

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/01/2016
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NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00194421.</p> <p>Complaint IN00194421 - Substantiated. Federal/State deficiencies related to the allegations are cited at F250 and F319. Survey date: March 1, 2016</p> <p>Facility number: 000138 Provider number: 155233 AIM number: 100266500</p> <p>Census bed type: SNF/NF: 66 Total: 66</p> <p>Census payor type: Medicare: 9 Medicaid: 39 Other: 18 Total: 66</p> <p>Sample: 3</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Q.R. completed by 14466 on March 08, 2016.</p>	F 0000	Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws.	
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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=G 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 record review and interview, the facility failed to provide medically related social services for one resident who did not receive an antidepressant medication dose increase or psychosocial interventions as recommended by the consulting Psychologist (Resident B). This deficient practice resulted in harm in that Resident B experienced a decline in mood since admission and attempted suicide.</p> <p>Findings include:</p> <p>Resident B's closed clinical record was reviewed on 3/1/2016 at 12:40 p.m. Diagnoses included, but were not limited to, major depressive disorder, history of cerebral infarction (stroke), and weakness. Resident B was admitted to the facility on 1/17/2016, following a hospital admission for urinary tract infection and intractable (uncontrollable) vomiting.</p>	F 0250	<p>F-250 It is the policy of the facility to provide medically related social services to attain or maintain the highest practicable physical, mental and psychosocial wellbeing of each resident. Resident B no longer resides in the facility. Residents who reside in the facility have the potential to be affected by this finding. Going forward, any resident who makes a statement which suggests a plan to attempt suicide will be placed on 1:1 supervision until they can be sent out and thoroughly assessed by psych services. Further, any medications recommended as the result of a psych visit within the facility will be initiated within 24 hours of the recommendation pending approval of the medication by the attending physician or the Medical Director (if the attending physician is not able to be reached) which will be obtained within the same 24 hour time frame. Psych services will personally exit with the SSD and/or the DON at which time any</p>	03/21/2016

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	<p>Resident B's admission Minimum Data Set (MDS) assessment, dated 1/24/2016, indicated a Brief Interview for Mental Status (BIMS) score of 9; indicating the resident was moderately cognitively impaired. Resident B's Mood score was 4; indicating no depression. The resident required staff assistance for all activities of daily living (ADL's) and self-propelled in his wheelchair for mobility.</p> <p>Resident B's change of [occupational] therapy MDS assessment, dated 2/21/2016, indicated a BIMS of 12; indicating the resident was moderately cognitively impaired. Resident B's Mood score was 9; indicating mild depression (5-9).</p> <p>Physician's orders for January and February, 2016 included, but were not limited to, "Citalopram Hydrobromide tablet [Celexa (antidepressant)] 10 mg [milligrams]. Give 10 mg by mouth one time a day for Depression. Start Date: 1/18/2016...Lorazepam [antianxiety medication] Tablet 0.5 mg. Give 0.5 mg by mouth every 8 hours as needed for Anxiety. Start Date: 1/17/2016...."</p> <p>Resident B's Medication Administration Record (MAR) for January and February, 2016, indicated the resident received Celexa 10 mg one time daily from</p>		<p>medication recommendations will be discussed so that the process to begin administering the medication can be initiated. Note: If for some reason the attending physician does not give approval for the medication recommended by psych services for a resident who has displayed suicidal ideations, the resident will be on 1:1 supervision until a new treatment plan can be agreed upon by the physician and psych services. As a further monitoring process, the results of visits from psych services will be presented by the SSD/Designee as part of the CQI meeting at the next CQI meeting following the psych services visit. Follow through with psych service recommendations; medications or otherwise, will be reviewed at that time. These processes will be ongoing and will be part of the CQI agenda. The residents seen by psych services will be included on the list of residents discussed at the weekly Behavior Management meetings.</p> <p>At an in-service held for all staff the following was reviewed: A. Change of Condition—definition/policy/notifications B. Suicidal Ideations-Define-What to do if you hear a resident express an ideation 1. Assessment 2. Notifications 3. Care planning/interventions 4. When is 1:1 supervision the appropriate intervention? 5. Psych services—role 6. Timely role out</p>	

