

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2014
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NAME OF PROVIDER OR SUPPLIER AUTUMN HILLS HEALTH AND REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey and the Investigation of Complaint IN00147384.</p> <p>Complaint IN00147384-unsubstantiated due to lack of evidence.</p> <p>Survey dates: April 14, 15, 16, 17, and 21, 2014</p> <p>Facility number: 000471 Provider number: 155572 AIM number: 100290390</p> <p>Survey team: Jennifer Redlin, RN-TC Caitlyn Doyle, RN Heather Hite, RN Julie Ferguson, RN Janelyn Kulik, RN (4/14/14 and 4/15/14) Lara Richards, RN (4/16/14) Heather Tuttle, Rn (4/16/14) Yolanda Love, RN (4/16/14) Cynthia Stramel RN (4/16/14)</p> <p>Census bed type: SNF/NF: 62 Residential: 8 Total: 70</p> <p>Census Payor type: Medicare: 10 Medicaid: 46 Other: 14 Total: 70</p>	F000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F000157 SS=D	<p>Residential sample: 7</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on April 25, 2014, by Janelyn Kulik, RN. 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or</p>						

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	<p>interested family member.</p> <p>Based on interview and record review, the facility failed to notify the physician as ordered for blood sugar readings outside the specified call parameters for 1 of 5 residents reviewed for unnecessary medications. (Resident #92)</p> <p>The findings included:</p> <p>1. The record for Resident #92 was reviewed on 4/16/14 at 9:00 a.m. The resident's diagnoses included, but were not limited to, Diabetes type 2, hyperlipidemia, esophageal reflux, hypertension, altered mental status, and dementia with behavioral disturbances.</p> <p>Review of Physician Orders from admission on 4/7/14 included an admission order dated 4/7/14 for "Accuchecks before meals and at bedtime. Before meals and at bedtime for blood sugars contact [physician] if sugar > 350 or <60."</p> <p>Review of the April 2014 MAR (Medication Administration Record) and April 2014 Blood Sugar Summary indicated BS (blood sugar) readings over 350 for the following dates: April 13, 2014 at 5:54 p.m. - BS 358 April 13, 2014 at 7:45 p.m. - BS 361</p> <p>Review of the Progress Notes, including eMAR (electronic Medication Administration Record) notes, for April 13, 2014 indicated a lack of documentation of blood sugars > 350 on that day and a lack of physician notification.</p> <p>A policy titled "Physician/ Family/ Responsible Party Notification for Change in</p>	F000157	<p>F157</p> <p>The facility requests paper compliance for this citation.</p> <p><i>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 solely because it is required by the provisions of federal and state law.</i></p> <p>1) Immediate actions taken for those resident identified: Resident#92, the physician was notified on 4/16/14 of blood sugars above parameters from 4/13/14. No new orders received.</p> <p>2) How the facility identified other residents: A full house audit was completed on 4/23/14 on all residents with orders for glucose monitoring and parameters reviewed.</p> <p>3) Measures put into place/system changes: The nurses were re-educated regarding physician notification on blood sugar parameters and documentation. Education initiated on 4/24/14 by the Director of Nursing.</p>	05/14/2014	

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F000221 SS=D	<p>Condition was provided by the administrator on 4/17/14 at 11:00 a.m. and deemed as current. This policy indicated: "1. Physician and family/ responsible party notification is to include, but is not limited to: ... blood glucose reading below 60 or greater than 400 unless specific parameters are given by the physician for reporting... 2. Physician and family/ responsible party notification will be documented in the progress notes, it should contain information regarding the resident condition, physician notification, and any physician orders obtained."</p> <p>In an interview with the Director of Nursing (DoN) on 4/16/14 at 3:00 p.m., she indicated physician notification of blood sugars outside parameters should be done as ordered and documented in the Progress Notes or eMAR notes. On 4/16/14 at 3:15 p.m. the Medical Records nurse further indicated the DoN had found no progress notes or eMAR notes indicating the physician was notified of blood sugars outside parameters on 4/13/14 for Resident #92.</p> <p>3.1-5(2) 3.1-5(3) 483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>Based on observation, record review and interview, the facility failed to ensure a resident was free from a physical restraint without the proper indications for use. The</p>	F000221	<p>Blood Sugar results will be reviewed at least 3x/week to ensure physician notification of results outside physician ordered parameters.</p> <p>DON or designee will be responsible for oversight of these audits.</p> <p>4) How the corrective actions will be monitored: The results of these audits will be reviewed in the Quality Assurance meeting monthly X 3, then quarterly x1 for a total of 6 months.</p> <p>5) Target Completion Date: May 14, 2014</p> <p>F221 The facility requests paper compliance for this citation. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the</p>	05/14/2014			

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	<p>facility also failed to ensure a proper physical restraint was in use and released per policy. (Resident's #64 and #66)</p> <p>Findings include:</p> <p>1. Record review for Resident #64 was done on 4/16/14, at 3:00 p.m. A reportable occurrence was reviewed that occurred on 4/5/14, at 10:00 p.m. The reportable occurrence investigation indicated in a statement from CNA #2 when she came on shift at 10:00 p.m., Terminated CNA #3 was "unhooking a gait belt that was strapped around the arms of a chair that Resident #64 was sitting in".</p> <p>The Significant Change Minimum Data Set (MDS) Assessment done on 1/30/14, indicated Resident #64 was cognitively impaired. The resident's diagnoses included, but were not limited to, heart failure, hypertension, diabetes mellitus, and dementia. The MDS indicated the resident was a limited 1 person assist with transfers and walking. The Assessment indicated no restraints were being used.</p> <p>The record lacked documentation Resident #64 had an assessment for a restraint.</p> <p>A statement from Terminated CNA #3 dated, 4/5/14, indicated she needed to do rounds but Resident #64 was getting up and down constantly. She indicated at the same time there were three other residents with behaviors which made Resident #64 even more anxious. The statement further indicated, "I didn't know what else to do to keep him safe from hurting himself so I grabbed a gait belt and put it over the arms of his chair and hooked it in front of him just to</p>		<p><i>provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies.</i></p> <p><i>The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1)</i></p> <p>Immediate actions taken for those resident identified:</p> <p>Resident #64: Remains restraint free. Resident#66: The adjusta-loop seatbelt is currently in use. A replacement seatbelt was ordered on 4/17/14 to use during laundering. Restraint released every 2 hours per facility policy. Resident will be reviewed for restraint reduction as appropriate. 2) How the facility identified other residents: A whole house audit was completed to identify residents with devices that could be interpreted as restraints. No other restraints were identified in the facility. 3) Measures put into place/system changes: Staff were re-educated regarding the definition of a restraint and the facility policy and procedure of restraint monitoring on 4/24/14. Staff were educated on the policy for reporting abuse and neglect and restraining a resident without a physicians order on 4/6/14 and re-education initiated 4/24/14. Random observation rounds will be completed on varied shifts 5 times a week to ensure restraints are applied and released appropriately. The DON or designee will be responsible for</p>		

