractured femur, aplastic anemia, diabetes, and chronic kidney disease with a kidney transplant.</p> <p>Review of the resident's admission MDS (minimum data set assessment) dated 7/5/12, indicated the resident was alert and oriented and able to feed herself.</p> <p>Review of the nursing notes indicated the following:</p> <p>7/20/12 at 7:34 p.m.-Patient had emesis times one.</p>	F0327	<p>Sufficient Fluid to maintain hydration: It is the policy of this facility to provide each resident with sufficient fluid intake to maintain proper hydration and health 1. Corrective action for residents affected: Resident # 21 and # 88 are no longer in the facility. 2. Other residents having the potential to be affected: All other residents have the potential to be affected. All resident meal records were reviewed for documentation of intakes. All residents on physician ordered intakes and outputs were also reviewed for documentation. 3. Measures to ensure practice does not recur: Nursing staff was re-educated on 10/18/12 and 10/23/12 on the policy/procedure of Hydration &amp; Nutrition in regards to prevention of dehydration and the tracking of the residents' hydration needs, including the use of intake sheets and computer charting. 4. Corrective action to be monitored by: DON/designee will monitor residents' intakes sheets and computer charting daily Monday thru Friday for documentation of intakes. Monitoring will be completed daily Monday thru Friday daily for 8 weeks, then monthly for 4 months. All</p>	10/23/2012	

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	<p>7/22/12 at 12:55 p.m.-Bouts of diarrhea, N.O. (new order) for immodium 2 milligrams, not to exceed 6 in twenty four hours. Fluids encouraged.</p> <p>7/26/12 at 3:00 p.m.-Resident had no episodes of emesis noted this shift.</p> <p>7/26/12 at 6:31 a.m.-Resident had two episodes of emesis this shift. First one was at 10:45 p.m. and it consisted of whole pieces of cooked carrots. The second episode was at 5am and it consisted of yellowish bile, no odor.</p> <p>7/29/12 at 2:19 pm-Large emesis of golden yellow fluids with eggs noted in it. Filled entire emesis basin, but when she was finished, she stated she felt better and had no further episodes.</p> <p>8/5/12 at 2:18 pm -A small to moderate emesis with golden like secretions and her nexium pill found in bed.</p> <p>8/9/12 at 3:22 pm-Resident had small emesis this am, medicated per orders.</p> <p>8/11/12 at 1:46 pm-Continues to have</p>		non-compliance issues noted during auditing will be addressed at monthly PI meetings.		

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	<p>emesis with golden secretions and eggs noted in it about one hour ago.</p> <p>8/14/12 at 2:46 pm-Resident had moderate emesis, medicated per orders.</p> <p>8/16/12 at 10:10 pm-Resident had emesis one time this shift shortly after giving her her 9 pm medications.</p> <p>8/16/12 at 3:34 pm-No emesis noted this shift, resident complained of nausea,, medicated per orders. Will continue to monitor.</p> <p>8/18/12 at 12:50 am-Resident had one episode of emesis and two runny diarrhea. Patient is afebrile and resting comfortably at present time. Will continue to monitor. Changed dressing according to orders because of diarrhea.</p> <p>8/21/12 at 3:42 pm-No emesis noted, resident had one episode of diarrhea, medicated per orders.</p> <p>8/21/12 at 8:49 pm-Resident in bed watching tv. Had 1 episode of emesis this shift. No diarrhea noted.</p> <p>8/22/12 at 10:28 pm-Resident had one episode of loose stools and emesis after dinner.</p>			

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	<p>8/25/12 at 3:42 pm-Resident refusing to eat offered alternate, but continues to decline food. BS (blood sugar) 54 offered snack, but only took bites. Emesis of golden secretions of moderate amount.</p> <p>Interview on 9/27/12 at 2:30 p.m. with LPN #6 indicated the resident had stomach problems and had been seen by a specialist. She indicated the resident was on Nexium (used to treat stomach acid) 40 milligrams per mouth every morning.</p> <p>Review of the clinical record indicated the resident had received an order on 7/23/12 for Immodium (for loose stools) 2 milligram caplets, give 2 caplets initially then give 1 caplet there after per mouth for loose stools, not to exceed 6 caplets in 24 hours. The resident also had an order for Zofran (to prevent nausea and vomiting) dated 6/29/12, 4 milligrams tablet orally every 6 hours as needed.</p> <p>Review of the clinical record on 9/28/12 at 10:00 a.m. indicated there was no documentation in the clinical record of the facility tracking the resident's loose stools and emesis other than the nursing notes and the times the staff gave the resident</p>						

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	<p><b>Immodium for loose stools.</b></p> <p>Review of the medication administration records for the month of August 2012 indicated the resident had been given immodium on 8/3/12 and 8/25/12. The resident had been given Zofran on 8/1, 8/2, 8/4, 8/5, 8/6, 8/9, 8/13, 8/14, 8/15, 8/21, 8/23, and 8/24/12.</p> <p>Review of the facility "Monthly Flow Report" of Meal Consumption for August 2012, indicated the facility recorded the resident's food consumption and snack consumption in percentages for each meal and snack time, but there was no documentation of the amount of fluids the resident consumed with each meal/snack.</p> <p>Review of the "Nutritional Data Collection/Assessment" completed on admission for this resident indicated she required 1720 to 2150 milliliters of fluid daily.</p> <p>Interview with the Regional Director of Clinical Services on 10/1/12 at 10:30 a.m. indicated there was documentation of the resident's fluid indicate on the "monthly Flow Report." She indicated the staff are to input the fluids the resident</p>			
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	<p>consumed in milliliters each shift.</p> <p>Review of the "monthly Flow Report" for August 2012 indicated the following:</p> <p>8/9/12 - 840 ml (milliliters) 8/11/12 - 720 ml 8/12/12 - 1200 ml 8/13/12 - 960 ml 8/17/12 - 960 ml 8/20/12 - 960 ml 8/21/12 - 960 ml 8/23/12 - 360 ml 8/24/12 - 960 ml 8/25/12 - 480 ml</p> <p>Review of the facility policy "Hydration and Nutrition" with a revision date of 10/08 indicated "An ongoing assessment of ability to consume and assimilate food and fluid by resident is conducted by nursing personnel."</p> <p>There was no system consistently implemented by the facility to ensure this residents hydration needs were being met daily, to ensure she did not become dehydrated.</p> <p>2. The record for Resident #88 was reviewed on 9/28/12 at 11:30 A.M. Diagnoses included, but were not limited to, cancer of the larynx, congestive heart failure, peripheral vascular disease, respiratory failure,</p>				