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	<p>January 18, 2016, until his discharge 2/24/2016.</p> <p>Resident B's Medication Administration Record (MAR) for January and February, 2016 indicated the resident received Lorazepam 0.5 mg 10 times from 1/20/2016 through 2/23/2016.</p> <p>A care plan for Resident B indicated, "Focus: At risk for decline in mood r/t [related to] dx [diagnosis]: deprssion [sic] and on antidepressant. Date Initiated: 1/20/2016. Makes negative statements about self and has unrealistic expectations about wanting to live alone in house...wanting to drive. PHQ-9 [MDS Mood score] shows mild depression. Date Initiated: 2/12/2016. Revision on 3/1/2016. Goal: Will have no decline in mood daily TNR [until next review]. Date Initiated: 1/20/2016. Interventions [all initiated 1/20/2016]: Antidepressant per order. Encourage family involvement...Monitor for effectiveness of meds and interventions. Notify MD, Family and IDT [interdisciplinary team] of any changes. Observe for adverse reaction to antidepressant such as but not limited to: [blank]. Psych [psychiatry/psychology] consult as needed."</p> <p>A care plan for Resident B indicated, "Focus: At risk for increased</p>		<p>of Psych services recommendations including meds 7. Role of attending physician 8. Questions/Answers Any staff who fail to comply with the points of the in-service will be further educated and or progressively disciplined as indicated. At the monthly Quality Assurance meeting the results of the Behavior Management meetings will be reviewed. This will include review of the monitoring of behaviors over the past month including any recommendations by psych services to see that notifications, assessments, care planning, interventions and any needed updating to CNA assignment sheets has taken place. And that all recommendations from psych services has been followed up on completely. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. The Administrator will monitor any Action Plan weekly until resolution. The facility respectfully requests a face to face IDR. The facility would like the opportunity to clearly and respectfully explain the circumstances surrounding the survey findings as their scope and severity do not reflect the facts</p>	

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	<p>anxiousness r/t dx: with need for anxiolytic [antianxiety]. Date Initiated: 1/20/2016. Becomes agitated when talking about past events and money. Yells and screams at staff. Date Initiated: 1/20/2016. Revision on: 3/1/2016. Goal: Will have no adverse reaction r/t Anxiolytic use TNR. Date Initiated: 1/20/2016. Interventions [all initiated 1/20/2016]: ...Anxiolytic per order...Encourage family involvement...Encourage to vent feelings...Monitor for effectiveness of meds and interventions. Notify md [sic], family and IDT of changes. Observe for adverse reactions to anxiolytic such as but not limited to: [blank]. Validate and assist."</p> <p>Resident B's Psychological Consultation note, related to a referral by the facility, dated 2/11/16, indicated, "the patient...just yesterday made a statement that if he had a gun he would probably shoot himself with it. The patient denies any active suicidal ideation in today's clinical contact, though notes that he feels at times as if his circumstances are so bleak that this becomes a consideration...he simply indicates that he is very frustrated with his life circumstances...[Resident B] notes that after he left the facility last year, he [went to] the home of his brother...that his brother in fact was helping himself to a</p>			

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	<p>great deal of the patient's money...there is little doubt that there is significantly increased depression ongoing with the patient...Recommendations (with attending Physician Discretion): 1. Please consider Celexa dosing increase to 20 mgs [milligrams] po [by mouth] qd [once daily]. 2. Continued follow up as appropriate, the patient seems to value from the opportunity to talk about his circumstances and the painful difficulties with which he continues to struggle at this juncture. 3. ...two strangers who essentially posed in his life as caretakers who he indicates took a lot of his money...This may be the case concurrently for brother, which I think in the long run is even sadder for the patient..."</p> <p>Resident B's Occupational Therapy Treatment Encounter Note, dated 2/13/2016, indicated, "...Comments: ...Resident expressed financial concerns to OTP [Occupational Therapist]. OTP reported to social services."</p> <p>Resident B's Occupational Therapy Recertification & Updated Plan of Treatment, dated 2/15/2016, indicated, "Progress: ...[Resident B] has made disparaging comments about himself and has stated that he wishes to die. Consult with SSD regarding sttements [sic]..."</p> <p>Physician's Progress Notes for Resident B, dated 2/15/2016, indicated, "...Is sad</p>			