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	<p>keep him from getting up for long enough to do my rounds."</p> <p>A statement from LPN #4 who worked on the unit 4/5/14, indicated she was unaware of the incident and the last time she saw Resident #64 was at 9:15 p.m., when he was lying in bed.</p> <p>An interview with the Administrator on 4/21/14, at 11:56 a.m., indicated CNA #2 did not tell her about the incident until the next morning. At this time Terminated CNA #3 was suspended and an investigation was started. She further indicated Terminated CNA #3 was terminated on 4/10/14, for improperly using a restraint on Resident #64.</p> <p>2. On 4/14/14 from 11:40 a.m. until 12:30 p.m., Resident #66 was observed sitting in a W/C (wheelchair) at a dining room table, wearing a soft waist lap restraint which clipped around the back of the W/C. The loose ends of the restraint belt were intertwined in the rest of the belt. The resident was unable to reach the clip to release the restraint independently. From 12:15 p.m., until 12:30 p.m., CNA #5 assisted the resident with her lunch. During this continued observation from 11:40 a.m., until 12:30 p.m., the restraint belt was not released.</p> <p>On 4/15/14, Resident #66 was continuously observed from 8:41 a.m., until 10:50 a.m. The following was observed: At 8:41 a.m., the resident was sitting in the W/C with anti-tippers in the dinning room, wearing a soft lap restraint clipped around the back of the W/C, with the loose ends of the restraint</p>		<p>oversight of these audits. 4) How the corrective actions will be monitored: The results of these audits will be reviewed in the Quality Assurance meeting monthly X 3, then quarterly x1 for a total of 6 months. . 5) Target Completion Date: May 14, 2014</p>	

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	<p>belt intertwined in the rest of the belt, watching a movie. At 9:00 a.m., the resident was encouraged to perform exercises in the W/C. At 9:15 a.m., the resident was observed still sitting in the W/C with her eyes closed, asleep. Staff attempted to wake up the resident throughout the next activity without success. At 9:27 a.m., the resident was asked to participate in another activity and was pulled up to the table for a dice game. At 10:50 a.m., the resident was observed asleep in the W/C at the table. During this continuous observation from 8:41a.m., until 10:50 a.m., the soft lap restraint was clipped around the back of the resident's W/C, with the loose ends intertwined in the belt. The restraint belt was not released at any time during the 2+ hour observation.</p> <p>On 4/15/14 at 1:57 p.m., Resident #66 was observed with eyes closed, sitting in the W/C in the dining room wearing a soft lap restraint clipped around the back of the W/C, with the loose ends of the restraint belt intertwined in the belt.</p> <p>On 4/16/14 at 8:39 am, Resident #66 was observed sitting in the dining room in the W/C wearing the soft lap restraint clipped around the back of the W/C, with the loose ends of the belt intertwined in the belt, quietly looking out the window. At 9:04 a.m., the resident remained sitting in the W/C wearing a soft lap restraint clipped around the back of the W/C, with the loose ends of the restraint belt intertwined in the belt, in the activity room for an activity.</p> <p>On 4/16/14 from 9:34 a.m., until 9:42 a.m., Restorative CNA #6 was observed in Resident #66's room performing ROM (Range of Motion) exercises. The resident</p>			

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	<p>remained in the W/C wearing a soft lap restraint clipped around the back of the W/C, with the loose ends of the restraint belt intertwined in the belt, throughout the exercises.</p> <p>Resident #66's record was reviewed on 4/17/14 at 10:15 am. The resident's diagnoses included, but were not limited to, senile dementia, osteoporosis, edema, Pseudobublar affect (uncontrollable episodes of crying), difficulty walking, and muscle weakness.</p> <p>A Physician's Order, dated 5/23/13, indicated an " adjusta-loop cushion belt, while up in W/C for safety."</p> <p>The care plans dated 4/15/14 indicated the following: "Focus... potential for decline in ADL (Activities for Daily Living) function related to dementia, immobility and use of criss-cross restraint for safety. Interventions: "...Notify restorative nurse of any decline..." "Focus...has a criss/cross seat belt for prevention of injury to self as characterized by high risk for injury/falls, impaired mobility, loss of balance, poor posture, and cognitive impairment and poor safety awareness...Interventions: Discuss necessity of restraining device for resident with resident/family in care plan quarterly and as needed, follow facility protocol to monitor ongoing need for safety device, apply soft criss-cross waist restraint seat belt when up in wheelchair and check every hour and remove and readjust every 2 hours..." "Focus...potential for decline in PROM (Passive Range Of Motion) related to decreased mobility and use of restraint for safety...Interventions:...complete PROM exercises...notify restorative nurse of any</p>			

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	<p>decline." "Focus...potential for falls...Interventions: Adjustaloop cushion belt while up in wheelchair for safety...check every 2 hours for positioning, check every hour while in restraint and reposition every two...staff education on removing seatbelt and not supervising resident..."</p> <p>The Annual MDS (Minimal Data Set) Assessment dated 03/18/14 indicated the following: Resident #66 had a BIMS (Brief Interview of Mental Status) score of 3 indicating severe cognitive impairment. The resident's bed mobility, transfer, dressing, toilet use,and locomotion off the unit indicated the resident needed extensive assistance, two person physical assist. Locomotion on the unit, eating, and personal hygiene indicated the resident needed extensive assistance, a one person assist. During moving on and off the toilet, surface to surface transfer, the resident was not steady and only able to stabilize with staff assistance. The resident's MDS indicated no impairment in upper and lower extremities (limbs). The resident's mobility device was a walker. The resident's MDS indicated a trunk restraint used daily while in a chair or out of bed.</p> <p>On 4/16/14 at 1:10 p.m., the DoN provided the policy for use of restraints and indicated this document was current. This policy indicated the following: "USE OF RESTRAINTS, ...Chemical/Physical restraints will only be used to treat resident's medical symptoms and only after other alternatives have been tried successfully...1. Chemical/Physical restraints will only be used upon written order of a physician, including the medical reason, and after obtaining</p>			

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	<p>consent...2. Restraints with locking devices will not be used...5. Physical restraints will be applied in such a manner that they can be quickly removed by staff in case of fire or other emergency...6. Restraints will be released every 2 hours and the resident will be checked every hour while in a restraint. The C.N.A. will complete documentation on the checking and releasing of the restraint..."</p> <p>During an interview on 4/16/14 at 10:00 a.m., Restorative CNA #6 indicated the restraint belt should be on while in the W/C and taken off while eating. At the same time, CNA #5 indicated the resident should also be repositioned every 2 hours.</p> <p>During an interview on 4/16/14 at 10:38 a.m., QMA #7 indicated the resident's restraint was applied correctly, staff was to reposition her in her seat every couple hours, and should release the restraint when taken to the bathroom, helped into bed or when repositioned in her chair.</p> <p>During an interview on 4/16/14 at 2:53 p.m., CNA #8 indicated we reposition her and release her restraint belt every 2 hours.</p> <p>During an interview on 4/17/14 at 10:54 a.m., the DoN indicated the resident had the restraint in use due to multiple falls and in the past they attempted to remove the restraint, " but she would scoot to the end of her W/C and that was a fall hazard. Then we tried an alarming belt so that we wouldn't have to be with her 1:1 all the time, and that did not work either, so we went to a criss-cross belt. But that got soiled a lot and we washed it a lot and it looked terrible so we ordered her a another belt. A clip belt is considered a locking device if the resident cannot unclip it</p>			

