

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155297	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/10/2012
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NAME OF PROVIDER OR SUPPLIER CONTINUING CARE CENTER OF LAPORTE HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1007 LINCOLNWAY LA PORTE, IN 46350
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: August 6, 7, 8, 9 & 10, 2012</p> <p>Facility number: 000194 Provider number: 155297 AIM number: 100267790</p> <p>Survey team: Lara Richards, RN, TC Heather Tuttle, RN Kathleen Vargas, RN</p> <p>Census bed type: SNF: 26 SNF/NF: 17 Total: 43</p> <p>Census payor type: Medicare: 16 Medicaid: 15 Other: 12 Total: 43</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 8/17/12 by Suzanne Williams, RN</p>	F0000		

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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F0156 SS=C	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes:</p>						

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	<p>A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the</p>			

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	<p>individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>Based on record review and interview, the facility failed to ensure residents received information on how to file a formal complaint with the State Agency. This had the potential to affect 43 residents residing in the facility.</p> <p>Findings include:</p> <p>Interview with the Resident Council Vice President on 8/10/12 at 1:15 p.m., indicated she was not aware on how to file a complaint with the State Agency. She indicated she had not received any information nor did she know where the information was posted.</p> <p>Review of the Resident Council Minutes for the past six months on 8/10/12 at 2:00 p.m., indicated there</p>	F0156	<p>1. The resident Council Vice President, res.#28 has recieved in writing the appropriate information on how to make contact with the state board of health complaint department. This was provided and reviewed with resident by the administrator and documented on the resident's record in progress notes.(see written attachment of content given to residents)2. The facility's failure to ensure all resident's recieved this information potentially affected the rights of all 43 residents residing in the facility.3. Written information on how to file a complaint will be given to all residents at the next Resident Council meeting on 09/05/12 and the written information will be reviewed line by line and discussed at length. This review and discussion will be recorded and documented in the minutes of the meeting. In</p>	09/07/2012	

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	<p>was no documentation related to informing the residents of how to file a complaint with the State Department of Health.</p> <p>Interview with the Activity Director on 8/10/12 at 2:05 p.m., indicated she goes over how to contact the State every month but she does not document that in her minutes.</p> <p>Interview with the Resident Council President on 8/10/12 at 2:15 p.m., indicated that she was not aware of how to file a complaint with the State.</p> <p>3.1-4(j)(3)(A)</p>		<p>addition, the residents will be physically shown where in the facility this information is posted and how they can locate it. Upon admission this information will be provided to all new residents in writing by the activities/social services staff. 4. Compliance with this process will be monitored by administrator, social services, and activities department staff during daily rounds and resident interviews. The results of these interviews will be logged and any concerns will be brought to the facility's Quality Assurance Committee for review and action planning on an ongoing basis.</p>		

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F0172 SS=C	<p>483.10(j)(1)&(2) RIGHT TO/FACILITY PROVISION OF VISITOR ACCESS</p> <p>The resident has the right and the facility must provide immediate access to any resident by the following:</p> <p>Any representative of the Secretary;</p> <p>Any representative of the State;</p> <p>The resident's individual physician;</p> <p>The State long term care ombudsman (established under section 307 (a)(12) of the Older Americans Act of 1965);</p> <p>The agency responsible for the protection and advocacy system for developmentally disabled individuals (established under part C of the Developmental Disabilities Assistance and Bill of Rights Act);</p> <p>The agency responsible for the protection and advocacy system for mentally ill individuals (established under the Protection and Advocacy for Mentally Ill Individuals Act);</p> <p>Subject to the resident's right to deny or withdraw consent at any time, immediate family or other relatives of the resident; and</p> <p>Subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, others who are visiting with the consent of the resident.</p> <p>The facility must provide reasonable access to any resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the</p>				

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	<p>resident's right to deny or withdraw consent at any time.</p> <p>Based on record review and interview, the facility failed to ensure the residents were provided information on who the Ombudsman was. This had the potential to affect the 43 residents residing in the facility.</p> <p>Findings include:</p> <p>Interview with the Resident Council Vice President on 8/10/12 at 1:15 p.m., indicated that she was not aware who the Ombudsman was for the facility.</p> <p>Review of the Resident Council Minutes for the past six months on 8/10/12 at 2:00 p.m., indicated there was no documentation to indicate the residents had been notified of who the Ombudsman was and how to contact her.</p> <p>Interview with the Activity Director on 8/10/12 at 2:05 p.m., indicated she tells the residents every month how to get in touch with the Ombudsman, however, she does not document this in her minutes.</p> <p>Interview with the Resident Council President on 8/10/12 at 2:15 p.m.,</p>	F0172	. The resident Council Vice President, res.#28 has recieved in writing the appropriate information on the identity of the facility's ombudsman and how to contact that individual and what their role as advocate is for the residents. This was provided and reviewed with resident by the administrator and documented on the resident's record in progress notes.(see written attachment of content given to residents)2. The facility's failure to ensure all resident's recieved this information potentially affected the rights of all 43 residents residing in the facility.3. Written information on the identity of the facility ombudsman and how to contact this individual as well as this person's role as advocate for the residents will be given to all residents at the next Resident Council meeting on 9/05/12 and the information will be reviewed and discussed at length. This review and discussion will be recorded and documented in the minutes of the meeting. In addition,the residents will be physically shown where in the facility this information is posted and how they can locate it. Upon admission this information will be provided to all new residents in writing by the activities/social services staff. 4. Compliance with this process will be monitored by administrator, social services,	09/07/2012			