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	<p>about overall physical condition...(9) Depression: stable. Describes himself as not necessarily happy...."</p> <p>There was no documentation in Resident B's clinical record to indicate Resident B received an increase of Celexa to 20 mg once daily, care plans were updated, or the physician was notified related to Resident B's increased depression scores, suicidal ideations, or psychology referral and recommendations.</p> <p>A Nurses Note, dated 2/24/2016 at 4:09 p.m., indicated, "Went into res [resident] room to do accu check [blood sugar test] and found res in w/c [wheelchair] with clear garbage bag over res head with black electric [sic] cord, appears as charger for phone, around res neck. removed bag and cord. res stated just let me kill myself....res crying and distraught, wanting to die."</p> <p>LPN #4 was interviewed on 3/1/2016 at 3:40 p.m. She indicated she entered Resident B's room to check his blood sugar and find him in his wheelchair with a plastic trash bag over his head and what appeared to be a cell phone cord wrapped around his neck with his hands holding the cord fisted under his chin and around his neck. She indicated she immediately tore the plastic bag open and assessed the resident. LPN # 4 indicated his color and</p>			

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	<p>vital signs remained "good" [within normal limits] and he never lost consciousness. Documented vital signs indicated the same. LPN # 4 indicated Resident B was crying and indicated he wished to die.</p> <p>A Social Services Note for Resident B, dated 2/25/2016 at 10:27 a.m., and signed by the SSD, indicated, "Res was sent to [hospital] for psych [psychiatric] evaluation and treatment for suicidal ideation. Res was seen by in house psych earlier this month. After visit no recommendation for inpatient psych treatment. Med [medication] adjustment recommendations in place. See psych notes in chart." The previous Social Services Note was dated 1/29/2016, and was related to a change in Power of Attorney (POA).</p> <p>The Social Services Director (SSD) was interviewed on 3/1/2016 at 12:41 p.m. She indicated Resident B had concerns related to family dynamics, possible misappropriation of funds by his POA, and unrealistic expectations about returning home to live independently. She indicated she assisted the resident with a change in POA and alerted Adult Protective Services (APS) regarding the possible misappropriation of funds by</p>			

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	<p>family and/or caretakers. She indicated she did not notify or enlist the help of the Ombudsman. The SSD indicated she obtained an order for a psychology consult after therapy staff reported Resident B was making "negative statements." The SSD indicated, "When I did all my PHQ-9 [MDS mood] assessments, they showed he fell in the mild range, which is five to nine. His last assessment was on 2/21[2016], after making the negative statements." On 3/1/2016 at 2:40 p.m., the SSD indicated she was responsible for psychology consults and forwarding recommendations to nursing and the attending physician. She indicated she received Resident B's Psychological Consultation, dated 2/11/16, via fax on 2/16/16, reviewed it, and faxed it to Physician C (who was covering for Resident B's physician, Physician D, while she was on maternity leave) that day. The SSD indicated she normally advises nursing staff of any medication recommendations, but could not provide any documentation that she had done so, and nothing was indicated in the clinical record that anyone was notified of the recommendations. The SSD indicated that she did not change Resident B's care plan, interventions, or frequency of interaction related to the psychologist's</p>			