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	<p>status post mandibular resection with tracheostomy.</p> <p>Admission orders dated 7/20/12 indicated Resident #88 was to receive a regular pureed diet with thin liquids. In addition, the resident was to receive Glucerna (nutritional supplement) 1.2 cal (calories) through a G-tube (feeding tube) at 60 cc (cubic centimeters) per hour for ten hours from 8:00 P.M. to 6:00 A.M. The resident was also to receive routine water flushes 120 cc every 8 hours, 30 ml water every three to four hours during tube feeding and 30 ml water with each medication pass.</p> <p>A note by the Registered Dietitian (RD) dated 7/27/12 at 12:48 P.M., indicated "Resident is on a Pureed consistency diet with thin liquids. Also on TF (tube feed) of Glucerna 1.2 at 60 ml/hr (milliliters per hour) from 8p-6a. Routine water flush is 120 ml q (every) 8 hrs. Requires these dietary restrictions due to left mandibular resection . Intake of oral is 75 - 100%. Wt 170.5 #. Ht 70". BMI (body mass index) 24.7 - normal wt. TF provides 720 calories, 30 gm (grams) protein, and 840 ml fee fluids and 920 ml total volume to supplement oral intake. Estimated needs are 2252 calories, 77.8 gm</p>				

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	<p>protein, and 2325 ml fluids."</p> <p>Review of daily oral fluid intakes for each shift on the Monthly Flow Reports for July and August 2012 indicated no oral fluid intakes were documented for the following:</p> <p>7/22/12: days and evenings 7/23/12: days and evenings 7/24/12: days, evenings and nights 7/25/12: days, evenings and nights 7/27/12: days and evenings 7/28/12: evenings and nights 7/29/12: evenings and nights 7/30/12: days evenings, and nights 8/1/12: days, evenings, and nights 8/2/12: days and evenings 8/3/12: days and evenings 8/4/12 days, evenings, and nights 8/5/12: days, evenings, and nights 8/6/12: days, evenings, and nights 8/7/12: days, evenings, and nights 8/8/12: days and evenings 8/9/12: evenings 8/10/12: days and evenings 8/11/12: evenings 8/12/12: evenings 8/13/12: evenings and nights 8/14/12: days and evenings 8/15/12: days and evenings 8/16/12: days and evenings 8/17/12: evenings 8/18/12: days, evenings, and nights 8/19/12: days, evenings, and nights</p>						

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	<p>8/20/12: evenings and nights 8/21/12: days and evenings 8/22/12: evenings 8/23/12: evenings</p> <p>A care plan dated 7/25/12, indicated the resident need as "nutrition/hydration." The care plan did not address oral fluids.</p> <p>CNA #16 was interviewed on 10/1/12 at 11:30 A.M. During the interview, CNA #16 indicated CNA's recorded oral fluid intakes on the computer for each shift.</p> <p>The Assistant Director of Nursing (ADON) was interviewed on 10/1/2012 at 11:00 A.M. During the interview the ADON indicated nursing staff were document intakes for residents on feeding tubes on the intake and output form and CNA's were to document oral fluids consumed on the Monthly Flow Report, which was in the facility's computer charting.</p> <p>3.1-46(b)</p>			

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F0329 SS=E	<p><b>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</b></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 provide clinical rationale for the use of psychotropic medications for 4 residents (Resident #77, Resident #63, Resident #62, Resident #36) of 10 residents reviewed for unnecessary medication.</p> <p>Findings include:</p> <p>1. The record for Resident #77 was reviewed on 9/26/12 at 1:30 P.M.</p>	F0329	Drug regimen is free from unnecessary drugs: It is the policy of this facility to ensure that each resident's drug regimen be free from unnecessary drugs. 1. Corrective action for residents affected: Resident # 77 has current care plan, behavior monitoring and a reduction in the medication Clozaril. Resident # 63 has current care plan, behavior monitoring and a reduction in the medication Risperdal Resident #62 has current care plan, behavior monitoring and a reduction in the	10/23/2012	

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	<p>Diagnoses included, but were not limited to senile dementia with delusional features and senile dementia with behavioral disturbances.</p> <p>A physician order monthly recap for September 2012 indicated Resident #77 was currently prescribed Clozaril (antipsychotic medication) 25 mg (milligrams) at bedtime.</p> <p>A pharmacy recommendation, signed by the physician on 12/7/11 as agreeing to the recommendation, indicated "please consider reducing the dose of Fazaclo (a form of clozapine) to 25 mg at bedtime, with the eventual goal of discontinuation, if possible." The rationale for the recommendation indicated "The Food and Drug Administration (FDA) has released a public health advisory and required product manufacturers to include a BOXED warning in the prescribing information for all antipsychotic medications which warns of potential for increased mortality when antipsychotic medications are used in elderly individuals with dementia-related behavioral disorders."</p> <p>A physician's order, dated 3/30/12, indicated Fazaclo 25 mg at bedtime</p>		<p>medication Risperdal Resident # 36 medication of Risperdal was discontinued. Resident has current care plans in place. 2. Other residents having the potential to be affected: Other residents receiving psychotropic medications have the potential to be affected. All residents with psychotropic medication orders were audited for appropriate diagnosis, updated care plans and behavior documentation. 3. Measures to ensure practice does not recur: On 10/18/12 and 10/23/12 all staff was in-serviced on the Behavior management policy/procedure. Licensed nursing staff was re-educated on policy of unnecessary drugs on 10/18/12 and 10/23/12. DON/designee along with Social Service designee will monitor for documentation of behaviors. Any new physician order for psychotropic medications will be reviewed/compared to documentation for clinical rationale of medication. 4. Corrective action to be monitored by: Monitoring will be completed daily Monday thru Friday on the Behavior log sheets for appropriate documentation and any new orders for psychotropic medications to ensure clinical rationale is present for use of the medications. Auditing will be ongoing daily. All non-compliance issues noted during auditing will be addressed at monthly PI</p>		

