

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155794	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/14/2016
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NAME OF PROVIDER OR SUPPLIER STRATFORD RETIREMENT LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2460 GLEBE ST CARMEL, IN 46032
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F 0000 Bldg. 00	<p>This visit was for the Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>This visit included the Investigation of Complaint IN00190183.</p> <p>Survey dates: March 6, 7, 8, 9,10,11 and 14, 2016.</p> <p>Facility number: 011151 Provider number: 155794 AIM number: N/A</p> <p>Census bed type: SNF: 14 Residential: 33 Total: 47</p> <p>Census payor type: Medicare: 4 Other: 10 Total: 14</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC16.2-3.1.</p> <p>Quality Review was completed by 21662 on March 18, 2016.</p>	F 0000		
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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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F 0250 SS=D Bldg. 00	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on interview and record review, the facility failed to ensure resident's needs were met for residents who required psychotropic medications for 2 of 5 residents who were reviewed for social services. (Residents #4 and #13)</p> <p>Findings include:</p> <p>1. Resident #4 's record was reviewed on 3/9/16 at 8:51 a.m. Diagnoses included, but were not limited to, dementia with behaviors, Bipolar Disorder, and Congestive Heart Failure (CHF).</p> <p>The Recapitulation, dated February 2016, indicated the resident had a Physician order, dated 3/4/15, for Venlafaxine HCL (Hydrochloride) (an anti-depressant medication) 37.5 mg (milligrams) give one tablet by mouth at bedtime for dementia with behaviors.</p> <p>The "Behavior/Intervention Monthly Flow Record," dated 2/16 and 3/16,</p>	F 0250	<p><u>What corrective action will be taken by the facility?</u> All residents were reviewed for use of psychopharmacological medications and the monitoring of such medications (attachment # 1). An inservice was conducted on 3/29/16 – the DON educated all nurses and SSD on the following topics: monitoring/tracking behaviors and review of psychopharmacological medication use policy. Resident # 13 was evaluated by our consulting psychiatrist on 3/24/16 and the correct diagnosis for utilization of antipsychotic drug therapy is documented and she will continue on her current GDR. Resident #4 diagnosis was changed to reflect the actual diagnosis for the utilization of the medication. The change of diagnosis occurred on 3/9/16. No other residents are currently on antipsychotic medications. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> All</p>	03/29/2016			

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	<p>indicated the Psychoactive Drug/Dose was Venlafaxine HCL 37.5 mg and the behavior was "Pinching Staff during Care."</p> <p>During an interview on 3/9/16 at 4:31 p.m., the SSD (Social Service Director) indicated Resident #4 had a behavior of pinching staff during care, but that was not why she was prescribed the Venlafaxine HCL. She indicated the resident was prescribed the Venlafaxine HCL for the diagnosis of Bipolar Disorder and the resident 's MAR (Medication Administration Record) needed updated because it indicated the Venlafaxine HCL was prescribed for dementia with behaviors.</p> <p>2. On 3/09/16 at 3:24 p.m., the record review for Resident #13 was completed. Diagnoses included, but were not limited to, cardiovascular disease, dementia with behavioral disturbance, high blood pressure, hypothyroidism, and edema.</p> <p>On 3/10/16 at 12:04 p.m., the Social Services Director (SSD) provided a document dated 12/7/15, from the resident's physician indicating the resident had a diagnosis of "... Psychotic disorder due to another medical condition, with delusions...." The SSD was requested to provide documentation related to specific behavior tracking for</p>		<p>residents currently on psychopharmacological medications were reviewed and audit was completed on 3/25/2016. The Behavior/Intervention Monthly Flow record will be utilized by nursing staff for monitoring psychopharmacological medications (attachment #2). Residents who use antipsychotic drugs receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. All residents were reviewed for use of and the monitoring of such medications. Audit completed 3/25/16 by the DON. <u>What measures will be put into place to ensure the practice does not recur?</u> The DON and/or SSD will review any addition of psychotropic medications and each new order will be reviewed to determine appropriateness of that order and that the supporting documentation is available to justify the use of the medication. The Behavior Management Committee will review all residents receiving psychopharmacological medications for previously mentioned monitoring and assessment purpose on 4/4/16. This meeting will occur on a monthly basis. <u>How will the corrective action be monitored to ensure the deficient practice does not</u></p>		