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	<p>second recommendation (above). The Director of Nursing (DON) was interviewed on 3/1/2016 at 2:45 p.m. The The DON indicated Resident B's recommended increased Celexa dose was never started. The DON indicated she learned Physician C was no longer covering for Physician D, but Resident B's psychology consult note and recommendations were not faxed/forwarded to Physician D.</p> <p>On 3/1/2016 at 3:33 p.m. the SSD was interviewed regarding the 2/25/2016 Social Services Note (above). She indicated, "Honestly, it was an assumption that it [medication increase] was in place."</p> <p>On 3/1/2016 at 3:50 p.m., the Administrator indicated the facility did not have a policy or procedure related to consults/referrals or consult/referral recommendations.</p> <p>A copy of the current Director of Social Services Job Description was provided by the Administrator on 3/1/2016 at 3:50 p.m. The document indicated, "...C. Role Responsibilities...5. Maintains significant social service progress notes on the resident's medical chart on a timely basis...6. Maintains a current social service plan...."</p>			

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F 0319 SS=G Bldg. 00	<p>On 3/1/2016 at 4:45 p.m., the DON indicated the SSD was responsible for following up on consults/referrals and recommendations.</p> <p>This Federal tag relates to Complaint IN00194421.</p> <p>3.1-34(a)</p> <p>483.25(f)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem.</p> <p>Based on record review and interview, the facility failed to ensure the attending physician was made aware of an antidepressant medication dose increase as recommended by the consulting Psychologist, update the plan of care, and provide appropriate and recommended interventions for a resident with increased depression and suicidal ideation (Resident B). This deficient practice caused harm in that Resident B experienced a decline in mood since</p>	F 0319	F-319 It is the policy of the facility to ensure that residents who display mental or psychosocial adjustment difficulties receive appropriate treatment and services to correct the assessed problems. Resident B no longer resides in the facility. Residents who live in the facility and who display or might in the future display mental or psychosocial adjustment difficulties have the potential to be affected by this finding. Going forward, the SSD/Designee will review the 24 Hour Report daily	03/22/2016			

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	<p>admission and attempted suicide.</p> <p>Findings include:</p> <p>Resident B's closed clinical record was reviewed on 3/1/2016 at 12:40 p.m. Diagnoses included, but were not limited to, major depressive disorder, history of cerebral infarction (stroke), and weakness. Resident B was admitted to the facility on 1/17/2016, following a hospital admission for urinary tract infection and intractable (uncontrollable) vomiting.</p> <p>Resident B's admission Minimum Data Set (MDS) assessment, dated 1/24/2016, indicated a Brief Interview for Mental Status (BIMS) score of 9; indicating the resident was moderately cognitively impaired. Resident B's Mood score was 4; indicating no depression. The resident required staff assistance for all activities of daily living (ADL's) and self-propelled in his wheelchair for mobility.</p> <p>Resident B's change of [occupational] therapy MDS assessment, dated 2/21/2016, indicated a BIMS of 12; indicating the resident was moderately cognitively impaired. Resident B's Mood score was 9; indicating mild depression (5-9).</p> <p>Physician's orders for January and</p>		<p>as well as any results of any visits by psych services so that this information can be reviewed at the next daily CQI meeting to see that all notifications to the physician and family have been made. At that time, any needed assessments will be initiated by the appropriate modalities, care plans will be addressed, CNA assignment sheets will be updated. Any psych services recommendations will be initiated by the SSD/Designee. Follow up on progress being made such as an ordered med or an ordered appointment will be reported at the CQI meetings by SSD/Designee. The Administrator/DON will see that this process is part of the CQI agenda ongoing. At an in-service held for all staff (See F-250 response for this element)</p> <p>At the monthly Quality Assurance meeting (See F-250 response for this element)</p> <p>The facility respectfully requests a face to face IDR. The facility would like the opportunity to clearly and respectfully explain the circumstances surrounding the survey findings as their scope and severity do not reflect the facts</p>	