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	<p>was discontinued and clozapine (generic Clozaril) 25 mg at bedtime was started.</p> <p>A physician's order, dated 5/3/12, indicated "D/C (discontinue) clozapine 25 mg at HS (bed time)." The order also indicated a CBC (complete blood count) was to be obtained and the resident was to be re-evaluated on 5/7/12.</p> <p>A review of the nursing notes indicated the following:</p> <p>5/4/12 at 6:10 P.M.: "Resident pleasant et cooperative. No behaviors noted."</p> <p>5/6/12 at 6:00 A.M.: "No noted behaviors, fever, s/s (signs and symptoms) of infection, or increased lethargy. Will continue to monitor."</p> <p>5/6/12 at 6:00 A.M.: "Late entry for 5/5/12 at 10 PM. Res has had no behaviors."</p> <p>5/6/12 at 9:50 P.M.: "No noted maladaptive behaviors. Currently resting quietly in bed, arouses easily. No noted (change) in LOC (level of consciousness). Will continue to monitor."</p>		meetings.		

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	<p>5/6/12 at 8:30 P.M.: "No (negative) behaviors this shift. Will continue to monitor."</p> <p>5/7/12 at 4:00 A.M.: "No noted behaviors, fever, s/s of infection, or increased lethargy. Will continue to monitor."</p> <p>5/7/12 at 9:30 A.M.: "No noted s/s of infection. No noted (change) in LOC. No Noted behaviors."</p> <p>5/7/12 at 9:30 P.M.: "No noted maladaptive behaviors."</p> <p>5/8/12 at 5:00 A.M.: "Pleasant and cooperative. No (negative) behaviors. Lab (CBC) returned and faxed to (Physician name). Will (nurse practitioner name) today."</p> <p>5/8/12 at 1:30 P.M.: "No behaviors. No s/s of lethargy."</p> <p>5/8/12 at 2:55 P.M.: " N.O. (new orders) Clozaril 12.5 mg PO (by mouth) daily at HS. CBC with diff (differential) weekly. Pharmacy faxed. Lab notified. (Nurse practitioner name) notified of CBC results et above order received (sic)."</p> <p>A physician order dated 5/8/12 indicated the Clozaril was re-started</p>						

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	<p>at 12.5 mg daily.</p> <p>A progress note from the nurse practitioner, dated 3/17/12, indicated "Medication review and referral to be done. Staff reports she has been eating and sleeping OK, lab results reviewed. Had 2 lb (pound) wt (weight) gain." The note also indicated the resident had a past history of delusions and hallucinations, but there were none at the present time. The note further indicated the resident was "Sitting quietly in a wheelchair in the hallway. Denies any problems, reports feeling OK, eating and sleeping OK."</p> <p>A progress note from the nurse practitioner, dated 4/11/12, indicated "Medication review and referral to be done. Staff reports she has been eating and sleeping OK, discussed in Behavioral Management Meeting. Lab results reviewed. Had 7 lb wt gain." The note also indicated the resident had a past history of delusions and hallucinations, but there were none at the present time. The note further indicated the resident was "Sitting quietly in a wheelchair in the hallway. Denies any problems, reports feeling OK, eating and sleeping OK."</p>			

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	<p>A progress note from the nurse practitioner, dated 5/18/12, indicated "Medication review and referral to be done. Staff reports she has been eating and sleeping OK, lab results reviewed. Had 2 lb (pound) wt (weight) gain." The note also indicated the resident had a past history of delusions and hallucinations, but there were none at the present time. The note further indicated the resident was "Sitting quietly in a wheelchair in the hallway. Denies any problems, reports feeling OK, eating and sleeping OK." There was no documentation in the note indicating the reason the Clozaril had been re-started.</p> <p>A Physician Progress Note for 4/4/12 indicated "No C/O (complaints) today. Nursing reports no new C/O or medical concerns."</p> <p>A Physician Progress Note for 5/2/12 indicated "No new C/O today. Nursing reports no new C/O or medical concerns."</p> <p>A Physician Progress Note for 6/6/12 indicated "No C/O today. Nursing reports no new C/O or medical concerns." There was no documentation in the note indicating the reason the Clozaril had been</p>			

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	<p>re-started.</p> <p>Behavior tracking sheets for Resident #77 for April 2012 and May 2012 indicated the facility was monitoring the resident for wandering and exit seeking, wandering into other residents' rooms, combative towards staff and others. There were no behaviors indicated on the tracking forms until 5/29/12, when the form indicated the resident had two episodes of exit seeking and wandering into others rooms.</p> <p>The facility Social Services Director (SSD) was interviewed on 9/27/12 at 9:15 A.M. During the interview, the SSD indicated psychotropic medications were started or increased based on data that indicated increases in behaviors. The SSD indicated the data was obtained on the monthly behavior tracking forms, which she reviewed daily, and in the nursing notes. The SSD further indicated the data was discussed with the interdisciplinary team and the physician or the nurse practitioner before starting or increasing a psychotropic medication. The SSD indicated there was no documentation to show why Clozaril was restarted for Resident #77. The SSD indicated sometimes the nurses just talk to the</p>				