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	<p>the reason the resident was on the medication. The SSD indicated the resident had not had behaviors and that was why she had no behavior tracking.</p> <p>On 3/10/16 at 3:38 p.m., the DON indicated she understood the need for behavior specific documentation regarding the resident's behaviors. She indicated at that time the SSD was responsible for behavior documentation. A request was made at that time for any behavior documentation and the behavior tracking policy. The DON was requested at that time to provide all behavior documentation for the use of Risperdal.</p> <p>On 3/10/16 at 4:30 p.m., the DON provided Resident #13's behavior documentation. She indicated at that time that was all the SSD provided. The document titled, "Behavior /Intervention Monthly Flow Record" indicated: June 2015- the resident was on Risperdal 2 milligrams for tearfulness and yelling. July 2015- the resident was on Risperdal 2 milligrams for tearfulness. January 2016- the resident was on Risperdal 2 milligrams for Anxiety yelling out at night. February 2016- the resident was on Trazodone (an antidepressant medication) 50 milligrams and Risperdal 2 milligrams for yelling out (anxious</p>		<p><u>recurand what QA will be put into place?</u> The DON and/or SSD will bring the results of the audits to the monthly QA Committee for review and recommendations. Any recommendation made by the committee will be followed up by the DON and/or SSD and the results will be brought to the next scheduled QA committee. This practice will continue for 3 months or until a pattern of compliance is established.</p>		

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F 0278 SS=D Bldg. 00	<p>mood) March 2016- the resident was on Rispderidone 1.5 milligrams daily, Duloxetine (an antidepressant) 30 milligrams daily for difficulty staying asleep and tearfulness.</p> <p>On 3/10/16 at 4:30 p.m., the DON also provided a document titled "Behavior Monitoring" dated 120/8/14 (sic). The policy indicated, "...Licensed nurse or designee will utilize behavior monitoring tool for patients who...Are taking psychotropic medications that require monitoring...1.2 If the form is being used to monitor the use of psychotropic drugs, include the specific diagnosis justifying the use of the drug. 1.2.1 Use of the form will continue for as long as the patient is taking the drug..."</p> <p>3.1-34(a)</p> <p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that</p>			

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	<p>the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on interview and record review, the facility failed to correctly identify and accurately assess the resident's status regarding Hospice for 1 of 1 residents reviewed for Hospice. (Resident #3)</p> <p>Findings include:</p> <p>Resident #3's record was reviewed on 3/9/16 at 11:08 a.m. Diagnoses included, but were not limited to, Congestive Heart Failure (CHF), dementia, cerebrovascular accident and Diabetes Mellitus.</p> <p>The resident had a Physician order dated 9/1/15, which indicated to admit to (name of Company) Hospice for diagnosis of cerebrovascular accident.</p>	F 0278	<p><u>What correctiveaction will be taken by the facility?</u> The MDS pertaining to resident #3 was modified to reflect the hospice documentation that is documented in the active record. This documentation specifically states that“the resident is terminally ill with a life expectancy of six months or less ifthe terminal illness ran its normal course”. The MDS Coordinator was educated on hospice requirements by the DON on3/24/16. <u>How will thefacility identify other residents having the potential to be affected by thesame practice and what corrective action will be taken?</u> No other residents were affected by this practice. All active records were audited for</p>	03/24/2016

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	<p>The resident's annual MDS (Minimum Data Set) assessment dated 2/18/16, indicated in the prognosis section the resident did not have a condition or chronic disease that resulted in a life expectancy of less than six months. A "Physician's Certification of Terminal Illness For Medicare Hospice Benefit: Certification/Recertification Statement" indicated Resident #3 was terminally ill with a life expectancy of six months or less if the terminal illness ran its normal course. The resident was admitted to hospice for other sequelae (a chronic condition that is a complication of an acute condition) following an unspecified cerebrovascular disease.</p> <p>During an interview on 3/10/16 at 1:13 p.m., the MDS Coordinator indicated when she looked through Resident #3's chart, she did not see the "Physician's Certification of Terminal Illness For Medicare Hospice Benefit: Certification/Recertification Statement," so she based her MDS assessment on the information, which was available in her chart. She indicated she did not know for a resident to be on Hospice, he or she would have to have a prognosis of terminally ill with a life expectancy of six months or less if the terminal illness ran</p>		<p>appropriate hospice documentation (attachment #3). Audit completed 3/24/16. Resident#3 is the only resident currently on hospice. <u>What measures will be put into place to ensure the practice does not recur?</u> The DON will conduct audits on all new residents that are placed on hospice. These findings will be reported to the next scheduled morning management interdisciplinary meeting for review and recommendations for follow-up. <u>How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The DON will bring the results of the audits to the monthly QA Committee for review and recommendations. Any recommendation made by the committee will be followed up by the DON and the results will be brought to the next scheduled QA committee. This practice will continue for 3 months until a pattern of compliance is established.</p>	