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	<p>February, 2016 included, but were not limited to, "Citalopram Hydrobromide tablet [Celexa (antidepressant)] 10 mg [milligrams]. Give 10 mg by mouth one time a day for Depression. Start Date: 1/18/2016...Lorazepam [antianxiety medication] Tablet 0.5 mg. Give 0.5 mg by mouth every 8 hours as needed for Anxiety. Start Date: 1/17/2016...."</p> <p>Resident B's Medication Administration Record (MAR) for January and February, 2016, indicated the resident received Celexa 10 mg one time daily from January 18, 2016, until his discharge 2/24/2016.</p> <p>Resident B's Medication Administration Record (MAR) for January and February, 2016, indicated the resident received Lorazepam 0.5 mg 10 times from 1/20/2016 through 2/23/2016.</p> <p>A care plan for Resident B indicated, "Focus: At risk for decline in mood r/t [related to] dx [diagnosis]: deprssion [sic] and on antidepressant. Date Initiated: 1/20/2016. Makes negative statements about self and has unrealistic expectations about wanting to live alone in house...wanting to drive. PHQ-9 [MDS Mood score] shows mild depression. Date Initiated: 2/12/2016. Revision on 3/1/2016. Goal: Will have</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/01/2016
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NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006
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	<p>no decline in mood daily TNR [until next review]. Date Initiated: 1/20/2016.</p> <p>Interventions [all initiated 1/20/2016]: Antidepressant per order. Encourage family involvement...Monitor for effectiveness of meds and interventions. Notify MD, Family and IDT [interdisciplinary team] of any changes. Observe for adverse reaction to antidepressant such as but not limited to: [blank]. Psych [psychiatry/psychology] consult as needed."</p> <p>A care plan for Resident B indicated, "Focus: At risk for increased anxiousness r/t dx: with need for anxiolytic [antianxiety]. Date Initiated: 1/20/2016. Becomes agitated when talking about past events and money. Yells and screams at staff. Date Initiated: 1/20/2016. Revision on: 3/1/2016. Goal: Will have no adverse reaction r/t Anxiolytic use TNR. Date Initiated: 1/20/2016. Interventions [all initiated 1/20/2016]: ...Anxiolytic per order...Encourage family involvement...Encourage to vent feelings...Monitor for effectiveness of meds and interventions. Notify md [sic], family and IDT of changes. Observe for adverse reactions to anxiolytic such as but not limited to: [blank]. Validate and assist."</p> <p>Resident B's Psychological Consultation note, related to a referral by the facility,</p>			

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	<p>dated 2/11/16, indicated, "the patient...just yesterday made a statement that if he had a gun he would probably shoot himself with it. The patient denies any active suicidal ideation in today's clinical contact, though notes that he feels at times as if his circumstances are so bleak that this becomes a consideration...he simply indicates that he is very frustrated with his life circumstances...[Resident B] notes that after he left the facility last year, he [went to] the home of his brother...that his brother in fact was helping himself to a great deal of the patient's money...there is little doubt that there is significantly increased depression ongoing with the patient...Recommendations (with attending Physician Discretion): 1. Please consider Celexa dosing increase to 20 mgs [milligrams] po [by mouth] qd [once daily]. 2. Continued follow up as appropriate, the patient seems to value from the opportunity to talk about his circumstances and the painful difficulties with which he continues to struggle at this juncture. 3. ...two strangers who essentially posed in his life as caretakers who he indicates took a lot of his money...This may be the case concurrently for brother, which I think in the long run is even sadder for the patient..."</p> <p>Resident B's Occupational Therapy</p>			

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	<p>Treatment Encounter Note, dated 2/13/2016, indicated, "...Comments: ...Resident expressed financial concerns to OTP [Occupational Therapist]. OTP reported to social services." Resident B's Occupational Therapy Recertification & Updated Plan of Treatment, dated 2/15/2016, indicated, "Progress: ...[Resident B] has made disparaging comments about himself and has stated that he wishes to die. Consult with SSD regarding sttements [sic]...." Physician's Progress Notes for Resident B, dated 2/15/2016, indicated, "...Is sad about overall physical condition...(9) Depression: stable. Describes himself as not necessarily happy...." There was no documentation in Resident B's clinical record to indicate Resident B received an increase of Celexa to 20 mg once daily, care plans were updated, or the physician was notified related to Resident B's increased depression scores, suicidal ideations, or psychology referral and recommendations.</p> <p>A Nurses Note, dated 2/24/2016 at 4:09 p.m., indicated, "Went into res [resident] room to do accu check [blood sugar test] and found res in w/c [wheelchair] with clear garbage bag over res head with black elecric [sic] cord, appears as charger for phone, around res neck. removed bag and cord. res stated just let</p>			