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	indicated she was not aware of who the Ombudsman was or how to get into contact with them. 3.1-4(j)(3)(C)		and activities department staff during daily rounds and resident interviews. The results of these interviews will be logged and any concerns will be brought to the facility's Quality Assurance Committee for review and action planning on an ongoing basis.		

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F0223 SS=D	<p>483.13(b), 483.13(b)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>Based on record review and interview, the facility failed to ensure each resident was free from abuse related to a resident's complaints of feeling threatened and intimidated by licensed staff for 1 of 1 allegations of abuse reviewed. (Resident #59)</p> <p>Findings include:</p> <p>On 8/9/12 at 1:30 p.m., an allegation of abuse from Resident #59 was reviewed. The allegation was provided by the Director of Nursing.</p> <p>Review of the incident report dated 6/13/12 at 4:15 p.m., indicated "[Resident #59's] husband reported to [LPN #2] that his wife had been treated inhumanly and that she was very scared due to the way she had been treated by her midnight nurse, [LPN #1]. Both the resident and her husband were interviewed by the Administrator [name]. During the</p>	F0223	<p>1. Resident #59 was discharged from the facility on 8/1/12 prior to the start of the survey process. Review of the documented progress notes following the alleged occurrence on 6/13/12 at 1600 hrs. state "patient had a good shift today...resident out playing bingo this evening with husband and other residents. ...no distress noted." Progress note documented 6/14/12 at 04:15hrs. states: "patient in bed sleeping....pleasant and cooperative with staff...no complaints". Reviw of these progress notes following the alleged incident shows no documented evidence of residual negative psychosocial effects from alleged incident. 2. All resident residing in the Continuing Care facility has the potential to be affected by this deficiency. The facility administrator interviewed the 5 additional cognitively intact residents and there were no additional allegations or concerns voiced of any potentially abusive occurrences by any staff</p>	09/28/2012	

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	<p>interview, the resident stated the midnight nurse, [LPN #1] was mean and told her to get back into bed and be quiet the rest of the night or she was going to give her a shot so she would be quiet. The resident then commented she was so distressed by this during the night that she did not sleep all night out of fear the nurse would come in while she was asleep and give her that shot. Resident's husband confirmed to Administrator that this is the same story she told him when he arrived to the facility today."</p> <p>Review of the investigation of the allegation, indicated LPN #2 reported to the Administrator on 6/13/12 at 4:30 p.m. that Resident #59's husband stated his wife told him that the night nurse was rude and mean to her telling her she had to settle down and stay in bed and that if she didn't she was going to get a shot. The resident was uncomfortable about the shot and the way the nurse said it. LPN #2 reported LPN #1 stated in report that she said this to Resident #59. The written statement from LPN #2 confirmed specifics given to her by the midnight nurse.</p> <p>Review of the written statement made by LPN #2 on 6/13/12, indicated</p>		<p>member. These interviews will continue to be done of random residents during rounding by the facility social services staff monthly X 3 mos. . If no concerns are identified then this will be done during quarterly social services assessments.3. All staff will be extensively educated all throughout the next 30 days in the following areas: Signs of elder abuse, Definitions of types of abuse, How when and to whom reporting must be done per policy and review of facility abuse policy, Dealing with aggression and catastrophic reactions, The language of behavior and modifying approaches of staff, Recognizing and managing signs of stress and burnout that put staff at risk to perpetrate potential abuse. These educational classes are scheduled as follows: *Language of Behavior, Aggression and Catastrophic Reaction and Therapeutic Techniques and Approaches on September 14th, 2012. * Recognizing and Managing Signs of Staff Stress and Burn Out that May Lead to Abuse on September 21st, 2012. *Signs of Elder Abuse, Definitions of Different Types of Abuse/Neglect/Misappropriation of Property, Review of Policy and Procedure for Reporting Abuse/Neglect/Misappropriation of Property on September 28th, 2012.(see attached educational content and handouts for these</p>		