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F 0309 SS=D Bldg. 00	<p>its normal course.</p> <p>3.1-31(a) 3.1-31(d)(3)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, interview and record review, the facility failed to assess and monitor a resident with edema for 1 of 13 residents reviewed for quality of care. (Resident #13)</p> <p>Findings include:</p> <p>On 3/09/16 at 3:24 p.m., the record review for Resident #13 was completed. Diagnoses included, but were not limited to, cardiovascular disease, dementia, high blood pressure, hypothyroidism, and edema.</p> <p>On 3/6/16 at 10:45 a.m., the resident was walking and would stop every few steps as she was short of breath and very somnolent. The resident had shoes with straps on. Her feet were swollen and bulging above the strap and the open part of the shoe .</p>	F 0309	<p><u>What corrective action will be taken by the facility?</u> The monitoring of edema in the lower extremity was placed on the MAR. Resident remains in therapy for 4 layer wraps. All healthcare staff educated by the DON on the documentation requirements for monitoring edema on 3/24/16. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> DON assessed all residents 3/25/16 (attachment #4). No other residents have been affected by this alleged deficient practice. The MAR will be audited for completion of edema monitoring on a daily basis for 4 weeks and then 3 times weekly for 3 months or until a pattern of compliance is established – audit will be completed by DON and/or designee (attachment #5). <u>What</u></p>	03/25/2016			

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	<p>On 3/7/16 at 10:35 a.m., the resident was observed to have black shoes on with a strap and her feet were swollen and her socks were bulging above the strap and the open part of the shoe.</p> <p>On 3/8/16 at 11:10 a.m., the the resident was observed to have black shoes on with a strap and her feet were swollen and her socks were bulging above the strap and the open part of the shoe.</p> <p>On 3/10/16 at 8:50 a.m., the resident was observed to have black shoes on with a strap and her feet were swollen and her socks were bulging above the strap and the open part of the shoe.</p> <p>The nursing notes dated 2/26/16 indicated the staff had spoke with Power of Attorney (POA) regarding four layer wraps for edema in her lower extremities and he agreed to the therapy. The therapy department was informed. There was no other documentation regarding the residents edema.</p> <p>A physicians order dated 3/2/16 indicated for physical therapy to evaluate and treat the resident for 4 layer wraps (a treatment for edema), the order was signed by the physician on 3/2/16.</p>		<p><u>measures will be put into place to ensure the practice does not recur?</u> The DON will bring any identified issues pertaining to the audit to the next scheduled morning management interdisciplinary meeting for review and recommendations for follow-up. <u>How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The DON will bring the results of the audits to the monthly QA Committee for review and recommendations. Any recommendation made by the committee will be followed up by the DON and the results will be brought to the next scheduled QA committee. This practice will continue for 3 months until a pattern of compliance is established.</p>		

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F 0312 SS=D Bldg. 00	<p>The physician progress notes were reviewed from April 2015 through March 2016. The progress notes indicated: 5/3/15,"...Change the treatment for edema from TED hose to tubigrips. 9/16/15"...Edema:trace edema in lower extremities...." No other documentation regarding edema was found in the resident record.</p> <p>On 3/10/16 12:45 p.m., the Director of Nursing (DON), indicated she did not think there was any information regarding the resident's edema. She indicated the resident had tubigrips but that the staff had not been applying high enough. A request was made for any information regarding monitoring of edema of her legs between September and current.</p> <p>On 3/14/16 at 3:15 p.m., the DON indicated she could not find any documentation regarding assessment and monitoring of the resident's edema.</p> <p>3.1-37(a)</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral</p>			

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	<p>hygiene. Based on observation, interview and record review, the facility failed to provide nail care for 1 of 2 residents reviewed for ADL's (Activities of Daily Living). (Resident #4) Findings include: On 3/7/16 at 10:03 a.m., Resident #4 was observed to have black debris under her fingernails on her left hand. Resident #4's record review was completed on 3/9/16 at 8:51 a.m. Diagnoses included, but were not limited to, dementia with behaviors, Congestive Heart Failure (CHF), and Diabetes Mellitus. On 3/9/16 at 10:00 a.m., Resident #4 was observed sitting in the activity room and had black debris under her fingernails on her left hand. The "CNA-ADL Tracking Form" dated 12/15, 1/16, 2/16 and 3/16, had a box next to "Nail Care (With bath & [and] PRN [as needed])" in the Personal Hygiene area, which indicated nail care had or had not been completed with the personal hygiene. The box next to "Nail Care" for these dates were blank. The "CNA Assignment Sheet" for Resident #4 indicated she ate with her fingers, check and clean her nails and her shower days were Mondays, Wednesdays</p>	F 0312	<p><u>What corrective action will be taken by the facility?</u> Resident #20 nails were cleaned and trimmed on 3-9-16. All dependent residents audited for nail grooming (attachment #6). Audit completed on 3/23/16. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> All dependent residents have the potential to be affected by this alleged deficient practice. An audit of all active residents was completed on 3/23/16 to identify lack of proper nail care by the DON. All other residents had appropriate nail care at the time of the audit. <u>What measures will be put into place to ensure the practice does not recur?</u> All nursing staff will receive directed in-service training by the DON by 3/29/16 pertaining to the facility's policy and procedure for providing personal nail hygiene involving the trimming and cleaning of fingernails. The staff will indicate on the shower sheets whether or not the resident's nails were trimmed and/or cleaned. This sheet was modified on 3/23/16 to reflect specific nail care (attachment #7). During room rounds (5 days per week), the IDT team will assess residents to ensure that personal hygiene has been completed on all residents utilizing attachment</p>	03/29/2016			