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	<p>physician or the nurse practitioner, instead of going through the team and using the data collected, and the physician or nurse practitioner makes a decision regarding the medication . The SSD indicated there was no documentation indicating Resident #77 had experienced any maladaptive behaviors in April 2012 or in May 2012 prior to re-starting the Clozaril.</p> <p>A facility policy entitled "Psychotropic Drug Reduction Program", with a revised date of 3/2007, indicated the objective was "To evaluate the use of psychotropic drugs (chemical restraints) in the facility in an effort to consistently ensure their appropriate utilization, thus reducing and preventing the use of psychotropic drugs (chemical restraints) whenever possible." The policy further indicated "All residents who are currently on any psychotropic medication will be evaluated to determine the necessity of the drug.</p> <p>2. Review of the clinical record for Resident #63 on 9/26/12 at 2:42 p.m., indicated the following: diagnoses included, but were not limited to, presenile delirium, intellectual disability, Down's syndrome, anxiety, depression, psychosis, delusional</p>			

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	<p>thinking, and agitation.</p> <p>A Behavioral Medicine Evaluation &amp; Management Note for Resident #63, dated 5/19/12, indicated she received Celexa (medication for depression) 20 mg (milligrams) q (every) day and Risperdal (medication to treat psychiatric conditions) 0.5 mg BID (twice a day). The note also indicated Resident #63 had a diagnosis of senile dementia with delusional features and anxiety disorder. The note further indicated she was doing okay with no problems in mood. On 5/4/12 Resident #63's personal care physician had ordered Ativan 0.5 mg BID PRN (as needed) for anxiety.</p> <p>A Behavioral Medicine Evaluation &amp; Management Note for Resident #63, dated 6/4/12, indicated she received Celexa 20 mg q day, Risperdal 0.5 mg BID, and Ativan 0.5 mg BID PRN. The note also indicated Resident #63 was more delusional, although she was doing okay with no problems in mood. The note further indicated to discontinue Risperdal, Haldol, Celexa and Ativan PRN and to start Lexapro 10 mg q day for anxiety and Risperdal 1 mg BID for agitated psychosis/delusional thinking. On 5/30/12 Resident #63's personal care physician had ordered Haldol</p>			

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	<p>(medication to treat psychiatric conditions) 1 mg BID.</p> <p>A physician's order for Resident #63, dated 6/4/12, indicated to discontinue Risperdal, discontinue Haldol, discontinue PRN Ativan, and discontinue Celexa. The order also indicated to start Lexapro 10 mg daily for anxiety and depression and to start Risperdal 1 mg BID for agitated psychosis and delusional thinking.</p> <p>A Physician's Progress Notes for Resident #63, dated 6/6/12, indicated "... psych (psychology) has stopped Haldol and increased Risperdal...."</p> <p>A Behavioral Medicine Evaluation &amp; Management Note for Resident #63, dated 7/23/12, indicated she received Lexapro 10 mg q day and Risperdal 1 mg BID. The note also indicated she was doing okay with no problems in mood.</p> <p>A Social Service Progress Note, dated 7/26/12, indicated Resident #63 was non-verbal.</p> <p>A Behavioral Medicine Evaluation &amp; Management Note for Resident #63, dated 8/17/12, indicated she received Lexapro 10 mg q day and Risperdal 1 mg BID. The note also indicated she</p>			

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	<p>was doing okay with no problems in mood.</p> <p>A physician's order for Resident #63, dated for the month of September, 2012, indicated Lexapro 10 mg daily for anxiety/depression and Risperidone 1 mg BID for agitation/psychosis/delusional thinking.</p> <p>A Behavioral Medicine Evaluation &amp; Management Note for Resident #63, dated 9/30/12, indicated she received Lexapro 10 mg q day and Risperdal 1 mg BID. The note also indicated she was doing okay with no problems in mood.</p> <p>Facility care plans for Resident #63 included the areas of: at risk for decline in upper extremity strength and mobility, at risk for contractures to bilateral upper extremities, at risk for developing pressures ulcers, behaviors of restless agitation, yelling out and non-compliant with care and combative towards staff, wandering, cries/yells out, depression, abrasions, falls, seizure activity, at risk for aspiration, at risk for abuse, activities, pain, at risk for choking, at risk for bleeding, communication, at risk for hearing difficulty, nutrition, psychotropic medication, and passive</p>				

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	<p>range of motion. There was no care plan for delusional thinking.</p> <p>A Behavior/Intervention Monthly Flow Record for Resident #63, dated for the month of September, 2012, indicated the facility was tracking her behaviors of continuous yelling out, screaming, and crying, restless and agitated, un-cooperative with activities of daily living care, wandering, and wandering into other residents rooms. Interventions to the behavior of continuous yelling out, screaming, and crying included redirect, 1 on 1, ambulate, activity, return to room, toilet, give food, give fluids, change position, backrub, reassurance, turn on television, and give stuffed animal. Interventions to the behavior of restless and agitated included 1 on 1, ambulate, activity, give food, give fluids, change position, encourage to rest, reassurance, validation of resident's feelings, and turn television on to cartoons. Interventions to the behavior of un-cooperative with activities of daily living care included reassurance, give object to hold, and re-approach later. Interventions to the problem of wandering included redirect, activity, return to room, give food, give fluids, change position, asses for pain, reassurance, and turn television on to cartoons.</p>			