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	<p>"What was said in shift report this a.m., related to [room number] and Resident #59 [name]. The LPN #1 [name] was giving shift report on the above named patient. She said that at approximately 3-3:30 a.m., this patient woke up and started asking where her family was. The nurse tried to redirect her and was unable to. The patient just became louder and louder. LPN #1 said that she shut this patient's door and told her that she knew exactly how she was acting and to get back into bed and be quiet the rest of the night or she was going to give her a shot so she would be quiet. Later, in the shift, the husband told me everything word for word that LPN #1 [name] had told his wife during the night. He said that his wife was treated very inhumanly and that she said she was very scared. She didn't even want to tell him for fear of being treated this way again or even worse."</p> <p>Review of the written statement provided by CNA #2 [name] who worked the midnight shift on 6/13/12 with LPN #1 indicated "The resident was screaming 'help me, why are you treating me like an animal?' She was upset that she had a bed alarm on. After I explained to her it was for her safety she then said 'how am I going</p>		<p>classes)4. The ongoing prevention of abuse, neglect, or misappropriation fo resident property will be monitored by the new Continuing Care Center Abuse Prevention Team. The purpose of this interdisciplinary team is to identify and correct situations in which abuse, neglect or misappropriation could allegedly occur. The team will proactively try to identify, intervene and correct situations that could put a resident or the facility at risk for an alleged abuse, neglect or misappropriation of property. The team will also be responsible for generating and monitoring reports for patterns, occurrences, and trends. The team will ensure that correct and timely reporting and investigations are carried out. Following any investigation the team will meet to analyze their findings and determine if any action or changes in policy, procedure, education, or staffing are needed to prevent further occurrences. This team's findings will be reported quarterly to the Continuing Care Quality Assurance Committee quarterly. This team will be established and protocol in place by 9/10/2012. (see attached CCC Abuse Prevention Team Protocol Policy)</p>				

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	<p>to get from the garage to the bathroom?' I said to her [name] you are in the hospital not your garage and I can help you to the bathroom. She yelled at me saying 'Well what do you want me to do pee my pants?' I then helped her to the bathroom and she crawled back into bed. I then went and got LPN #1 to try to calm her down. LPN #1 went in her room and I stood outside the door. LPN #1 began talking to her asking her what was wrong. The resident again stated that we treat her like an animal and that we are going to pay for it. She asked to call her husband [name], LPN #1 dialed the number for her. She began arguing with him and then hung up on him. She was still yelling at us and said we're in big trouble. LPN #1 said [name] if you can't calm down I am going to have to give you something to help you calm down. The resident [name] said 'You cant' give me anything without my consent.' LPN #1 then said 'If I feel you are in danger to yourself or others I can give you something.'"</p> <p>Review of the written statement provided by LPN #1 indicated, "The resident's alarms were going off and I ran down the hall to her room. The resident was sitting on the edge of her bed. The resident began yelling</p>			

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	'where's my family? I woke up and no one is here. Get my family up here or there is gonna be hell to pay.' I tried explaining to her that her family was at home in bed asleep. She was yelling 'don't tell me that, I don't care, just get someone up here.' I asked the resident if she knew what time it was she said she did not care. I told her that it was going on midnight and that she needs to try and get some rest. She again began yelling 'I do not care what time it is just get my family up here.' I could not reason with her at this time. I then said to the resident, [name] you are an adult and I am adult so we are going to have an adult conversation. She began listening. I said [name] you are a grown adult and I believe that you are alert and oriented and that you know that this behavior is inappropriate and that you should not be behaving this way. I explained to her that her doctor ordered some medication that I could give her to help her calm down and get some rest. She began to yell 'I'm not taking any medicine and you're not given me a shot.' I then explained to her that she was disturbing the other residents waking them up and upsetting them. She started yelling 'I don't care just get my family up here or there is gonna be hell to pay.' Her face was flushed and			

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	<p>she was shaking her finger at me. I explained to the resident that if she cannot calm down and continues to disturb others and risks injuring herself by getting up unassisted which she had made several attempts to do that the doctor ordered her some medication in the form of a shot that I could give her to help her calm down and get some rest. She began yelling 'you're not giving me a shot, just let me call my husband.' I tried explaining to her that it was late and that her husband was probably sleeping. She replied, 'Ok please let me make just one call.' I said ok we will call your husband and then after that will you lay down and try to get some rest, she said 'yes.' The resident then talked to her husband for a few minutes, began yelling and hung up on him. Then I said ok are you ready to lay down and try to get some rest? She didn't answer me, she just crawled up in bed and covered herself up, asked where her call light was and I handed it to her."</p> <p>The record for Resident #59 was reviewed on 8/10/12 at 12:36 p.m. The resident was admitted to the facility on 5/8/12 and discharged home on 8/1/12.</p> <p>The resident's diagnoses included,</p>			