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	<p>and Fridays.</p> <p>The resident's record lacked documentation she refused nail care. During an interview on 3/9/16 at 3:38 p.m., the Director of Nursing (DON) indicated the nail care area of the "CNA-ADL Tracking Form" was not used to document nail care. She indicated there was no place for the CNA's to document they did nail care, but nail care was a part of the residents shower day protocol. The DON indicated Resident #4 ate with her fingers, so she got food under her fingernails.</p> <p>During an interview on 3/9/16 at 3:54 p.m., the DON indicated she had documented the resident had refused nail care in the past and the CNA's provided nail care as long as the resident allowed them to do it. She indicated the CNA's did not document the nail care they provided to the residents on the shower sheets.</p> <p>During an interview on 3/10/16 at 11:47 a.m., the DON indicated she did not find any documentation in Resident #4's record that she had refused nail care.</p> <p>During an interview on 3/10/16 at 3:06 p.m., CNA #1 indicated Resident #4 would resist when providing nail care on the right hand when she tried to open the right hand to do the nail care, but the</p>		<p>#6. The IDT will bring any identified issues to the next scheduled morning management interdisciplinary meeting for review and recommendations for follow-up. <u>How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The DON will bring the results of the audits to the monthly QA Committee for review and recommendations. Any recommendation made by the committee will be followed up by the DON and the results will be brought to the next scheduled QA committee. This practice will continue for 3 months until a pattern of compliance is established.</p>		

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F 0329 SS=D Bldg. 00	<p>resident would allow her to open the left hand and do nail care. 3.1-38(a)(3)(E)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review, the facility failed to quantitatively measure specific targeted behaviors to support the use of psychotropic</p>	F 0329	<u>What correctiveaction will be taken by the facility?</u> All residents were reviewed for use of psychopharmacological medications and the monitoring of such medications (attachment #	03/29/2016

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	<p>medications the residents were receiving in order to determine their effectiveness for 2 of 5 residents reviewed for unnecessary medications. (Residents #4 and #13)</p> <p>Findings include:</p> <p>1. Resident #4's record was reviewed on 3/9/16 at 8:51 a.m. Diagnoses included, but were not limited to, dementia with behaviors, Bipolar Disorder, and Congestive Heart Failure (CHF).</p> <p>The Recapitulation, dated February 2016, indicated the resident had a Physician order dated 3/4/15, for Venlafaxine HCL (Hydrochloride) (an anti-depressant medication) 37.5 mg (milligrams) give one tablet by mouth at bedtime for dementia with behaviors.</p> <p>The "Behavior/Intervention Monthly Flow Record," dated 2/16 and 3/16, indicated the Psychoactive Drug/Dose was Venlafaxine HCL 37.5 mg and the behavior was "Pinching Staff during Care."</p> <p>During an interview on 3/9/16 at 4:31 p.m., the SSD (Social Service Director) indicated Resident #4 had a behavior of pinching staff during care, but that was not why she was prescribed the</p>		<p>1). An inservice was conducted on 3/29/16 – the DON educated all nurses and SSD on the following topics: monitoring/tracking behaviors and review of psychopharmacological medication use policy. Resident # 13 was evaluated by our consulting psychiatrist on 3/24/16 and the correct diagnosis for utilization of antipsychotic drug therapy is documented and she will continue on her current GDR. Resident #4 diagnosis was changed to reflect the actual diagnosis for the utilization of the medication. The change of diagnosis occurred on 3/9/16. No other residents are currently on antipsychotic medications. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> All residents currently on psychopharmacological medications were reviewed and audit was completed on 3/25/2016. The Behavior/Intervention Monthly Flow record will be utilized by nursing staff for monitoring psychopharmacological medications (attachment #2). Residents who use antipsychotic drugs receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. All residents were reviewed for use</p>	

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	<p>Venlafaxine HCL. She indicated the resident was prescribed the Venlafaxine HCL for the diagnosis of Bipolar Disorder and the resident's MAR (Medication Administration Record) needed updated because it indicated the Venlafaxine HCL was prescribed for dementia with behaviors.</p> <p>During an interview on 3/10/16 at 3:31 p.m., the Director of Nursing indicated she understood Resident #4 needed specific targeted behavior monitoring for her Venlafaxine HCL. She indicated she had a behavior of pinching the staff during care, but that was not the reason she was prescribed the Venlafaxine HCL.</p> <p>2. On 3/09/16 at 3:24 p.m., the record review for Resident #13 was completed. Diagnoses included, but were not limited to, cardiovascular disease, dementia with behavioral disturbance, high blood pressure, hypothyroidism, and edema.</p> <p>The last psychiatric progress notes were documented 12/23/13.</p> <p>The Physicians Order Recapitulation indicated: Risperidone (an antipsychotic medication) 1.50 milligrams daily for dementia with behaviors (11/11/14).</p> <p>There was a physician's order dated</p>		<p>of and the monitoring of such medications. Audit completed 3/25/16 by the DON. <u>What measures will be put into place to ensure the practice does not recur?</u> The DON and/or SSD will review any addition of psychotropic medications and each new order will be reviewed to determine appropriateness of that order and that the supporting documentation is available to justify the use of the medication. The Behavior Management Committee will review all residents receiving psychopharmacological medications for previously mentioned monitoring and assessment purpose on 4/4/16. This meeting will occur on a monthly basis. <u>How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The DON and/or SSD will bring the results of the audits to the monthly QA Committee for review and recommendations. Any recommendation made by the committee will be followed up by the DON and/or SSD and the results will be brought to the next scheduled QA committee. This practice will continue for 3 months or until a pattern of compliance is established.</p>		