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F000225 SS=D	<p>themselves." The DoN indicated the resident should have been checked every hour by staff for visualizing if the belt was too tight or physically checking the restraint. The DoN further indicated the restraint should have been released every 2 hours, at meals, and during activities.</p> <p>During an interview on 4/17/14 at 12:00 p.m. with the DoN, she indicated the resident's criss-cross restraint belt had been sent to the laundry and the resident currently had the wrong restraint belt on, which was the soft lap restraint belt that clipped around the W/C. She indicated the resident had on the wrong restraint belt during the observations made throughout the survey. The DoN further indicated the incorrect soft lap clip restraint belt had been removed and she would re-educate the staff on restraints.</p> <p>3.1-3 (w) 3.1-26 (b) 3.1-26 (c) 3.1-26 (f) 3.1-26 (h) 3.1-26 (o) 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide</p>			

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	<p>registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and interview the facility failed to report allegations of abuse timely to the Administrator of the facility and failed to report an injury of unknown origin to the Indiana State Department of Health related to a bruise greater than 10 cm on the right inner thigh for 2 of 3 abuse allegations reviewed. (Resident's #64 and #93)</p> <p>Findings include:</p> <p>1. Record review for Resident #64 was done on 4/16/14, at 3:00 p.m. A reportable</p>	F000225	<p>F225 The facility requests paper compliance for this citation. 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 solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those resident identified:</p>	05/14/2014			

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	<p>occurrence was reviewed that occurred on 4/5/14, at 10:00 p.m. The reportable occurrence investigation indicated in a statement from CNA #2 when she came on shift at 10:00 p.m., Terminated CNA #3 was "unhooking a gait belt that was strapped around the arms of a chair that Resident #64 was sitting in".</p> <p>The Significant Change Minimum Data Set (MDS) Assessment done on 1/30/14, indicated Resident #64 was cognitively impaired. The resident's diagnoses included, but were not limited to, heart failure, hypertension, diabetes mellitus, and dementia. The MDS indicated the resident was a limited 1 person assist with transfers and walking. The Assessment indicated no restraints were being used.</p> <p>A statement from Terminated CNA #3 dated 4/5/14, indicated she needed to do rounds but Resident #64 was getting up and down constantly. She indicated at the same time there were three other residents with behaviors which made Resident #64 even more anxious. The statement further indicated, "I didn't know what else to do to keep him safe from hurting himself so I grabbed a gait belt and put it over the arms of his chair and hooked it in front of him just to keep him from getting up for long enough to do my rounds."</p> <p>A statement from LPN #4 who worked on the unit 4/5/14, indicated she was unaware of the incident and the last time she saw Resident #64 was at 9:15 p.m., when he was lying in bed.</p> <p>An interview with the Administrator on 4/21/14, at 11:56 a.m., indicated CNA #2 did</p>		<p>Resident #64: Report sent to ISDH, as well as incident report with physician and responsible party notification completed 4/6/14. A head to toe assessment was completed on 4/6/14 with no new negative findings. The CNA was removed from the schedule pending outcome of investigation and then later terminated on 4/10/14 upon completion. Resident #93: The resident no longer resides at this facility. 2) How the facility identified other residents: Review of all allegations in the last 30 days to ensure allegations were reported immediately to the Executive Director. New admissions for the last 30 days will be reviewed for undocumented skin issues. 3) Measures put into place/system changes: The staff were re-educated regarding requirements of abuse allegation reporting by the Executive Director beginning 4/6/14 and again 4/24/14. The Interdisciplinary Team will review all new skin concerns and other potential reportable concerns/ allegations at least 3x/week to ensure incidents are reported timely and according to reporting criteria. Licensed nurses will be re-educated regarding completing skin assessments on admission. Follow-up skin assessment will be completed on new admissions by the wound</p>		

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	<p>not inform her about the incident immediately. The Administrator was not informed of the incident until the following morning. At this time Terminated CNA #3 was suspended and an investigation was started. She further indicated Terminated CNA #3 was terminated on 4/10/14, for improperly using a restraint on Resident #64.</p> <p>2. Record review for Resident #93 was done on 4/16/14 at 3:30 p.m. A reportable occurrence was reviewed of a bruise measuring 23 centimeters (cm) x 6 cm that occurred on 4/10/14.</p> <p>A Nursing Admission Assessment of Resident #93 on 4/4/14, indicated the resident had intermittent confusion. The resident's diagnoses included, but were not limited to, dementia, hypertension, congestive heart failure, and depressive disorder. The Assessment indicated the skin was pink and intact. The Assessment lacked documentation of any bruising to the skin.</p> <p>An Initial Non-pressure Skin Report dated, 4/10/14, indicated there was a bruise to the right inner thigh that was light purple in color, measured 23 cm x 6 cm, and was first observed on 4/10/14. A Nursing Note (NN) dated, 4/11/14 at 8:18 a.m., indicated Resident #93 had a purple discoloration to the right inner upper thigh that was found by the nurse. The NN indicated the resident's husband indicated the resident fell outside of their private home prior to admission to the facility.</p> <p>The record lacked documentation Resident #93 had any bruising until 4/10/14.</p> <p>An interview with the Administrator and the</p>		<p>nurse or designee on the next business day after admission to ensure all skin issues are identified and documented. The administrator and DON will be responsible for oversight of these audits. 4) How the corrective actions will be monitored: The results of these audits will be reviewed in the Quality Assurance meeting monthly X 3, then quarterly x1 for a total of 6 months. 5) Target Completion Date: May 14, 2014</p>				

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F000226 SS=D	<p>Director of Nursing (DoN) on 4/16/14 at 4:10 p.m., indicated the Administrator was notified of the bruise on 4/10/14, but did not report the bruise to the State Department of Health as an injury of unknown origin or do any investigation because Resident #93's husband indicated she had it before admission to the facility. The DoN indicated when the resident was admitted to the facility the nurse on shift did not do a full head to toe skin assessment of the resident because the resident refused and the nurse did not document this. The DoN further indicated from the Nursing Assessment done on admission on 4/4/14, to the time the bruise was found on 4/10/14, the staff should have completed a full head to toe skin assessment and noticed the bruise.</p> <p>3.1-28(c) 3.1-28(e) 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview the facility failed to follow the facility abuse policy related to reporting allegations of abuse to the administrator immediately. The facility also failed to the to report an injury of unknown origin to the Indiana State Department of Health related to a bruise greater than 10 cm on the right inner thigh for 2 of 3 abuse allegations reviewed. (Resident's #64 and #93)</p>	F000226	<p>F226 The facility requests paper compliance for this citation. 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 solely because it is required by the provisions of federal and state law. 1)</p>	05/14/2014			