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	<p>but were not limited to, muscle weakness, urinary tract infection, hypertension, and cardiac pacemaker.</p> <p>Review of the Minimum Data Set (MDS) admission assessment dated 5/17/12, indicated the resident was alert and oriented with a (BIMS) brief interview for mental status of 13. The resident was coded as having no behaviors, no psychosis, and no hallucinations. The resident needed limited assistance with transfers, extensive assist with bed mobility, and limited assist with toileting. The resident was coded as not taking any psychotropic medications.</p> <p>Review of a care plan dated 6/3/12, indicated the resident [name] uses Ativan as needed for anxiety. The nursing approaches were to administer Ativan 1 milligram (mg) by mouth or intramuscularly (IM) every six hours as needed, and offer 1 to 1 visits, fluids, and toileting.</p> <p>Review of the current 7/1/08 policy regarding Reportable Unusual Occurrences provided by the Director of Nursing indicated, "...The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown</p>						

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	<p>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>Interview with LPN #2 on 8/9/12 at 1:20 p.m., indicated she was the nurse who took report from the midnight nurse (LPN #1) on 6/13/12. She indicated that she did not immediately report any of the information to the Administrator she received from the shift report from LPN #1. She indicated later in the day when the resident's husband reported to her that his wife was treated inhumanly and was scared to go sleep that was when she reported the allegation to the Administrator and the Director of Nursing (DON).</p> <p>Interview with the Director of Nursing on 8/9/12 at 2:10 p.m., indicated the allegation was not reported timely to the Administrator or herself when LPN #2 had received report in the morning from LPN #1. She indicated the day shift starts at 6:45 a.m.</p> <p>Interview with the Administrator on 8/9/12 at 2:44 p.m., indicated the</p>						

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	<p>allegation of abuse was not reported to her until 4:15 p.m., on 6/13/12. She indicated she had interviewed the resident and her husband and wrote down their statements.</p> <p>3.1-27(b)</p>			

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F0225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>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 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</p>	F0225	1. Resident #59 was discharged	09/28/2012			

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	<p>interview, the facility failed to ensure each resident was free from abuse, related to immediately reporting a resident's allegation of feeling threatened and intimidated by licensed staff to the Administrator for 1 of 1 allegation of abuse reviewed. (Resident #59)</p> <p>Findings include:</p> <p>On 8/9/12 at 1:30 p.m., an allegation of abuse from Resident #59 was reviewed. The allegation was provided by the Director of Nursing.</p> <p>Review of the incident report dated 6/13/12 at 4:15 p.m., indicated "[Resident #59's] husband reported to [LPN #2] that his wife had been treated inhumanly and that she was very scared due to the way she had been treated by her midnight nurse, [LPN #1]. Both the resident and her husband were interviewed by the Administrator [name]. During the interview, the resident stated the midnight nurse, [LPN #1] was mean and told her to get back into bed and be quiet the rest of the night or she was going to give her a shot so she would be quiet. The resident then commented she was so distressed by this during the night that she did not</p>		<p>from the facility on 8/1/12 prior to the start of the survey process. Review of the documented progress notes following the alleged occurrence on 6/13/12 at 1600 hrs. state "patient had a good shift today...resident out playing bingo this evening with husband and other residents. ...no distress noted." Progress note documented 6/14/12 at 04:15hrs. states: "patient in bed sleeping....pleasant and cooperative with staff....no complaints". Review of these progress notes following the alleged incident shows no documented evidence of residual negative psychosocial effects from alleged incident. 2. All resident residing in the Continuing Care facility has the potential to be affected by this deficiency.The facility administrator interviewed the 5 additional cognitively intact residents and there were no additional allegations or concerns voiced of any potentially abusive occurrences by any staff member. These interviews will continue to be done of random residents during rounding by the facility social services staff monthlyX 3mos. If no areas of concern then these will be done with social services assessments quarterly.3. All staff will be extensively educated all throughout the next 30 days in the following areas: Signs of elder abuse, Definitions of types of</p>				

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	<p>sleep all night out of fear the nurse would come in while she was asleep and give her that shot. Resident's husband confirmed to Administrator that this is the same story she told him when he arrived to the facility today."</p> <p>Review of the investigation of the allegation, indicated LPN #2 reported to the Administrator on 6/13/12 at 4:30 p.m. that Resident #59's husband stated his wife told him that the night nurse was rude and mean to her telling her she had to settle down and stay in bed and that if she didn't she was going to get a shot. The resident was uncomfortable about the shot and the way the nurse said it. LPN #2 reported LPN #1 stated in report that she said this to Resident #59. The written statement from LPN #2 confirmed specifics given to her by the midnight nurse.</p> <p>Review of the written statement made by LPN #2 on 6/13/12, indicated "What was said in shift report this a.m., related to [room number] and Resident #59 [name]. The LPN #1 [name] was giving shift report on the above named patient. She said that at approximately 3-3:30 a.m., this patient woke up and started asking where her family was. The nurse</p>		<p>abuse, How when and to whom reporting must be done per policy and review of facility abuse policy, Dealing with aggression and catastrophic reactions, The language of behavior and modifying approaches of staff, Recognizing and managing signs of stress and burnout that put staff at risk to perpetrate potential abuse. These educational classes are scheduled as follows: *Language of Behavior, Aggression and Catastrophic Reaction and Therapeutic Techniques and Approaches on September 14th, 2012. * Recognizing and Managing Signs of Staff Stress and Burn Out that May Lead to Abuse on September 21st, 2012. *Signs of Elder Abuse, Definitions of Different Types of Abuse/Neglect/Misappropriation of Property, Review of Policy and Procedure for Reporting Abuse/Neglect/Misappropriation of Property on September 28th, 2012.(see attached educational content and handouts for these classes)4. The ongoing prevention of abuse, neglect, or misappropriation fo resident property will be monitored by the new Continuing Care Center Abuse Prevention Team. The purpose of this interdisciplinary team is to identify and correct situations in which abuse, neglect or misappropriation could allegedly occur. The team will proactively try to identify,</p>		