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	<p>3/24/15 indicating, "...Is on antipsychotic medication for psychosis due to general medical condition..."</p> <p>On 3/09/16 at 3:17 p.m., the Director of Nursing (DON) was informed regarding concerns with the resident had received an antipsychotic of Risperdal for dementia with behaviors. A request was made for clarification of diagnosis for use of Risperdal. She indicated at that time the Social Services Director oversees the behavior documentation.</p> <p>On 3/10/16 at 12:04 p.m., the Social Services Diector (SSD) provided a document dated 12/7/15, from the resident's physician indicating the resident had a diagnosis of "... Psychotic disorder due to another medical condition, with delusions...." The SSD was requested to provide documentation related to specific behavior tracking for the reason the resident was on the medication. The SSD indicated the resident had not had behaviors and this was why she had no behavior tracking.</p> <p>03/10/16 at 3:38 p.m., the DON indicated she understood the need for behavior specific documentation regarding the resident's behaviors and the diagnosis as to why the resident was on the medication. A second request was</p>			

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	<p>made at that time for any behavior documentation and the behavior tracking policy. The DON was requested at that time to provide all behavior documentation for the use of Risperdal.</p> <p>On 3/10/16 at 4:30 p.m., the DON provided Resident #13's behavior documentation. She indicated at that time that was all the SSD provided. The document titled,"Behavior /Intervention Monthly Flow Record" indicated: June 2015- the resident was on Risperdal 2 milligrams for tearfulness and yelling. July 2015- the resident was on Risperdal 2 milligrams for tearfulness. January 2016- the resident was on Risperdal 2 milligrams for Anxiety yelling out at night. February 2016- the resident was on Trazodone (an antidepressant medication)50 milligrams and Risperdal 2 milligrams for yelling out (anxious mood) March 2016- the resident was on Rispderidone 1.5 milligrams daily, Duloxetine (an antidepressant) 30 milligrams daily for difficulty staying asleep and tearfulness.</p> <p>On 3/10/16 at 4:30 p.m., the DON also provided a document titled "Behavior Monitoring" dated 120/8/14 (sic). The policy indicated,"...Licensed nurse or</p>			

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F 0371 SS=F Bldg. 00	<p>designee will utilize behavior monitoring tool for patients who...Are taking psychotropic medications that require monitoring...1.2 If the form is being used to monitor the use of psychotropic drugs, include the specific diagnosis justifying the use of the drug. 1.2.1 Use of the form will continue for as long as the patient is taking the drug..."</p> <p>3.1-48(a)(2) 3.1-48(a)(3)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to ensure foods were stored and served under sanitary conditions for 13 of 14 residents served from the kitchen.</p> <p>Findings include:</p> <p>1. The kitchen tour began on 3/6/16 at 10:23 a.m., with Sous Chef #2 in attendance.</p>	F 0371	<p><u>What correctiveaction will be taken by the facility?</u> The DDS educated the dietary staff on proper food storage, labeling, properly covering equipment and disposal of expired foods on 3/10/16. <u>How will thefacility identify other residents having the potential to be affected by thesame practice and what corrective action will be taken?</u> All residents have the potential to be affected by the alleged practice. The DDS and/or designee will monitor the main</p>	03/25/2016			