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	<p>Findings include:</p> <p>1. Record review for Resident #64 was done on 4/16/14, at 3:00 p.m. A reportable occurrence was reviewed that occurred on 4/5/14, at 10:00 p.m. The reportable occurrence investigation indicated in a statement from CNA #2 when she came on shift at 10:00 p.m., Terminated CNA #3 was "unhooking a gait belt that was strapped around the arms of a chair that Resident #64 was sitting in".</p> <p>The Significant Change Minimum Data Set (MDS) Assessment done on 1/30/14, indicated Resident #64 was cognitively impaired. The resident's diagnoses included, but were not limited to, heart failure, hypertension, diabetes mellitus, and dementia. The MDS indicated the resident was a limited 1 person assist with transfers and walking. The Assessment indicated no restraints were being used.</p> <p>A statement from Terminated CNA #3 dated 4/5/14, indicated she needed to do rounds but Resident #64 was getting up and down constantly. She indicated at the same time there were three other residents with behaviors which made Resident #64 even more anxious. The statement further indicated, "I didn't know what else to do to keep him safe from hurting himself so I grabbed a gait belt and put it over the arms of his chair and hooked it in front of him just to keep him from getting up for long enough to do my rounds."</p> <p>A statement from LPN #4 who worked on the unit 4/5/14, indicated she was unaware of the incident and the last time she saw Resident</p>		<p>Immediate actions taken for those resident identified: Resident #64: Report sent to ISDH, as well as incident report with physician and responsible party notification completed 4/6/14. A head to toe assessment was completed on 4/6/14 with no new negative findings. The CNA was removed from the schedule pending outcome of investigation and then later terminated on 4/10/14 upon completion. Resident #93: The resident no longer resides at this facility. 2) How the facility identified other residents: Review of all allegations in the last 30 days to ensure allegations were reported immediately to the Executive Director. New admissions for the last 30 days will be reviewed for undocumented skin issues. 3) Measures put into place/system changes: The staff were re-educated regarding requirements of abuse allegation reporting by the Executive Director beginning 4/6/14 and again 4/24/14. The Interdisciplinary Team will review all new skin concerns and other potential reportable concerns/ allegations at least 3x/week to ensure incidents are reported timely and according to reporting criteria. Licensed nurses will be re-educated regarding completing skin assessments on admission. Follow-up skin</p>				

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	<p>#64 was at 9:15 p.m., when he was lying in bed.</p> <p>An interview with the Administrator on 4/21/14, at 11:56 a.m., indicated CNA #2 did not inform her about the incident immediately. The Administrator was not informed of the incident until the following morning. At this time Terminated CNA #3 was suspended and an investigation was started. She further indicated Terminated CNA #3 was terminated on 4/10/14, for improperly using a restraint on Resident #64.</p> <p>A facility policy on Abuse dated 01/2012, and received as current from the Administrator, indicated "...b. iv. Administrator must be notified immediately of situation, and he/she must conduct an investigation immediately..."</p> <p>2. Record review for Resident #93 was done on 4/16/14 at 3:30 p.m. A reportable occurrence was reviewed of a bruise measuring 23 centimeters (cm) x 6 cm that occurred on 4/10/14.</p> <p>A Nursing Admission Assessment of Resident #93 on 4/4/14, indicated the resident had intermittent confusion. The resident's diagnoses included, but were not limited to, dementia, hypertension, congestive heart failure, and depressive disorder. The Assessment indicated the skin was pink and intact. The Assessment lacked documentation of any bruising to the skin.</p> <p>An Initial Non-pressure Skin Report dated, 4/10/14, indicated there was a bruise to the right inner thigh that was light purple in color, measured 23 cm x 6 cm and was first observed on 4/10/14. A Nursing Note (NN) dated, 4/11/14 at 8:18 a.m., indicated</p>		<p>assessment will be completed on new admissions by the wound nurse or designee on the next business day after admission to ensure all skin issues are identified and documented. The administrator and DON will be responsible for oversight of these audits. 4) How the corrective actions will be monitored: The results of these audits will be reviewed in the Quality Assurance meeting monthly X 3, then quarterly x1 for a total of 6 months. 5) Target Completion Date: May 14, 2014</p>		

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	<p>Resident #93 had a purple discoloration to the right inner upper thigh that was found by the nurse. The NN indicated the resident's husband indicated the resident fell outside of their private home prior to admission to the facility.</p> <p>The record lacked documentation Resident #93 had any bruising until 4/10/14.</p> <p>An interview with the Administrator and the Director of Nursing (DoN) on 4/16/14 at 4:10 p.m., indicated the Administrator was notified of the bruise on 4/10/14, but did not report the bruise to the State Department of Health as an injury of unknown origin or do any investigation because Resident #93's husband indicated she had it before admission to the facility. The DoN indicated when the resident was admitted to the facility the nurse on shift did not do a full head to toe skin assessment of the resident because the resident refused and the nurse did not document this. The DoN further indicated from the Nursing Assessment done on admission on 4/4/14, to the time the bruise was found on 4/10/14, the staff should have completed a full head to toe skin assessment and noticed the bruise.</p> <p>A facility policy on Administrative Accidents And Incidents Investigating And Reporting dated 1/2012, and received as current from the Administrator, indicated "... Policy Interpretation and Implementation: Occurrences to be reported: Facilities are required by law to report unusual occurrences...to the Long Term Care Division..." "...Large area of Contusion: A large contusion that would be reportable, would be any contusion that is 10 centimeters or greater in diameter, or an irregular</p>			

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F000282 SS=E	<p>contusion measuring 10 centimeters by 11 centimeters or greater..."</p> <p>3.1-28(a) 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review, and interview, the facility failed to follow physician's orders and care plans, related to monitoring for side effects of psychoactive medications, a laboratory test, and physician notification of blood sugar results outside the specified call parameters for 3 of 5 residents reviewed for unnecessary medications and for use of a physical restraint for 1 of 2 residents reviewed for physical restraints of the 2 who met the criteria for physical restraints. (Residents #37, #8, #92, and #66)</p> <p>Findings include:</p> <p>1. The record for Resident #37 was reviewed on 4/15/14 at 4:06 p.m. The resident's diagnoses included, but were not limited to, vascular dementia with delusions, generalized anxiety disorder, and depressive disorder.</p> <p>Review of the 3/2014 Medication Administration Record (MAR) indicated orders for Remeron (an antidepressant medication) 7.5 milligrams (mg) daily at bedtime, Zoloft (an antidepressant medication) 200 mg daily, Diazepam (an antianxiety medication) 2 mg two times a day,</p>	F000282	<p>F282 The facility requests paper compliance for this citation. 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 solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those resident identified: Resident #37, The physician was notified on 4/21/14 of not documenting for side effects until 3/24/14 with no new orders received. Resident #8, The physician was notified and a order for a TSH was obtained on 4/21/14 and drawn on 4/23/14. Results were within normal limits, and no new orders were received. Resident #92, The physician was notified on 4/16/14 of blood sugars above parameters from 4/13/14. No new orders received. Resident #66, The adjusta-loop seatbelt is</p>	05/14/2014			