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	<p>tried to redirect her and was unable to. The patient just became louder and louder. LPN #1 said that she shut this patient's door and told her that she knew exactly how she was acting and to get back into bed and be quiet the rest of the night or she was going to give her a shot so she would be quiet. Later, in the shift, the husband told me everything word for word that LPN #1 [name] had told his wife during the night. He said that his wife was treated very inhumanly and that she said she was very scared. She didn't even want to tell him for fear of being treated this way again or even worse."</p> <p>Review of the written statement provided by CNA #2 [name] who worked the midnight shift on 6/13/12 with LPN #1, indicated "The resident was screaming 'help me, why are you treating me like an animal?' She was upset that she had a bed alarm on. After I explained to her it was for her safety she then said 'how am I going to get from the garage to the bathroom?' I said to her [name] you are in the hospital not your garage and I can help you to the bathroom. She yelled at me saying 'Well what do you want me to do pee my pants?' I then helped her to the bathroom and she crawled back into bed. I then</p>		<p>intervene and correct situations that could put a resident or the facility at risk for an alleged abuse, neglect or misappropriation of property. The team will also be responsible for generating and monitoring reports for patterns, occurrences, and trends. The team will ensure that correct and timely reporting and investigations are carried out. Following any investigation the team will meet to analyze their findings and determine if any action or changes in policy, procedure, education, or staffing are needed to prevent further occurrences. This team's findings will be reported quarterly to the Continuing Care Quality Assurance Committee quarterly. This team will be established and protocol in place by 9/10/2012. (see attached CCC Abuse Prevention Team Protocol Policy)</p>		

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	<p>went and got LPN #1 to try to calm her down. LPN #1 went in her room and I stood outside the door. LPN #1 began talking to her asking her what was wrong. The resident again stated that we treat her like an animal and that we are going to pay for it. She asked to call her husband [name], LPN #1 dialed the number for her. She began arguing with him and then hung up on him. She was still yelling at us and said we're in big trouble. LPN #1 said [name] if you can't calm down I am going to have to give something to help you calm down. The resident [name] said 'You cant' give me anything without my consent.' LPN #1 then said 'If I feel you are in danger to yourself or others I can give you something.'"</p> <p>Review of the written statement provided by LPN #1 indicated, "The resident's alarms were going off and I ran down the hall to her room. The resident was sitting on the edge of her bed. The resident began yelling 'where's my family? I woke up and no one is here. Get my family up here or there is gonna be hell to pay.' I tried explaining to her that her family was at home in bed asleep. She was yelling 'don't tell me that, I don't care, just get someone up here.' I asked the resident if she knew what time it</p>						

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	<p>was, she said she did not care. I told her that it was going on midnight and that she needs to try and get some rest. She again began yelling 'I do not care what time it is just get my family up here.' I could not reason with her at this time. I then said to the resident, [name] you are an adult and I am adult so we are going to have an adult conversation. She began listening. I said [name] you are a grown adult and I believe that you are alert and oriented and that you know that this behavior is inappropriate and that you should not be behaving this way. I explained to her that her doctor ordered some medication that I could give her to help her calm down and get some rest. She began to yell 'I'm not taking any medicine and you're not given me a shot.' I then explained to her that she was disturbing the other residents waking them up and upsetting them. She started yelling 'I don't care just get my family up here or there is gonna be hell to pay.' Her face was flushed and she was shaking her finger at me. I explained to the resident that if she cannot calm down and continues to disturb others and risks injuring herself by getting up unassisted, which she had made several attempts to do, that the doctor ordered her some medication in the form of a shot</p>			