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	<p>a. The following food items were observed in the dry storage room: 1-10 pound 6 ounce can sliced peaches were dented. 1-6 pound 8 ounce can sliced bamboo shoots were dented.</p> <p>During an interview at that time, Sous Chef #2 indicated dented cans were placed in the office and given back to the company for credit.</p> <p>b. The following food items were observed without dates or labels in the Service Salad refrigerator: A plastic container with 10 pounds sliced peaches. A plastic container with 3 pounds cut up lettuce. A plastic container with 4 pounds Ranch dressing.</p> <p>During an interview at that time, Sous Chef #2 indicated food items should be labeled and dated prior to being placed in the refrigerator.</p> <p>c. The following food items were observed in paper or plastic bags and were not sealed closed: A paper bag with 4 pounds French fries without a label and a date and the bag was left open. A plastic bag with one pound frozen</p>		<p>kitchen for proper food storage, labeling, properly covering equipment and disposal of expired foods on a daily basis (attachment #8). The CDM will continue the established policy and procedure of conducting a sanitation audit (attachment #9) of the main kitchen on a weekly basis and the RD will audit on a monthly basis. <u>What measures will be put into place to ensure the practice does not recur?</u> The DDS and/or designee will monitor the main kitchen for proper food storage, labeling, properly covering equipment and disposal of expired foods on a daily basis. The CDM will continue sanitation audits on a weekly basis and the RD on a monthly basis. The CDM will bring any identified issue to the next scheduled morning management interdisciplinary meeting for review and recommendations for follow-up. <u>How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The CDM will bring the results of the audits to the monthly QA Committee for review and recommendations. Any recommendation made by the committee will be followed up by the CDM and the results will be brought to the next scheduled QA Committee. This practice will continue for 3 months until a pattern of compliance is</p>		

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	<p>potato chips with the top of the bag left open.</p> <p>A plastic bag with one pound chicken wings with the top of the bag left open.</p> <p>A plastic bag with two pounds tator tots with the top of the bag left open.</p> <p>A plastic bag with Chicken tenders with the top of the bag left open.</p> <p>A plastic bag with Calamari with the top of the bag left open.</p> <p>A plastic bag with ½ pound French fries with the top of the bag left open.</p> <p>A plastic bag with 2 pork tenderloins with the top of the bag left open.</p> <p>During an interview at that time, Sous Chef #2 indicated all the bags with food items should have been closed and sealed and the French fries should have been labeled and dated.</p> <p>2. On 3/6/16 at 10:54 a.m., the Director of Dining joined the kitchen tour and Sous Chef #2 left the tour and returned to his kitchen duties.</p> <p>a. The following food items were observed in the walk-in freezer with their packages ripped open:</p> <p>1/2 pound Strawberry ice cream left in a five pound container with the plastic wrap covering the top of the ice cream container ripped open.</p> <p>2 pounds smoked Atlantic Salmon package was ripped open on the side of</p>		established.	

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	<p>the package.</p> <p>During an interview at that time, the Director of Dining indicated any food in the freezer should be wrapped securely.</p> <p>b. The mixer was not covered while not being used.</p> <p>During an interview at that time, the Director of Dining indicated the mixer should be covered when the mixer was not being used.</p> <p>A current policy titled "Food Storage" dated 7/16/12, provided by the Director of Dining on 3/10/16 at 11:50 a.m., indicated "Policy:.. Food is stored, prepared, and transported at appropriate temperatures and by methods designed to prevent contamination or cross contamination. Procedure:.. 4. Plastic containers with tight-fitting covers must be used for storing cereals, cereal products, flour, sugar, dried vegetables, and broken lots of bulk foods. All containers must be legible and accurately labeled... 8. All Stock must be rotated with each new order received. Rotating stock is essential to ensure the freshness and highest quality of all foods... e. Foods will be stored and handled to maintain the integrity of the packaging until ready for use...13. Leftover food is stored in covered containers or wrapped carefully and securely. Each item is</p>			

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	<p>clearly labeled and dated before being refrigerated. Leftover food is used within 3 days or discarded... 14. Refrigerated Food Storage:... f. All foods should be covered, labeled and dated. All foods will be checked to assure that foods (including leftovers) will be consumed by their safe use by dates, or frozen (where applicable) or discarded...."</p> <p>A current policy titled "General Food Preparation and Handling" dated 7/16/12, provided by the Director of Dining on 3/10/16 at 11:50 a.m., indicated "Policy: Food items will be prepared to conserve maximum nutritive value, develop and enhance flavor and free of injurious organisms and substances. Procedures:.. 2. Food Storage: a. Foods are received, checked and stored properly as soon as they are delivered. b. Potentially hazardous food is refrigerated or frozen except when being handled. Food is covered for storage... c. Food in broken packages or swollen cans (cans with a compromised seal) or food with an abnormal appearance or odor will not be served...."</p> <p>A current policy titled "Receiving and Storage Safety" dated 7/16/12, provided by the Director of Dining on 3/10/16 at 11:50 a.m., indicated "... 3. All containers will be clearly labeled...."</p>			

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F 0425 SS=D Bldg. 00	<p>3.1-21(i)(1)</p> <p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on observation, interview and record review the facility failed to have a medication available for 1 of 5 residents reviewed for unnecessary medications. (Resident # 33)</p> <p>Findings include:</p> <p>1. On 3/09/16 at 10:37 a.m. the record review for Resident #33 was completed.</p>	F 0425	<p><u>What corrective action will be taken by the facility?</u> Pharmacy notified of the missing medication (Vitamin D3) on 3/10/16. Medication was delivered to the facility on 3/10/16. This medication was administered upon arrival. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></p>	03/25/2016