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	<p>Interventions to the behavior of wandering into other resident rooms included redirect, ambulate around building, activity, return to room, give, give fluids, change position, reassurance, and turn television on cartoon channel.</p> <p>Review of the Behavior/Intervention Monthly Flow Records for Resident #63, for the months of February, 2012, March, 2012, April, 2012, May, 2012, June, 2012, July, 2012, August, 2012, and September, 2012, did not indicate Resident #63 displayed any of the behaviors of continuous yelling/crying/screaming, restless and agitated, un-cooperative with activities of daily living care, wandering, and wandering into other's rooms. The record did not indicate Resident #63 was being monitored by staff for depression and delusional thinking.</p> <p>Social Service #5, was interviewed on 9/26/12 at 1:05 p.m. During the interview she indicated behavior books were located at the nursing station for staff to use to record behaviors. Behavior flow records were completed by staff when behaviors occurred. The behavior flow records also included interventions staff should use. She also indicated an alert form was</p>			

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	<p>available for staff to document any new behaviors. She further indicated she checked the behavior flow records daily and the information was shared with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON). A meeting was held monthly with nurse practitioner to discuss behaviors and gradual dose reductions. She also indicated the nurse practitioner makes recommendations for medications along with the pharmacist.</p> <p>Social Service #5, was interviewed on 9/26/12 at 3:27 p.m. During the interview she indicated Resident #63's Risperdal was increased on 6/4/12 due to an increase in the behaviors of yelling out and screaming.</p> <p>The Regional Director of Clinical Services was interviewed on 9/28/12 at 9:36 a.m. During the interview she indicated the Nurse Practitioner was responsible for the psychotropic medication and dosage recommendations for Resident #63.</p> <p>The Regional Director of Clinical Services was interviewed on 9/28/12 at 10:30 a.m. During the interview she indicated she was not able to locate any entries concerning</p>				

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	<p>delusional thinking in the nurse's notes.</p> <p>CNA #13 was interviewed on 9/28/12 at 12:25 p.m. During the interview she indicated each nurse's station contained a behavior book where staff were to record any behaviors of residents.</p> <p>LPN #14 was interviewed on 10/1/12 at 9:10 a.m. During the interview she indicated Resident #63 was admitted to the facility with the diagnoses of delusional thinking. She also indicated Resident #63 was non-verbal and her yelling out was for attention. As soon as staff spent time with her her yelling would stop. Resident #63 lived with her sister prior to her placement in the facility. She further indicated she did not feel Resident #63 displayed any delusional thinking.</p> <p>3. Review of the clinical record for Resident #62 on 9/26/12 at 8:45 a.m., indicated the following: diagnoses included, but were not limited to, depressive disorder, Alzheimer's disease, dementia with behavioral disturbances, presenile dementia, and altered mental state.</p>			

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	<p>A hospital Behavioral Health Psychiatric Evaluation for 11/23/11, indicated "...There are no voices or vision; no paranoia...."</p> <p>An admission physician order for Resident #62, dated 11/28/11, indicated Remeron 7.5 mg daily for depression.</p> <p>A Cornell Scale for Depression in Dementia for Resident #62, dated 11/28/11, indicated a total score of 8, which indicated significant depressive symptoms.</p> <p>A Geriatric Depression Scale for Resident #62, dated 11/29/11, indicated a total score of greater than 5 which indicated depression.</p> <p>A Social Service Progress Note: Resident Interview for Resident #62, dated 12/24/11, indicated there were no behavioral symptoms.</p> <p>An Initial Assessment Form Behavior/Psychiatric for Resident #62, dated 4/11/12, indicated staff reported she was depressed, isolating herself, and not being able to sleep. The clinical impression indicated the resident admitted to some depression, but reported it comes and goes. Resident #62 also admitted to</p>						

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	<p>being hospitalized in the past for feeling depressed. The form further indicated a recommendation of increasing Remeron from 7.5 mg HS to 15 mg HS (hour of sleep) for depression.</p> <p>A Social Service Progress Note: Resident Interview, dated 2/22/12, indicated Resident #62 expressed feeling tired at times. The note also indicated no signs or symptoms of depression or psychosocial distress was noted.</p> <p>A Behavioral Medicine Evaluation &amp; Management Note for Resident #62, dated 5/7/12, indicated she received Remeron 15 mg q HS for depression. The note also indicated Resident #62 became irritable when asked about delusional thinking. The note also indicated to increase Remeron to 30 mg HS for depression and insomnia and to start Risperdal 0.5 mg HS for delusional thinking.</p> <p>A Social Service Progress Note: Resident Interview, dated 5/23/12, indicated Resident #62 denied being tired or having trouble sleeping. The note also indicated she expressed feeling depressed all the time lately.</p> <p>A Behavioral Medicine Evaluation &amp;</p>			

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	<p>Management Note for Resident #62, dated 6/15/12, indicated staff reports she is less depressed, some isolating, and has had less delusional thinking. The note also indicated Resident #62 became irritable when asked about delusional thinking.</p> <p>A Behavioral Medicine Evaluation &amp; Management Note for Resident #62, dated 7/20/12, indicated she received Remeron 30 mg q HS for depression and Risperdal 0.5 mg q HS for delusional thinking.</p> <p>A Behavioral Medicine Evaluation &amp; Management Note for Resident #62, dated 8/8/12, she received Remeron 30 mg q HS for depression and Risperdal 0.5 mg q HS for delusional thinking. The note also indicated Resident #62 denied any problems, although staff reports some increase in depression and delusional thinking.</p> <p>A Social Service Progress Note: Resident Interview for Resident #62, dated 8/22/12, indicated there were no behavioral symptoms.</p> <p>A Behavioral Medicine Evaluation &amp; Management Note for Resident #62, dated 9/12/12, indicated she received Remeron 30 mg q HS for depression and Risperdal 0.5 mg q HS for</p>			