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	<p>that I could give her to help her calm down and get some rest. She began yelling 'you're not giving me a shot, just let me call my husband.' I tried explaining to her that it was late and that her husband was probably sleeping. She replied, 'Ok please let me make just one call.' I said ok we will call your husband and then after that will you lay down and try to get some rest, she said 'yes.' The resident then talked to her husband for a few minutes, began yelling and hung up on him. Then I said ok are you ready to lay down and try to get some rest? She didn't answer me, she just crawled up in bed and covered herself up, asked where her call light was and I handed it to her."</p> <p>Interview with LPN #2 on 8/9/12 at 1:20 p.m., indicated she was the nurse who took report from the midnight nurse [LPN #1] on 6/13/12. She indicated that she did not immediately report any of the information to the Administrator she received from shift report from LPN #1. She indicated later in the day when the resident's husband reported to her that his wife was treated inhumanly and was scared to go sleep, that was when she reported the allegation to the Administrator and the Director of Nursing (DON).</p>			

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	<p>Interview with the Director of Nursing on 8/9/12 at 2:10 p.m., indicated the allegation was not reported timely to the Administrator or herself when LPN #2 had received report in the morning from LPN #1. She indicated the day shift starts at 6:45 a.m.</p> <p>Interview with the Administrator on 8/9/12 at 2:44 p.m., indicated the allegation of abuse was not reported to her until 4:15 p.m., on 6/13/12. She indicated she had interviewed the resident and her husband and wrote down their statements.</p> <p>3.1-28(c)</p>				

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F0226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>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 ensure their abuse prevention protocol was implemented related to reporting and investigating a resident's complaints of feeling threatened and intimidated by licensed staff for 1 of 1 allegation of abuse reviewed. (Resident #59)</p> <p>Findings include:</p> <p>On 8/9/12 at 1:30 p.m., an allegation of abuse from Resident #59 was reviewed. The allegation was provided by the Director of Nursing.</p> <p>Review of the incident report dated 6/13/12 at 4:15 p.m., indicated "[Resident #59's] husband reported to [LPN #2] that his wife had been treated inhumanly and that she was very scared due to the way she had been treated by her midnight nurse, [LPN #1]. Both the resident and her husband were interviewed by the Administrator [name]. During the interview, the resident stated the</p>	F0226	. Resident #59 was discharged from the facility on 8/1/12 prior to the start of the survey process. Review of the documented progress notes following the alleged occurrence on 6/13/12 at 1600 hrs. state "patient had a good shift today...resident out playing bingo this evening with husband and other residents. ...no distress noted." Progress note documented 6/14/12 at 04:15hrs. states: "patient in bed sleeping....pleasant and cooperative with staff....no complaints". Reviw of these progress notes following the alleged incident shows no documented evidence of residual negative psychosocial effects from alleged incident. 2. All resident residing in the Continuing Care facility has the potential to be affected by this deficiency.The facility administrator interviewed the 5 additional cognitively intact residents and there were no additional allegations or concerns voiced of any potentially abusive occurrences by any staff member. These interviews will continue to be done of random residents during rounding by the	09/28/2012

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	<p>midnight nurse, [LPN #1] was mean and told her to get back into bed and be quiet the rest of the night or she was going to give her a shot so she would be quiet. The resident then commented she was so distressed by this during the night that she did not sleep all night out of fear the nurse would come in while she was asleep and give her that shot. Resident's husband confirmed to Administrator that this is the same story she told him when he arrived to the facility today."</p> <p>Review of the investigation of the allegation indicated LPN #2 reported to the Administrator on 6/13/12 at 4:30 p.m., that Resident #59's husband stated his wife told him that the night nurse was rude and mean to her telling her she had to settle down and stay in bed and that if she didn't she was going to get a shot. The resident was uncomfortable about the shot and the way the nurse said it. LPN #2 reported LPN #1 stated in report that she said this to Resident #59. The written statement from LPN #2 confirmed specifics given to her by the midnight nurse.</p> <p>Review of the written statement made by LPN #2 on 6/13/12, indicated "What was said in shift report this</p>		<p>facility social services staff monthly X 3 mos. If no concerns then this will be done with quarterly social services assessments.3. All staff will be extensively educated all throughout the next 30 days in the following areas: Signs of elder abuse, Definitions of types of abuse, How when and to whom reporting must be done per policy and review of facility abuse policy, Dealing with aggression and catastrophic reactions, The language of behavior and modifying approaches of staff, Recognizing and managing signs of stress and burnout that put staff at risk to perpetrate potential abuse. These educational classes are scheduled as follows: *Language of Behavior, Aggression and Catastrophic Reaction and Therapeutic Techniques and Approaches on September 14th, 2012. * Recognizing and Managing Signs of Staff Stress and Burn Out that May Lead to Abuse on September 21st, 2012. *Signs of Elder Abuse, Definitions of Different Types of Abuse/Neglect/Misappropriation of Property, Review of Policy and Procedure for Reporting Abuse/Neglect/Misappropriation of Property on September 28th, 2012.(see attached educational content and handouts for these classes)4. The ongoing prevention of abuse, neglect, or misappropriation fo resident</p>				