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	<p>Diagnoses included history of deep vein thromboses, high blood pressure, osteoporosis and constipation.</p> <p>On 03/10/16 at 8:42 a.m., LPN #4 was giving medications to Resident #33. LPN #4 prepared all of the medications for the resident and the resident began to take them. The resident asked LPN #4 where her Vitamin D3 was. LPN #4 indicated she would have to check the Medication Administration Record (MAR). The resident indicated she did not think the Vitamin D3 had been given to her since she got here on March 5th. An observation of the March 2016 MAR at that time indicated on the back of the MAR the medication was unavailable on 3/7/16. There was no other documentation found at that time. LPN #4 indicated she would have to call the pharmacy to request the medication.</p> <p>On 3/10/16 at 12:40 p.m., the information was requested from the DON as to why resident had not received her Vitamin D3.</p> <p>On 3/10/16 at 4:35 p.m., the DON indicated she had ordered the medication for the resident from the pharmacy, but she had no information as to why the medication had not been delivered before.</p>		<p>All MARS/TARS audited for missing medications on 3/11/16(attachment #10). No other residents were affected by this alleged deficient practice. <u>What measures will be put into place to ensure the practice does not recur?</u> The DON and/or designee will audit the MARS 3 times perweek. The DON will bring any identified issues to the next scheduled morning management interdisciplinary meeting for review and recommendations for follow-up. <u>How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The DON will bring the results of the audits to the monthly QA Committee for review and recommendations. Any recommendation made by the committee will be followed up by the DON and the results will be brought to the next scheduled QA committee. This practice will continue for 3 months until a pattern of compliance is established.</p>		

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R 0000 Bldg. 00	<p>3.1-25(a)</p> <p>This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00190183.</p> <p>Complaint IN00190183- Substantiated. No deficiencies related to the allegations are cited.</p> <p>Residential Census: 33</p> <p>Sample: 7</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-5.</p> <p>Quality Review was completed by 21662 on March 18, 2016.</p>	R 0000		
R 0214 Bldg. 00	<p>410 IAC 16.2-5-2(a) Evaluation - Deficiency</p> <p>(a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident.</p> <p>Based on interview and record review,</p>	R 0214	<u>What corrective action will be taken by the facility?</u> Resident	03/28/2016

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	<p>the facility failed to evaluate the resident's needs at least semiannually for 1 of 7 residents being reviewed for semiannual evaluations. (Resident #35)</p> <p>Findings include:</p> <p>Resident #35's record was reviewed on 3/14/16 at 11:07 a.m. Diagnoses included, but were not limited to, multiple cerebral infarctions, dementia, and Diabetes Mellitus.</p> <p>The Resident Care Director indicated the "Assisted Living Assessment" was the resident's "Service Plan" and "Evaluation."</p> <p>The resident's current "Assisted Living Assessment" was dated 3/4/15.</p> <p>During an interview on 3/14/16 at 2:50 p.m., the Resident Care Director indicated the resident's last semiannual evaluation was completed on 3/4/15. She indicated he should have had one in September to evaluate his needs.</p>		<p>#35 was discharged from the community on 12/10/2015 and was not negatively affected by the alleged deficiency. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> The DON educated the RCD on the requirement for evaluation of the nursing needs of each resident on 3/25/16. The RCD and/or designee will audit all active residents to ensure that appropriate and timely Wellcare assessments have been completed for 3 months (see attachment #11). The RCD and/or designee will complete any delinquent service assessments immediately. Audits completed 3/28/16. <u>What measures will be put into place to ensure the practice does not recur?</u> All service assessments will be tracked utilizing the electronic clinical documentation system that will alert us to when the Wellcare assessments are due beginning (3/28/16). The assessment report used to identify due dates for Wellcare assessments will be ran on a weekly basis by the RCD and/or DON. <u>How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The RCD will bring the results of the audits to the monthly QA Committee for review</p>		

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R 0273 Bldg. 00	<p>410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview and record review, the facility failed to ensure foods were stored and served under sanitary conditions for 33 of 33 residents served from the kitchen.</p> <p>Findings include:</p> <p>1. The kitchen tour began on 3/6/16 at 10:23 a.m., with Sous Chef #2 in attendance.</p> <p>a. The following items were observed in the dry storage room: 1-10 pound 6 ounce can sliced peaches were dented. 1-6 pound 8 ounce can sliced bamboo shoots were dented.</p> <p>During an interview at that time, Sous</p>	R 0273	<p>and recommendations. Any recommendations made by the committee will be followed up by the RCD and the results will be brought to the next scheduled QA Committee. This practice will continue for 3 months until a pattern of compliance is established.</p> <p><u>What corrective action will be taken by the facility?</u> The DDS educated the dietary staff on proper food storage, labeling, properly covering equipment and disposal of expired foods on 3/10/16. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> All residents have the potential to be affected by the alleged practice. The DDS and/or designee will monitor the main kitchen for proper food storage, labeling, properly covering equipment and disposal of expired foods on a daily basis (attachment#8). The CDM will continue the established policy and procedure of conducting a sanitation audit (attachment#9) of the main kitchen on a weekly basis and the RD will audit on a</p>	03/25/2016	