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	<p>delusional thinking. The note also indicated Resident #62 denied any problems, although staff reports some increase in depression and delusional thinking.</p> <p>A Behavior/Intervention Monthly Flow Record for Resident #62, dated for the month of September, 2012, indicated the facility was tracking her behaviors of self-isolating and uncooperative with assistance with daily living care (showers). Interventions to the behavior of self-isolation included 1 on 1, ambulate, activity, encourage resident to come out of room, validation of feelings, and reassurance. Interventions to the behavior of uncooperative with assistance with daily living care included offer resident choice when to take showers, educated on importance of assistance with daily living, and re-approach later. The record did not indicate staff were monitoring the behavior of depression and delusional thinking.</p> <p>Review of the Behavior/Intervention Monthly Flow Records for Resident #62, for the months of July, 2012, August, 2012, and September, 2012, did not indicate Resident #63 was being monitored by staff for</p>			

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	<p>delusional thinking.</p> <p>Facility care plans for Resident #62 included the areas of: depression, at risk for bleeding, non-compliant with showering, self-isolates herself in her room, active range of motion to bilateral lower and upper extremities, activities of daily living assistance, at risk for break in skin integrity, at risk for falls, at risk for pain, hypertension, at risk for psychotropic drug induced side effects related to antidepressant medication and psychotropic medication, diagnosis of insomnia, nutrition, and activities. There was no care plan for delusional thinking.</p> <p>Social Service #5 was interviewed on 9/26/12 at 1:05 p.m. During the interview she indicated behavior books were located at the nursing station for staff to use to record behaviors. Behavior flow records were completed by staff when behaviors occurred. The behavior flow records also included interventions staff should use. She also indicated an alert form was available for staff to document any new behaviors. She further indicated she checked the behavior flow records daily and the information was shared with the DON and the ADON. A meeting was held monthly with</p>			

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	<p>nurse practitioner to discuss behaviors and gradual dose reductions. She also indicated the nurse practitioner makes recommendations for medications along with the pharmacist.</p> <p>Social Service #5 was interviewed on 9/26/12 at 1:20 p.m. During the interview she indicated she thought the Risperdal for Resident #62 was for dementia.</p> <p>Certified Nursing Assistant #11 was interviewed on 9/26/12 at 1:54 p.m. During the interview she indicated she takes care of Resident #62 every day. She also indicated she talks with Resident #62 when providing care and has never noticed any delusional thinking.</p> <p>LPN #6 and RN #2 were interviewed on 9/26/12 at 2:22 p.m. During the interview they indicated they were the nursing staff who worked with Resident #62 and were not aware of Resident #62 expressing any delusional thoughts.</p> <p>The Regional Director of Clinical Services was interviewed on 9/27/12 at 8:45 a.m. During the interview she indicated review of the nurses notes did not indicate any entries</p>			

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	<p>concerning delusional thinking for Resident #62.</p> <p>4. Review of the clinical record for Resident #36 on 9/26/12 at 1:56 p.m., indicated the following: diagnoses included, but were not limited to, altered mental status, anxiety, and senile dementia with depressive features.</p> <p>A Social Service Assessment for Resident #36, dated 7/17/12, indicated a diagnosis of altered mental status and history of depression. The assessment also indicated a referral would be sent to psych services.</p> <p>A facility care plan for Resident #36, dated 7/2/12, indicated the problem area of resident has hallucinations/delusions. Approaches to the problem included, but were not limited to, do not argue with resident, talk with resident in calm voice when behavior is disruptive, and provide her with reassurance/validation of her feelings.</p> <p>A Social Service Progress Note: Resident Interview for Resident #36, dated 7/24/12, indicated she voiced no concerns. The note also indicated no signs/symptoms of depression or</p>			

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	<p>psychosocial distress were noted.</p> <p>An Initial Assessment Form Behavior/Psychiatric for Resident #36, dated 8/8/12, indicated staff reported she has been depressed and anxious. The form also indicated a history of psychotropic medication and alteration in thinking.</p> <p>A Social Service Progress Note: Resident Interview for Resident #36, dated 8/10/12, indicated she voiced no concerns. The note also indicated no signs/symptoms of depression or psychosocial distress were noted.</p> <p>A Weekly Care Management Review for Resident #36, dated 8/12/12 through 8/18/12, indicated no signs/symptoms of depression or psychosocial distress noted.</p> <p>A Weekly Care Management Review for Resident #36, dated from 8/19/12 through 8/26/12, indicated no signs/symptoms of depression or psychosocial distress noted.</p> <p>A Social Service Progress Note: Resident Interview for Resident #36, dated 9/12/12, indicated she was alert with confusion, but able to voice needs. The interview also indicated the resident voiced no concerns and</p>			

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	<p>no signs/symptoms of depression or psychosocial distress were noted.</p> <p>A physician's order for Resident #36, dated 9/12/12, indicated to start Risperdal 0.25 mg daily for delusional thinking.</p> <p>A Behavior/Intervention Monthly Flow Record for Resident #36, dated for the month of September, 2012, indicated the facility was tracking her behaviors of hallucinations, delusion and paranoia, verbally abusive towards staff and others, elopement risk, uncooperative with assistance with daily living care and medication, and sleep disturbance/insomnia. Interventions to the behavior of hallucination, delusions, and paranoia included redirect, 1 on 1, activity, encourage to rest, reassurance, and validation of resident's feelings . Interventions to the behavior of verbally abusive towards staff and others included redirect, activity, return to room, re-approach later, reassurance, and validation of resident's feelings. Interventions to the behavior of elopement risk included redirect, 1 on 1, implement elopement procedures, and notify family and physician. Interventions to the problem for the behavior of uncooperative with assistance with</p>			

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	<p>daily living care and medication included educated on importance of care, re-approach later, reassurance and validation of resident's feelings. Interventions to the behavior of sleep disturbance/insomnia included activity, give fluids, turn resident's television on, and give book or magazine.</p> <p>Review of the Behavior/Intervention Monthly Flow Records for Resident #36, for the month of September, 2012, did not indicate Resident #36 displayed any of the behaviors of hallucination, delusions, and paranoia, verbally abusive towards staff and others, elopement risk, un-cooperative with assistance with daily living care and medication, and sleep disturbance/insomnia.</p> <p>Social Service #5 was interviewed on 9/26/12 at 1:05 p.m. During the interview she indicated behavior books were located at the nursing station for staff to use to record behaviors. Behavior flow records were completed by staff when behaviors occurred. The behavior flow records also included interventions staff should use. She also indicated an alert form was available for staff to document any new behaviors. She further indicated</p>			