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	<p>a.m., related to [room number] and Resident #59 [name]. The LPN #1 [name] was giving shift report on the above named patient. She said that at approximately 3-3:30 a.m., this patient woke up and started asking where her family was. The nurse tried to redirect her and was unable to. The patient just became louder and louder. LPN #1 said that she shut this patient's door and told her that she knew exactly how she was acting and to get back into bed and be quiet the rest of the night or she was going to give her a shot so she would be quiet. Later, in the shift, the husband told me everything word for word that LPN #1 [name] had told his wife during the night. He said that his wife was treated very inhumanly and that she said she was very scared. She didn't even want to tell him for fear of being treated this way again or even worse."</p> <p>Review of the written statement provided by CNA #2 [name] who worked the midnight shift on 6/13/12 with LPN #1, indicated "The resident was screaming 'help me, why are you treating me like an animal?' She was upset that she had a bed alarm on. After I explained to her it was for her safety she then said 'how am I going to get from the garage to the</p>		<p>property will be monitored by the new Continuing Care Center Abuse Prevention Team. The purpose of this interdisciplinary team is to identify and correct situations in which abuse, neglect or misappropriation could allegedly occur. The team will proactively try to identify, intervene and correct situations that could put a resident or the facility at risk for an alleged abuse, neglect or misappropriation of property. The team will also be responsible for generating and monitoring reports for patterns, occurrences, and trends. The team will ensure that correct and timely reporting and investigations are carried out. Following any investigation the team will meet to analyze their findings and determine if any action or changes in policy, procedure, education, or staffing are needed to prevent further occurrences. This team's findings will be reported quarterly to the Continuing Care Quality Assurance Committee quarterly. This team will be established and protocol in place by 9/10/2012. (see attached CCC Abuse Prevention Team Protocol Policy)</p>				

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	<p>bathroom?' I said to her [name] you are in the hospital not your garage and I can help you to the bathroom. She yelled at me saying 'Well what do you want me to do pee my pants?' I then helped her to the bathroom and she crawled back into bed. I then went and got LPN #1 to try to calm her down. LPN #1 went in her room and I stood outside the door. LPN #1 began talking to her asking her what was wrong. The resident again stated that we treat her like an animal and that we are going to pay for it. She asked to call her husband [name], LPN #1 dialed the number for her. She began arguing with him and then hung up on him. She was still yelling at us and said we're in big trouble. LPN #1 said [name] if you can't calm down I am going to have give something to help you calm down. The resident [name] said 'You cant' give me anything without my consent.' LPN #1 then said 'If I feel you are in danger to yourself or others I can give you something.'"</p> <p>Review of the written statement provided by LPN #1 indicated "The resident's alarms were going off and I ran down the hall to her room. The resident was sitting on the edge of her bed. The resident began yelling 'where's my family? I woke up and no</p>			

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	<p>one is here. Get my family up here or there is gonna be hell to pay.' I tried explaining to her that her family was at home in bed asleep. She was yelling 'don't tell me that I don't care just get someone up here.' I asked the resident if she knew what time it was she said she did not care. I told her that it was going on midnight and that she needs to try and get some rest. She again began yelling 'I do not care what time it is just get my family up here.' I could not reason with her at this time. I then said to the resident, [name] you are an adult and I am adult so we are going to have and adult conversation. She began listening. I said [name] you are a grown adult and I believe that you are alert and oriented and that you know that this behavior is inappropriate and that you should not be behaving this way. I explained to her that her doctor ordered some medication that I could give her to help her calm down and get some rest. She began to yell 'I'm not taking any medicine and you're not given me a shot.' I then explained to her that she was disturbing the other residents waking them up and upsetting them. She started yelling 'I don't care just get my family up here or there is gonna be hell to pay.' Her face was flushed and she was shaking her finger at me. I</p>			

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	<p>explained to the resident that if she cannot calm down and continues to disturb others and risks injuring herself by getting up unassisted which she had made several attempts to do that the doctor ordered her some medication in the form of a shot that I could give her to help her calm down and get some rest. She began yelling 'you're not giving me a shot, just let me call my husband.' I tried explaining to her that it was late and that her husband was probably sleeping. She replied, 'Ok please let me make just one call.' I said ok we will call your husband and then after that will you lay down and try to get some rest, she said 'yes.' The resident then talked to her husband for a few minutes, began yelling and hung up on him. Then I said ok are you ready to lay down and try to get some rest? She didn't answer me, she just crawled up in bed and covered herself up, asked where her call light was and I handed it to her."</p> <p>Review of the current 7/1/08 policy regarding Reportable Unusual Occurrences provided by the Director of Nursing indicated, "...The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of</p>				

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	<p>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>Review of the current 7/1/08 Abuse Prohibition Review, provided by the Director of Nursing, indicated "it is not only the responsibility of every employee of [name of facility] to not only report abuse situations, but also suspicion of abuse and unusual observations and circumstances, to their immediate supervisor."</p> <p>Interview with LPN #2 on 8/9/12 at 1:20 p.m., indicated she was the nurse who took report from the midnight nurse (LPN #1) on 6/13/12. She indicated that she did not immediately report any of the information to the Administrator she received from shift report from LPN #1. She indicated later in the day when the resident's husband reported to her that his wife was treated inhumanly and was scared to go sleep, that was when she reported the allegation to the Administrator and the Director of Nursing (DON).</p> <p>Interview with the Director of Nursing</p>				