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	<p>Seroquel (an antipsychotic medication) 50 mg two times a day, and Xanax (an antianxiety medication) 0.5 mg every 8 hours. The resident had received the medications as ordered.</p> <p>A Physician's Order, dated 3/24/14, indicated to observe for and document any side effects of antipsychotic, antidepressant, antianxiety, and hypnotic medications every shift.</p> <p>There was lack of documentation in the record to indicate the Remeron, Zoloft, Diazepam, Seroquel, and Xanax medications had been monitored for side effects prior to 3/24/14.</p> <p>Review of the current care plan, dated 12/19/13, indicated the resident used antianxiety, antidepressant, and antipsychotic medications. Nursing interventions included, "administer medications as ordered. Monitor/document for side effects...Monitor/record/report...side effects and adverse reactions of psychoactive medications."</p> <p>Interview with the DoN (Director of Nursing) on 4/21/14 at 10:06 a.m., indicated she could not find any documentation the antidepressant, antipsychotic, and antianxiety medications had been monitored for side effects prior to 3/24/14. She further indicated the resident should have been monitored for side effects of the medications.</p> <p>2. Record review for Resident #8 was done on 4/15/14, at 3:59 p.m. The Significant Change Minimum Data Set (MDS) Assessment was done on 1/22/14, and indicated the resident was cognitively</p>		<p>currently in use. A replacement seatbelt was ordered on 4/17/14 to use during laundering. Restraint released every 2 hours per facility policy. Resident will be reviewed for restraint reduction as appropriate. 2) How the facility identified other residents: A full house audit was conducted on 4/23/14 for residents receiving medications requiring side effect monitoring; resident's receiving glucose monitoring and residents using restraint devices. An audit of lab orders since 4/1/14 was completed with no issues identified. 3) Measures put into place/system changes: The nurses will be re-educated regarding physical restraints, physician notification of blood sugar results outside parameters, completing lab orders and documentation of side effects for psychotropic medications. Blood Sugar results will be reviewed at least 3x/week to ensure physician notification of results outside parameters. New admissions and new orders for psychotropic medications will be audited at least weekly to ensure orders are in place for monitoring of side effects. Lab orders will be reviewed at least 3x/week to ensure labs are drawn as ordered. Random observation rounds will be completed 5 times a week on varied shifts to ensure restraints are applied and released appropriately. The DON</p>		

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	<p>impaired. The diagnoses included, but were not limited to, dementia, hypothyroidism, chronic kidney disease and diabetes mellitus.</p> <p>A care plan indicated: Resident has Hypothyroidism medication prescribed as ordered, interventions include to obtain and monitor lab/diagnostic work as ordered. Report results to Physician and follow up as indicated.</p> <p>Physician Orders for the month of April 2014, indicated an order for Synthroid tablet (thyroid medication) 300 micrograms (mcg) every day and an order for a TSH (thyroid function lab) to be drawn every January and July. A review of the Medication Administration Record (MAR) for the month of April 2014, indicated the resident was administered the medication every day.</p> <p>A lab results form dated 1/27/14, indicated the TSH was 9.750 H (high level) in a reference range of 0.270-4.200. Written on the bottom of the form was current medication dose of 275 mcg every day and orders to increase it to 300 mcg every day and recheck lab in 2 weeks.</p> <p>The record lacked documentation of any TSH lab completed after 1/27/14.</p> <p>An interview with the DoN on 4/21/14, at 1:09 p.m., indicated the nurse that received the lab report wrote the Physician's order on the bottom of the report to increase the medication and recheck the lab in 2 weeks. She further indicated the TSH lab should have been completed but had not been.</p>		<p>or designee will be responsible for oversight of these audits. 4) How the corrective actions will be monitored: The results of these audits will be reviewed in the Quality Assurance meeting monthly X 3, then quarterly x1 for a total of 6 months.5) Target Completion Date: May 14, 2014</p>	

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	<p>3. The record for Resident #92 was reviewed on 4/16/14 at 9:00 a.m. The resident's diagnoses included, but were not limited to, Diabetes type 2, hyperlipidemia, esophageal reflux, hypertension, altered mental status, and dementia with behavioral disturbances.</p> <p>Review of Physician Orders from admission on 4/7/14 included an admission order dated 4/7/14 for "Accuchecks before meals and at bedtime. Before meals and at bedtime for blood sugars contact [physician] if sugar > 350 or <60."</p> <p>Review of the April 2014 MAR (Medication Administration Record) and April 2014 Blood Sugar Summary indicated BS (blood sugar) readings over 350 for the following dates: April 13, 2014 at 5:54 p.m. - BS 358 April 13, 2014 at 7:45 p.m. - BS 361</p> <p>Current Medication Orders as of 4/13/14 included but were not limited to: Metformin HCl 1000mg 1 tablet by mouth two times a day for hyperglycemia (elevated blood sugar) Novolog 70/30 Insulin 15 units subcutaneously one time a day related to diabetes. Call <60 or >350 Novolog 70/30 Insulin 8 units subcutaneously at bedtime related to diabetes. Call <60 or >350</p> <p>Review of the Progress Notes, including eMAR (electronic Medication Administration Record) notes, for April 13, 2014 indicated a lack of documentation of blood sugars > 350 on that day and a lack of physician notification.</p> <p>Resident #92 had a written care plan in place</p>			

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	<p>for his diagnosis of Diabetes Mellitus which included the intervention to administer diabetes medication as ordered by doctor and monitor/ document for side effects and effectiveness. The care plan also indicated he "has a diagnosis of dementia with behavioral disturbances. BIMS [Brief Interview of Mental Status] score of (05) indicates severe cognitive impairment."</p> <p>In an interview with the Director of Nursing (DoN) on 4/16/14 at 3:00 p.m., indicated physician notification of blood sugars outside parameters should be done as ordered and documented in the Progress Notes or eMAR notes. On 4/16/14 at 3:15 p.m. the Medical Records nurse further indicated the DoN had found no progress notes or eMAR notes indicating the physician was notified of blood sugars outside parameters on 4/13/14 for Resident #92.</p> <p>4. On 4/14/14 from 11:40 a.m., until 12:30 p.m., Resident #66 was observed sitting in a W/C (wheelchair) at a dining room table, wearing a soft waist lap restraint which clipped around the back of W/C. The loose ends of the restraint belt were intertwined in the rest of the belt. The resident was unable to reach the buckle to release the restraint independently. From 12:15 p.m., until 12:30 p.m., CNA #5 assisted the resident with her lunch. During this continued observation from 11:40 a.m., until 12:30 p.m., the restraint belt was not released.</p> <p>On 4/15/14, Resident #66 was continuously observed from 8:41 a.m., until 10:50 a.m. The following was observed: At 8:41 a.m.,</p>			
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	<p>the resident was sitting in the W/C with anti-tippers in the dining room, wearing a soft lap restraint clipped around the back of the W/C, with the loose ends of the restraint belt intertwined in the rest of the belt, watching a movie. At 9:00 a.m., the resident was encouraged to perform exercises in the W/C. At 9:15 a.m., the resident was observed still sitting in the W/C with eyes closed, asleep. Staff attempted to wake up the resident throughout the next activity without success. At 9:27 a.m., the resident was asked to participate in another activity and was pulled up to the table for a dice game. At 10:50 a.m., the resident was observed asleep in the W/C at the table. During this continuous observation from 8:41 a.m., until 10:50 a.m., the soft lap restraint was clipped around the back of the resident's W/C, with the loose ends intertwined in the belt. The restraint belt was not released at any time during the 2+ hour observation.</p> <p>On 4/15/14 at 1:57 p.m., Resident #66 was observed with eyes closed, sitting in the W/C in the dining room wearing a soft lap restraint clipped around the back of the W/C, with the loose ends of the restraint belt intertwined in the belt.</p> <p>On 4/16/14 at 8:39 am, Resident #66 was observed sitting in the dining room in the W/C wearing the soft lap restraint clipped around the back of the W/C, with the loose ends of the belt intertwined in the belt, quietly looking out the window. At 9:04 a.m., the resident remained sitting in the W/C wearing a soft lap restraint clipped around the back of the W/C, with the loose ends of the restraint belt intertwined in the belt, in the activity room for an activity.</p>				