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	<p>Chef #2 indicated dented cans were placed in the office and given back to the company for credit.</p> <p>b. The following food items were observed without dates or labels in the Service Salad refrigerator: A plastic container with 10 pounds sliced peaches. A plastic container with 3 pounds cut up lettuce. A plastic container with 4 pounds Ranch dressing.</p> <p>During an interview at that time, Sous Chef #2 indicated food items should be labeled and dated prior to being placed in the refrigerator.</p> <p>c. The following food items were observed in paper or plastic bags and were not sealed closed: A paper bag with 4 pounds French fries without a label and a date and the bag was left open. A plastic bag with one pound frozen potato chips with the top of the bag left open. A plastic bag with one pound chicken wings with the top of the bag left open. A plastic bag with two pounds tator tots with the top of the bag left open. A plastic bag with Chicken tenders with the top of the bag left open.</p>		<p>monthlybasis. <u>What measures willbe put into place to ensure the practice does not recur?</u> The DDS and/or designee will monitor the main kitchen forproper food storage, labeling, properly covering equipment and disposal ofexpired foods on a daily basis. The CDMwill continue sanitation audits on a weekly basis and the RD on a monthly basis. The CDM will bring any identifiedissue to the next scheduled morning management interdisciplinary meeting forreview and recommendations for follow-up. <u>How will thecorrective action be monitored to ensure the deficient practice does not recurand what QA will be put into place?</u> The CDM will bring the results of the audits to the monthly QA Committee for review and recommendations. Any recommendation made by the committee will be followed up by the CDM and the results will be brought to the next scheduled QA Committee. This practice will continue for 3 months oruntil a pattern of compliance is established.</p>	

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	<p>A plastic bag with Calamari with the top of the bag left open.</p> <p>A plastic bag with ½ pound French fries with the top of the bag left open.</p> <p>A plastic bag with 2 pork tenderloins with the top of the bag left open.</p> <p>During an interview at that time, Sous Chef #2 indicated all the bags with food items should have been closed and sealed and the French fries should have been labeled and dated.</p> <p>2. On 3/6/16 at 10:54 a.m., the Director of Dining joined the kitchen tour and Sous Chef #2 left the tour and returned to his kitchen duties.</p> <p>a. The following food items were observed in the walk-in freezer with their packages ripped open:</p> <p>1/2 pound Strawberry ice cream left in a five pound container with the plastic wrap covering the top of the ice cream container ripped open.</p> <p>2 pounds smoked Atlantic Salmon package was ripped open on the side of the package.</p> <p>During an interview at that time, the Director of Dining indicated any food in the freezer should be wrapped securely.</p> <p>b. The mixer was not covered while not being used.</p> <p>During an interview at that time, the Director of Dining indicated the mixer</p>			

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	<p>should be covered when the mixer was not being used.</p> <p>A current policy titled "Food Storage" dated 7/16/12, provided by the Director of Dining on 3/10/16 at 11:50 a.m., indicated "Policy:... Food is stored, prepared, and transported at appropriate temperatures and by methods designed to prevent contamination or cross contamination. Procedure:... 4. Plastic containers with tight-fitting covers must be used for storing cereals, cereal products, flour, sugar, dried vegetables, and broken lots of bulk foods. All containers must be legible and accurately labeled... 8. All Stock must be rotated with each new order received. Rotating stock is essential to ensure the freshness and highest quality of all foods... e. Foods will be stored and handled to maintain the integrity of the packaging until ready for use...13. Leftover food is stored in covered containers or wrapped carefully and securely. Each item is clearly labeled and dated before being refrigerated. Leftover food is used within 3 days or discarded... 14. Refrigerated Food Storage:... f. All foods should be covered, labeled and dated. All foods will be checked to assure that foods (including leftovers) will be consumed by their safe use by dates, or frozen (where</p>			

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	<p>applicable) or discarded...."</p> <p>A current policy titled "General Food Preparation and Handling" dated 7/16/12, provided by the Director of Dining on 3/10/16 at 11:50 a.m., indicated "Policy: Food items will be prepared to conserve maximum nutritive value, develop and enhance flavor and free of injurious organisms and substances. Procedures:..</p> <p>2. Food Storage: a. Foods are received, checked and stored properly as soon as they are delivered. b. Potentially hazardous food is refrigerated or frozen except when being handled. Food is covered for storage... c. Food in broken packages or swollen cans (cans with a compromised seal) or food with an abnormal appearance or odor will not be served...."</p> <p>A current policy titled 'Receiving and Storage Safety' dated 7/16/12, provided by the Director of Dining on 3/10/16 at 11:50 a.m., indicated "... 3. All containers will be clearly labeled...."</p>			