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	<p>she checked the behavior flow records daily and the information was shared with the DON and the ADON. A meeting was held monthly with nurse practitioner to discuss behaviors and gradual dose reductions. She also indicated the nurse practitioner makes recommendations for medications along with the pharmacist.</p> <p>LPN #6 and RN #2 were interviewed on 9/26/12 at 2:37 p.m. During the interview they indicated they were the nursing staff who worked with Resident #36 and were not aware of Resident #36 expressing any delusional thoughts.</p> <p>The Regional Director of Clinical Services was interviewed on 9/27/12 at 8:45 a.m. During the interview she indicated review of the nurses notes did not indicate any entries concerning delusional thinking for Resident #36.</p> <p>Certified Nursing Assistant #11 was interviewed on 10/1/12 at 9:00 a.m. During the interview she indicated she takes care of Resident #36 every day and talks with Resident #36 when providing care. She also indicated Resident #36 could be sarcastic, but never voiced any delusional thoughts.</p>			

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	<p>A current facility policy "Psychotropic Medication Administration Mental Health Referral Consultation", with a revision date of 10/08 and provided by the Regional Director of Clinical Services on 10/1/12 at 8:53 a.m., indicated "...All residents currently receiving any psychotropic medication will be reviewed to insure that there is a diagnosis and documentation to clinically support the appropriate use of the medication...."</p> <p>3.1-48(b)(1) 3.1-48(a)(4)</p>			
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F0441 SS=E	<p><b>483.65</b> <b>INFECTION CONTROL, PREVENT SPREAD, LINENS</b> 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, record review, and interview, the facility failed to</p>	F0441	Infection control It is the policy of this facility to have and maintain	10/23/2012

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	<p>ensure 1 of 2 nurses observed for glucometer use for blood sugar testing and medication pass, used gloves, washed her hands, or disinfected the glucometer with the appropriate disinfectant after use. This affected 2 of 3 residents (Resident #60, Resident #19) observed for blood sugar testing, and 2 randomly observed residents (Resident #1, Resident #19).</p> <p>Findings include:</p> <p>During observation of the medication pass on Preston Front Hall, beginning at 3:30 p.m., on 9/25/12, LPN #1 was noted to use a glucometer to take the blood sugar reading on Resident #60. The LPN was observed washing her hands prior to taking the blood sugar reading, but did not use gloves when checking the resident's blood sugar.</p> <p>After taking Resident #60's blood sugar, LPN #1 proceeded to put a sweater on the resident's roommate, Resident #19, without washing her hands, then went to the medication cart, laid the glucometer on top of the medication cart, drew up the insulin for Resident #60, and gave the resident 10 units of Insulin. The LPN did not wash her hands after giving the resident insulin, and proceeded to</p>		<p>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: 1. Corrective action for residents affected: Residents #60, #19, and #1 suffered no ill effects/harm. 2. Other residents having the potential to be affected: Other residents identified with blood sugar checks orders have the potential to be affected. Nurse #1 was re-educated on policy for obtaining glucometer checks and for adhering to infection control procedures in regards to hand washing and glove usage. 3. Measures to ensure practice does not recur: On 10/18/12 and 10/23/12, licensed nursing staff was re-educated on policy for completing glucometer checks and following infection control procedures, including the use of the appropriate disinfecting product. . 4. Corrective action to be monitored by: All licensed nursing staff has completed skills check off for completing gluco-meters and following infection control during such treatment. DON/designee will observe licensed nurses for compliance with infection control procedures during glucometer checks daily for 2 weeks, then weekly for 2 weeks, then monthly for 5 months. Non compliance issues noted during observations</p>				

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	<p>document the medications in the Medication Administration Record. The LPN then prepared a medication for Resident #1, gave the resident the oral medication, then washed her hands.</p> <p>At 4:05 p.m., on 9/25/12, LPN #1 picked up the same glucometer she had used on Resident # 60 and used alcohol wipes to clean the glucometer. Resident #54 was sitting in a wheelchair beside the medication cart, waiting for the LPN to perform a finger stick for his blood sugar reading. When questioned regarding the use of alcohol wipes to disinfect the glucometer, LPN # 1 indicated she normally cleaned the glucometer using alcohol wipes. She looked on her medication cart and indicated there was no other disinfectant on the medication cart to clean the glucometers.</p> <p>At 4:15 p.m., on 9/25/12, the Director of Nursing Services and the Director of Clinical Services were made aware that LPN #1 had used alcohol wipes to disinfect the glucometer. All of the medication carts in the facility were then checked at 4:18 p.m. , on 9/25/12, with the Director of Clinical Services. There was a container of "NOW", a disinfectant, on the</p>		will be addressed during monthly PI meetings for review.	