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	<p>On 4/16/14 from 9:34 a.m., until 9:42 a.m., Restorative CNA #6 was observed in Resident #66's room performing ROM (Range of Motion) exercises. The resident remained in the W/C wearing a soft lap restraint clipped around the back of the W/C, with the loose ends of the restraint belt intertwined in the belt, throughout the exercises.</p> <p>Resident #66's record was reviewed on 4/17/14 at 10:15 a.m. The resident's diagnoses included, but were not limited to, senile dementia, osteoporosis, edema, Pseudobublar affect (uncontrollable episodes of crying), difficulty walking, and muscle weakness.</p> <p>A Physician's Order, dated 5/23/13, indicated an " adjusta-loop cushion belt, while up in W/C for safety."</p> <p>The care plans dated 4/15/14 indicated the following: "Focus... potential for decline in ADL (Activities for Daily Living) function related to dementia, immobility and use of criss-cross restraint for safety. Interventions: "...Notify restorative nurse of any decline..." "Focus...has a criss/cross seat belt for prevention of injury to self as characterized by high risk for injury/falls, impaired mobility, loss of balance, poor posture, and cognitive impairment and poor safety awareness...Interventions: Discuss necessity of restraining device for resident with resident/family in care plan quarterly and as needed, follow facility protocol to monitor ongoing need for safety device, apply soft criss-cross waist restraint seat belt when up in wheelchair and check every hour and remove and readjust every 2 hours..." "Focus...potential for decline in PROM</p>						

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	<p>(Passive Range Of Motion) related to decreased mobility and use of restraint for safety...Interventions:...complete PROM exercises...notify restorative nurse of any decline."</p> <p>"Focus...potential for falls...Interventions: Adjustaloop cushion belt while up in wheelchair for safety...check every 2 hours for positioning, check every hour while in restraint and reposition every two...staff education on removing seatbelt and not supervising resident..."</p> <p>During an interview on 4/16/14 at 10:00 a.m., Restorative CNA #6 indicated the restraint belt should be on while in the W/C and taken off while eating. At the same time, CNA #5 indicated the resident should also be repositioned every 2 hours.</p> <p>During an interview on 4/16/14 at 10:38 a.m., QMA #7 indicated the resident's restraint was applied correctly, staff were to reposition her in her seat every couple of hours, and should release the restraint when taken to the bathroom, helped into bed or when repositioned in her chair.</p> <p>During an interview on 4/16/14 at 2:53 p.m., CNA #8 indicated we reposition her and release her restraint belt every 2 hours.</p> <p>During an interview on 4/17/14 at 10:54 a.m., the DoN indicated the resident had the restraint in use due to multiple falls and in the past they attempted to remove the restraint, "but she would scoot to the end of her W/C and that was a fall hazard. Then we tried an alarming belt so that we wouldn't have to be with her 1:1 all the time, and that did not work either, so we went to a criss-cross belt. But that got soiled a lot and we washed it a lot</p>			

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F000329 SS=D	<p>and it looked terrible so we ordered her another belt. A clip belt is considered a locking device if the resident cannot unclip it themselves." The DoN indicated the resident should have been checked every hour by staff for visualizing if the belt was too tight or physically checking the restraint. The DoN further indicated the restraint should have been released every 2 hours, at meals, and during activities.</p> <p>During an interview on 4/17/14 at 12:00 p.m. with the DoN, she indicated the resident's criss-cross restraint belt had been sent to the laundry and the resident currently had the wrong restraint belt on, which was the soft lap restraint belt that clipped around the W/C. She indicated the resident had on the wrong restraint belt during the observations made throughout the survey. The DoN further indicated the incorrect soft lap clip restraint belt had been removed and she would re-educate the staff on restraints.</p> <p>3.1-35(g)(2) 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</p>			
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	<p>drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure residents were free from unnecessary medications related to monitoring for side effects of psychoactive medications, a laboratory test, and physician notification of blood sugar results outside the specified call parameters for 3 of 5 residents reviewed for unnecessary medications. (Residents #37, #8, and #92)</p> <p>Findings include:</p> <p>1. The record for Resident #37 was reviewed on 4/15/14 at 4:06 p.m. The resident's diagnoses included, but were not limited to, vascular dementia with delusions, generalized anxiety disorder, and depressive disorder.</p> <p>Review of the 3/2014 Medication Administration Record (MAR) indicated orders for Remeron (an antidepressant medication) 7.5 milligrams (mg) daily at bedtime, Zoloft (an antidepressant medication) 200 mg daily, Diazepam (an antianxiety medication) 2 mg two times a day, Seroquel (an antipsychotic medication) 50 mg two times a day, and Xanax (an antianxiety medication) 0.5 mg every 8 hours. The resident had received the medications as ordered.</p>	F000329	<p>F329</p> <p>The facility requests paper compliance for this citation.</p> <p><i>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 solely because it is required by the provisions of federal and state law.</i></p> <p>1) Immediate actions taken for those resident identified:</p> <p>Resident #37, The physician was notified on 4/21/14 of not documenting for side effects until 3/24/14 with no new orders received.</p> <p>Resident #8, The physician was notified and a order for a TSH was obtained on 4/21/14 and drawn on 4/23/14. Results were within normal limits, and no new orders were received.</p> <p>Resident #92, The physician was notified on 4/16/14 of blood sugars above parameters from 4/13/14. No</p>	05/14/2014			