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	<p>me kill myself....res crying and distraught, wanting to die."</p> <p>LPN #4 was interviewed on 3/1/2016 at 3:40 p.m. She indicated she entered Resident B's room to check his blood sugar and find him in his wheelchair with a plastic trash bag over his head and what appeared to be a cell phone cord wrapped around his neck with his hands holding the cord fisted under his chin and around his neck. She indicated she immediately tore the plastic bag open and assessed the resident. LPN # 4 indicated his color and vital signs remained "good" [within normal limits] and he never lost consciousness. Documented vital signs indicated the same. LPN # 4 indicated Resident B was crying and indicated he wished to die.</p> <p>A Social Services Note for Resident B, dated 2/25/2016 at 10:27 a.m., and signed by the SSD, indicated, "Res was sent to [hospital] for psych [psychiatric] evaluation and treatment for suicidal ideation. Res was seen by in house psych earlier this month. After visit no recommendation for inpatient psych treatment. Med [medication] adjustment recommendations in place. See psych notes in chart." The previous Social Services Note was dated 1/29/2016 and was related to a change in Power of</p>			

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	<p>Attorney (POA).</p> <p>The Social Services Director (SSD) was interviewed on 3/1/2016 at 12:41 p.m. She indicated Resident B had concerns related to family dynamics, possible misappropriation of funds by his POA, and unrealistic expectations about returning home to live independently. She indicated she assisted the resident with a change in POA and alerted Adult Protective Services (APS) regarding the possible misappropriation of funds by family and/or caretakers. She indicated she did not notify or enlist the help of the Ombudsman. The SSD indicated she obtained an order for a psychology consult after therapy staff reported Resident B was making "negative statements." The SSD indicated, "When I did all my PHQ-9 [MDS mood] assessments, they showed he fell in the mild range, which is five to nine. His last assessment was on 2/21[2016], after making the negative statements." On 3/1/2016 at 2:40 p.m., the SSD indicated she was responsible for psychology consults and forwarding recommendations to nursing and the attending physician. She indicated she received Resident B's Psychological Consultation, dated 2/11/16, via fax on 2/16/16, reviewed it, and faxed it to</p>			

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	<p>Physician C (who was covering for Resident B's physician, Physician D, while she was on maternity leave) that day. The SSD indicated she normally advises nursing staff of any medication recommendations, but could not provide any documentation that she had done so, and nothing was indicated in the clinical record that anyone was notified of the recommendations. The SSD indicated that she did not change Resident B's care plan, interventions, or frequency of interaction related to the psychologist's second recommendation (above). The Director of Nursing (DON) was interviewed on 3/1/2016 at 2:45 p.m. The The DON indicated Resident B's recommended increased Celexa dose was never started. The DON indicated she learned Physician C was no longer covering for Physician D, but Resident B's psychology consult note and recommendations were not faxed/forwarded to Physician D.</p> <p>On 3/1/2016 at 3:33 p.m. the SSD was interviewed regarding the 2/25/2016 Social Services Note (above). She indicated, "Honestly, it was an assumption that it [medication increase] was in place."</p> <p>On 3/1/2016 at 3:50 p.m., the Administrator indicated the facility did</p>			

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	<p>not have a policy or procedure related to consults/referrals or consult/referral recommendations.</p> <p>A copy of the current Director of Social Services Job Description was provided by the Administrator on 3/1/2016 at 3:50 p.m. The document indicated, "...C. Role Responsibilities...5. Maintains significant social service progress notes on the resident's medical chart on a timely basis...6. Maintains a current social service plan..."</p> <p>On 3/1/2016 at 4:45 p.m., the DON indicated the SSD was responsible for following up on consults/referrals and recommendations.</p> <p>This Federal tag relates to Complaint IN00194421.</p> <p>3.1-43(a)(1)</p>			