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	<p>medication cart on Preston Hall (back hall). The information on the container indicated the disinfectant was "virucidal, tuberculocidal, bactericidal, pseudomonicidal, kills HIV -1." LPN #2 was interviewed at this time regarding the "NOW" disinfectant, and indicated she used this to disinfect the glucometers.</p> <p>There was also a container of the "NOW" on the medication cart on Beecher Hall, along with a container of Sani Cloths, however, RN #2 indicated he did not use the "NOW", but used the Sani Cloth disinfectant.</p> <p>There was a container of Sani Cloth wipes on the medication cart on the memory care unit. At 4:30 p.m. on 9/25/12, LPN #4 indicated she used these to clean the glucometers.</p> <p>The Competency/Skills Checklist for LPN #1 was reviewed, at 5:30 p.m., on 9/25/12, and indicated the LPN had been inserviced and checked off for competency regarding glucometer procedures on 4/15/12.</p> <p>Review of the policy for Cleaning and Disinfection of the Glucometer, provided by the Regional Director of Clinical Services, at 8:15 a.m., on 9/26/12, indicated Super Sani-cloth or</p>			

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	<p>Sani-Cloth Plus wipe (individual wipe) or an equivalent product that kills hepatitis B and blood-borne pathogens were to be used to disinfect the glucometer. The policy indicated the following procedure was to be completed in the resident's room after a glucometer check before leaving the room, and the canister or tub of wipes was not to be taken into the resident's room, but one wipe was to be placed in a disposable cup to transport it into the resident's room;</p> <ol style="list-style-type: none"> <li>1. Dispose of the glucose strip in the biohazard container (sharps container) in the resident's room.</li> <li>2. Place a barrier (e.g., a paper towel) on the table surface.</li> <li>3. Place the glucometer on the barrier.</li> <li>4. Remove your gloves, wash or sanitize your hands, and put on fresh gloves.</li> <li>5. Place a second barrier on the table surface, away from and not touching the first barrier.</li> <li>6. Use the damp paper towel to remove any visible blood or body fluids. Dispose of the paper towel appropriately.</li> <li>7. Pick up the glucometer from the first barrier and disinfect it with a Super Sani-Cloth wipe or an equivalent product that kills hepatitis B and blood-borne pathogens. Follow</li> </ol>			

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	<p>the manufacturer's guidelines for wet time when applying disinfectant. Pay close attention to the strip holder area and be sure to not over-saturate the area.</p> <p>8. Place the glucometer down on the second barrier. Allow enough time to dry per the manufacturer's instructions.</p> <p>9. Dispose of the first barrier.</p> <p>10. Remove your gloves and wash or sanitize your hands.</p> <p>11. After the glucometer is dry, throw away the second barrier and put the glucometer away.</p> <p>12. Follow hand hygiene protocol."</p> <p>The manufacturer's instructions for "NOW" a germicidal cleaner wipe, provided by the Regional Director of Nursing Services, at 10:35 a.m., on 9/28/12, indicated the wipes were effective against several blood-borne pathogens, but Hepatitis B was not included in this list.</p> <p>3.1-18(l)</p>				

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F0514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to ensure progress notes from the Nurse Practitioner were available in the clinical record for 2 residents (Resident #77 and Resident #63) of 10 residents reviewed for unnecessary medication.</p> <p>Findings include:</p> <p>1. The record for Resident #77 was reviewed on 9/27/12 at 1:30 P.M. Diagnoses included, but were not limited to senile dementia with delusional features and senile dementia with behavioral disturbances.</p> <p>A physician order monthly recap for September 2012 indicated Resident</p>	F0514	<p>Records complete/accurate/accessible It is the policy of this facility to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. 1. Corrective action for residents affected: Resident # 77 has current Psychological progress notes on the chart. Resident #63 has current psychological progress notes on the chart 2. Other residents having the potential to be affected: Other residents receiving psychiatric services have the potential to be affected. Medical records for those identified at risk were reviewed for complete progress notes. 3. Measures to ensure practice does not recur: Licensed nursing</p>	10/23/2012	

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	<p><b>#77</b> current medications included, but were not limited to Clozaril (antipsychotic medication) 25 mg (milligrams) at bedtime</p> <p>LPN #15 was interviewed on 9/27/12 at 9:30 A.M. During the interview, LPN #15 indicated Resident #77's psychiatric medications were reviewed by the Nurse Practitioner (NP) each month.</p> <p>A review of Resident #77's record did not indicate any progress notes written by the NP for the past year.</p> <p>The facility Social Services Director (SSD) was interviewed on 9/27/12 at 2:15 P.M. The SSD indicated follows Resident #77 and has reviewing her psychiatric medications since at least since December 2011. The SSD indicated there were notes from the NP in Resident #77's chart. The SSD further indicated it was difficult to get documentation from the NP.</p> <p>On 10/1/12 at 11:00 A.M., the Regional Director of Clinical Services was able to furnish NP progress dating from December 2011 up to September 2012. The Regional Director of Clinical Services indicated she had just obtained them from the</p>		<p>staff and Social Service person were in-serviced on 10/18/12 and 10/23/12 on maintaining accurate clinical records in regards to Psychological services. 4. Corrective action to be monitored by: Social service staff /DON will monitor for progress notes on the chart by auditing of all residents receiving psychological services bi-weekly to ensure progress notes have been received and are on the chart. Such auditing will be completed daily ongoing. Non compliance issues noted during auditing will be addressed at monthly PI meetings.</p>		

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	<p>office of the NP.</p> <p>2. Review of the clinical record for Resident #63 on 9/26/12 at 2:42 p.m., indicated the following: diagnoses included, but were not limited to, presenile delirium, intellectual disability, Down's syndrome, anxiety, depression, psychosis, delusional thinking, and agitation.</p> <p>A Behavioral Medicine Evaluation &amp; Management Note for Resident #63, dated 8/17/12, indicated she received Lexapro 10 mg (milligrams) q (every) day and Risperdal 1 mg BID (twice a day).</p> <p>A physician's order for Resident #63, dated for the month of September 2012, indicated Lexapro 10 mg daily for anxiety/depression and Risperidone 1 mg BID for agitation/psychosis/delusional thinking.</p> <p>Social Service #5 was interviewed on 9/26/12 at 1:05 p.m. During the interview she indicated a meeting was held monthly with nurse practitioner to discuss behaviors and gradual dose reductions. She also indicated the nurse practitioner makes recommendations for medications along with the pharmacist.</p>			

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	<p>Behavior Consultation notes from the Nurse Practitioner for Resident #63 were not available in the facility until the last day of the survey on 10/1/12.</p> <p>3.1-50(a)(1)</p>			