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	<p>A Physician's Order, dated 3/24/14, indicated to observe for and document any side effects of antipsychotic, antidepressant, antianxiety, and hypnotic medications every shift.</p> <p>There was lack of documentation in the record to indicate the Remeron, Zoloft, Diazepam, Seroquel, and Xanax medications had been monitored for side effects prior to 3/24/14.</p> <p>Review of the current care plan, dated 12/19/13, indicated the resident used antianxiety, antidepressant, and antipsychotic medications. Nursing interventions included, "administer medications as ordered. Monitor/document for side effects...Monitor/record/report...side effects and adverse reactions of psychoactive medications."</p> <p>Interview with the DoN (Director of Nursing) on 4/21/14 at 10:06 a.m., indicated she could not find any documentation the antidepressant, antipsychotic, and antianxiety medications had been monitored for side effects prior to 3/24/14. She further indicated the resident should have been monitored for side effects of the medications.</p> <p>2. Record review for Resident #8 was done on 4/15/14, at 3:59 p.m. The Significant Change Minimum Data Set (MDS) Assessment was done on 1/22/14, and indicated the resident was cognitively impaired. The resident's diagnoses included, but were not limited to, dementia, hypothyroidism, chronic kidney disease and diabetes mellitus.</p>		<p>new orders received.</p> <p>2) How the facility identified other residents: A full house audit was conducted on 4/23/14 for residents receiving medications requiring side effect monitoring and resident's receiving glucose monitoring. An audit of lab orders since 4/1/14 was completed with no issues identified.</p> <p>3) Measures put into place/system changes: The nurses will be re-educated regarding physician notification of blood sugars outside parameters, completing lab orders, and documentation of side effects for psychotropic medications. Blood Sugar results will be reviewed at least 3x/week to ensure physician notification for results outside physician ordered parameters. New admissions and new orders for psychotropic medications will be audited at least weekly to ensure orders are in place for monitoring of side effects. Lab orders will be reviewed at least 3x/week to ensure labs are drawn as ordered. The DON or designee will be responsible for oversight of these audits.</p> <p>4) How the corrective actions will be monitored:</p>				

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	<p>A care plan indicated: Resident has Hypothyroidism medication prescribed as ordered, interventions include to obtain and monitor lab/diagnostic work as ordered. Report results to Physician and follow up as indicated.</p> <p>Physician Orders for the month of April 2014, indicated an order for Synthroid tablet (thyroid medication) 300 micrograms (mcg) every day and an order for a TSH (thyroid function lab) to be drawn every January and July. A review of the Medication Administration Record (MAR) for the month of April 2014, indicated the resident was administered the medication every day.</p> <p>A lab results form dated 1/27/14, indicated the TSH was 9.750 H (high level) in a reference range of 0.270-4.200. Written on the bottom of the form was current medication dose of 275 mcg every day and orders to increase it to 300 mcg every day and recheck lab in 2 weeks.</p> <p>The record lacked documentation of any TSH lab completed after 1/27/14.</p> <p>An interview with the DoN on 4/21/14, at 1:09 p.m., indicated the nurse that received the lab report wrote the Physician's order on the bottom of the report to increase the medication and recheck the lab in 2 weeks. She further indicated the TSH lab should have been completed but had not been.</p> <p>3. The record for Resident #92 was reviewed on 4/16/14 at 9:00 a.m. The resident's diagnoses included, but were not limited to,</p>		<p>The results of these audits will be reviewed in the Quality Assurance meeting monthly X 3, then quarterly x1 for a total of 6 months.</p> <p>5) Target Completion Date: May 14, 2014</p>		

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	<p>Diabetes type 2, hyperlipidemia, esophageal reflux, hypertension, altered mental status, and dementia with behavioral disturbances.</p> <p>Review of Physician Orders from admission on 4/7/14 included an admission order dated 4/7/14 for "Accuchecks before meals and at bedtime. Before meals and at bedtime for blood sugars contact [physician] if sugar > 350 or <60."</p> <p>Review of the April 2014 MAR (Medication Administration Record) and April 2014 Blood Sugar Summary indicated BS (blood sugar) readings over 350 for the following dates: April 13, 2014 at 5:54 p.m. - BS 358 April 13, 2014 at 7:45 p.m. - BS 361</p> <p>Current Medication Orders as of 4/13/14 included but were not limited to: Metformin HCl 1000mg 1 tablet by mouth two times a day for hyperglycemia (elevated blood sugar) Novolog 70/30 Insulin 15 units subcutaneously one time a day related to diabetes. Call <60 or >350 Novolog 70/30 Insulin 8 units subcutaneously at bedtime related to diabetes. Call <60 or >350</p> <p>Review of the Progress Notes, including eMAR (electronic Medication Administration Record) notes, for April 13, 2014 indicated a lack of documentation of blood sugars > 350 on that day and a lack of physician notification.</p> <p>Resident #92 had a written care plan in place for his diagnosis of Diabetes Mellitus which included the intervention to administer diabetes medication as ordered by doctor and monitor/ document for side effects and</p>			

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F000371 SS=E	<p>effectiveness. The care plan also indicated he "has a diagnosis of dementia with behavioral disturbances. BIMS [Brief Interview of Mental Status] score of (05) indicates severe cognitive impairment."</p> <p>In an interview with the Director of Nursing (DON) on 4/16/14 at 3:00 p.m., indicated physician notification of blood sugars outside parameters should be done as ordered and documented in the Progress Notes or eMAR notes. On 4/16/14 at 3:15 p.m. the Medical Records nurse further indicated the DON had found no progress notes or eMAR notes indicating the physician was notified of blood sugars outside parameters on 4/13/14 for Resident #92.</p> <p>3.1-48(a)(3) 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</p> <p>Based on observation, interview, and record review, the facility failed to distribute food under sanitary conditions, related to improper sanitization of dishes in a 3 compartment sink in the kitchen and touching residents' food without gloves or hand washing for 1 of 1 meals observed of 3 dining areas observed (Alzheimer's Care Unit, ACU). This had the potential to affect 10 of 62 residents in the facility who received a puree diet and 13 of 13 residents who resided on the ACU and</p>	F000371	F371 The facility requests paper compliance for this citation. 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 solely because it is required by the provisions of federal and state law. 1)	05/14/2014	

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	<p>received their meals on the ACU. (Kitchen and ACU)</p> <p>Findings Include:</p> <p>1. On 4/16/14 at 10:54 a.m., during the full Kitchen Sanitation Tour with the Dietary Manager the following was observed:</p> <p>At 11:15 a.m. the Dietary Manager was observed washing dishes in the 3 compartment sink. She washed the puree blender container in soapy water, rinsed the dish in the water compartment, dipped the dish in the sanitizer compartment, and placed the dish on the side of the sink to dry. The Dietary Manager waited for the blender container to dry and used the dish to make the spinach puree.</p> <p>At 11:25 a.m. the Dietary Manager was observed washing dishes in the 3 compartment sink. She washed the puree blender container in soapy water, rinsed the dish in the water compartment, dipped the dish in the sanitizer compartment, and placed the dish on the side of the sink to dry.</p> <p>Interview with the Dietary Manager at the time of the observation indicated she washed the dishes clean, dipped them in the rinse, dipped them in the sanitizer for a few seconds and then let them dry. She further indicated there were 10 residents who received puree diets in the facility.</p> <p>A facility policy on Cleaning Dishes Manual Dishwashing, dated 2003, and received as current from the Dietary Manager, indicated "...Sink 3-Sanitize...3. Place dishes in the sanitizing sink...(chlorine-10 seconds) (all others-30 seconds)..."</p>		<p>Immediate actions taken for those resident identified: #1 The correct policy was posted above the 3 compartment sink on 4/16/14 and the dietary manager and dietary consultant reviewed proper procedure for 3 compartment sinks on 4/30/14.</p> <p>#2 The nursing staff were educated on hand washing policy and procedure for tray service and competencies initiated on 4/24/14. 2) How the facility identified other residents: All residents have potential to be affected. 3) Measures put into place/system changes: The dietary staff will be re-educated regarding the policy/procedure for 3 compartment sink. Staff will be re-educated on policy/procedure on hand washing/ sanitizing during meal tray service. Dietary Manager or designee will observe use of 3 compartment sink for appropriate soak time at least 3x/week at varied times after meal service. DON/designee or Infection Control nurse will observe meal service at least 3x/week on varied shifts to ensure proper hand washing/ sanitizing techniques are being used. 4) How the corrective actions will be monitored: The results of these audits will be reviewed in the Quality Assurance meeting monthly X 3, then quarterly x1 for a total of 6 months. 5) Target Completion Date: May 14, 2014</p>				

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	<p>Interview with the Dietary Manager on 4/17/14 at 2:20 p.m., indicated she had not properly sanitized the dishes in the 3 compartment sink. She further indicated she should have kept the dishes in the sanitizer compartment for 30 seconds.</p> <p>2. During an observation of the noon meal on the ACU on 4/14/14 at 11:40 a.m., the following was observed:</p> <p>CNA #5 buttered Resident #33's bread roll. CNA#5 touched the bread roll with her hands and was not wearing gloves.</p> <p>CNA #5 went back to the serving cart and picked up Resident #75's tray, brought it to the resident and placed the meal plate in front of the resident. CNA #5 applied pepper to Resident #75's meal, buttered his bread roll and opened his milk carton. CNA #5 did not wash her hands or use hand sanitizer, touched the bread roll with her hands, and was not wearing gloves.</p> <p>CNA #5 left the dining room and got coffee for Resident #87 from the cart in hallway and brought it to him.</p> <p>CNA #5 went back to the serving cart and picked up Resident #9's tray and brought it to the resident. CNA #5 buttered the resident's bread roll, opened her milk carton, and buttered her potatoes. CNA #5 did not wash her hands or use hand sanitizer, touched the bread roll with her hands and was not wearing gloves.</p> <p>CNA #5 then applied hand sanitizer to her hands.</p>			

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NAME OF PROVIDER OR SUPPLIER AUTUMN HILLS HEALTH AND REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310
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F000441 SS=D	<p>A facility policy on Proper Food Handling dated 6/15/12, and received as current from the Dietary Manager, indicated "...1) The Food Service Employees will wash hands and don food-safe gloves prior to direct contact with food...2) Dietary employees shall use utensils for food assembly and service to avoid direct contact with ready to eat foods...3)The Food Service Employee will wash hands and change gloves (if worn), prior to direct contact with food, following contact with any non sterile surfaces..."</p> <p>Interview with Dietary Manager on 4/17/14 at 2:00 p.m., indicated CNA #5 should have washed her hands before handling the food and in between residents. She further indicated gloves should have been worn when handling the food.</p> <p>3.1-21(i)(3) 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p>			

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	<p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation and interview, the facility failed to ensure proper infection control practices and standards were maintained during peri-care on a female resident for 1 of 2 residents reviewed for physical restraints of the 2 who met the criteria. This had the potential to affect 13 residents residing in the AC (Alzheimer's Care) unit. (Resident #66)</p> <p>Findings include:</p> <p>On 4/16/14 at 9:45 a.m. during a random resident observation, Restorative CNA #6 performed peri-care on Resident #66. Restorative CNA #6 applied gloves and did the following: applied Peri care foaming wash to a clean washcloth, wiped the resident's peri area from back to front (starting at the anus), then turned resident on her left side,</p>	F000441	<p>F441 The facility requests paper compliance for this citation. <i>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 solely because it is required by the provisions of federal and state law.</i> 1) Immediate actions taken for those resident identified: Resident #66 demonstrates no signs or symptoms of urinary tract infection. CNA #6 was re-educated on 4/21/14 regarding the procedure for perineal care. 2) How the facility identified other residents: All incontinent</p>	05/14/2014			

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R000000	<p>folded the wash cloth and cleansed the perianal area from front to back, then applied a new brief on the resident. During an interview with Restorative CNA #6 at the time of the observation, she indicated she attended an inservice on peri-care "a couple months ago." She further indicated she should have wiped the resident's peri area from front to back, not back to front.</p> <p>During an interview on 4/21/14 at 11:00 a.m., the DoN indicated CNA #6 had performed incorrect peri care and should have wiped the resident from front to back.</p> <p>3.1-18(a)</p>	R000000	<p>residents dependent for perineal care have the potential to be affected. 3) Measures put into place/system changes: Nursing staff will be re-educated regarding procedure for perineal care. The Infection Control Nurse or designee will randomly observe perineal care performed on at least 3 residents per week on varied shifts. 4) How the corrective actions will be monitored: The results of these audits will be reviewed in the Quality Assurance meeting monthly X 3, then quarterly x1 for a total of 6 months. 5) Target Completion Date: May 14, 2014</p>	
R000349	<p>The following State Residential findings cited are in accordance with 410 IAC 16.2. 410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.</p> <p>Based on record review and interview, the facility failed to maintain clinical records that were complete and accurately documented</p>	R000349	<p>R349 <i>The facility requests paper compliance for this citation.</i></p>	05/14/2014

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	<p>related to monitoring a bruit and thrill for an arteriovenous (AV) fistula for 1 of 1 residents reviewed for dialysis in the sample of 7. (Resident #1)</p> <p>Findings include:</p> <p>The record for Resident #1 was reviewed on 4/16/14 at 9:45 a.m. The resident's diagnoses included, but were not limited to, end stage renal disease and dialysis.</p> <p>Review of the April 2014 Physician's Order Summary (POS), indicated the resident was to have her dialysis fistula checked for bruit and thrill every shift.</p> <p>Review of the April 2014 Treatment Administration Record (TAR), indicated there was no area to document where the bruit and thrill was checked every shift. Review of the Nursing progress notes from the month of October 2013 through April 2014, indicated there was no documentation where the resident's dialysis fistula was checked every shift.</p> <p>Interview with LPN #1 on 4/16/14 at 1:50 p.m., indicated there was no documentation to indicate the resident's fistula was being monitored each shift. She indicated that she does check the fistula, but she does not document it.</p> <p>Interview with the Nurse Consultant on 4/16/14 at 2:00 p.m., indicated documentation should have been completed every shift related to the bruit and thrill of the resident's dialysis fistula.</p>		<p><i>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 solely because it is required by the provisions of federal and state law.</i></p> <p>1) Immediate actions taken for those resident identified: Resident #1, the order was corrected to appear on TAR for documentation for dialysis fistula bruit & thrill.</p> <p>2) How the facility identified other residents: There are no other residents on the residential unit receiving dialysis.</p> <p>3) Measures put into place/system changes: New admissions and new orders for monitoring dialysis fistulas will be audited at least weekly to ensure orders are in place for monitoring of bruit & thrill.</p> <p>The DON or designee will be responsible for oversight of these audits.</p> <p>4) How the corrective actions will be monitored: The results of these audits will be reviewed in the Quality Assurance</p>				

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