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	<p>on 8/9/12 at 2:10 p.m., indicated the allegation was not reported timely to the Administrator or herself when LPN #2 had received report in the morning from LPN #1. She indicated the day shift starts at 6:45 a.m.</p> <p>Interview with the Administrator on 8/9/12 at 2:44 p.m., indicated the allegation of abuse was not reported to her until 4:15 p.m., on 6/13/12. She indicated she had interviewed the resident and her husband and wrote down their statements.</p> <p>3.1-28(a)</p>			

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F0241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, record review and interview, the facility failed to ensure the residents' dignity was maintained related to the lack of utilizing a dignity bag for a resident with a urinary catheter in place, for 1 of 3 residents reviewed for urinary catheter use of the 7 residents who met the criteria for urinary catheter use. (Resident #56)</p> <p>Findings include:</p> <p>Resident #56 was observed on 8/8/12 at 9:02 a.m. She was sitting on the edge of the bed. The resident was observed to have a urinary catheter in place (a tube inserted into the bladder to drain urine). There was a drainage bag attached to the bed frame that had a collection of yellow urine. The drainage bag was not in a dignity bag, a bag that is opaque and does not allow the urine to be observed.</p> <p>On 8/8/12 at 11:29 a.m. and at 12:30 p.m., the resident was observed sitting on the edge of the bed. The</p>	F0241	<p>1. Resident # 56 has recieved a foley drainage bag dignity cover from central supply. 2. All other residents with foley catheter drainage bags have the potential to have their dignity compromised. To prevent this from occuring the CCC DNS has ordered 24 urinary drainage bag dignity covers to ensure there is an adequate supply of these covers for all foley residents. These will arrive and be in place on all drainage bags by 9/7/12. (see attached PO form)3. The staff will be educated on 9/7/12 on the need to maintain and preserve resident dignity by ensuring that all residents with a foley cath drainage bag has a dignity cover while up out of bed. When residents are in bed staff will be instructed to make sure the drainage bag is positioned on the bed so that the white opaque side is showing and not the urine exposed side so upon entering the room the resident's dignity is preserved. (see education content forwarded)4. The ongoing use and placement of the drainage bag dignity covers will be monitored by the charge nurses on the units for each team</p>	09/07/2012
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	<p>urinary catheter bag was hooked to the bottom of the bed frame. The catheter bag was not in a dignity bag, the urine in the bag was visible from the door of the resident's room.</p> <p>On 8/9/12 at 1:49 p.m., the resident was observed in a chair in her room. The resident's urinary catheter drainage bag was attached to the chair. The drainage bag was not in a dignity bag, the resident's urine was visible.</p> <p>The resident was observed on 8/9/12 at 4:19 p.m. She was seated in a wheelchair in her room. The resident's urinary catheter drainage bag was attached to the bottom of the wheelchair. The urinary catheter drainage bag was not in a dignity bag. There was urine visible in the drainage bag.</p> <p>The record for Resident #56 was reviewed on 8/9/12 at 2:48 p.m. The resident had diagnoses that included, but were not limited to, osteoarthritis, overactive bladder and hypertension.</p> <p>The Physician Order Sheet, dated August 2012, indicated an indwelling catheter was anchored in place.</p> <p>The Quarterly Minimum Data Set</p>		daily each shift. The additional monitoring by DNS, administrator, or case managers will occur weekly during unit rounds. Any deficient use of covers will be addressed at the time they are found and corrected by appropriate staff.		

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	<p>(MDS) assessment, dated 7/3/12, indicated the resident had an indwelling catheter in place.</p> <p>Certified Nursing Assistant #1 was interviewed on 8/9/12 at 4:40 p.m. She indicated dignity bags were used for residents with urinary catheters. She indicated Resident #56 did not have a dignity bag in place for her urinary catheter. She did not know why a dignity bag was not used for the resident's urinary catheter.</p> <p>Interview with the Director of Nursing on 8/9/12 at 4:45 p.m., indicated the resident's urinary drainage bag should either be in a dignity bag or should be turned and positioned so that the urine in the bag is not visible.</p> <p>3.1-3(t)</p>				

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F0329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure the residents were free from unnecessary medications related to the lack of attempting to use non-pharmaceutical interventions prior to the administration of antianxiety medications and for the lack of an indication for the use of an antianxiety medication for 1 of 10 residents reviewed for unnecessary medications. (Resident #31)</p>	F0329	<p>1. Resident # 31 now has a documented diagnosis of anxiety per MD. We have also documented the non-pharmaceutical interventions for this individual on her current careplan. 2. All residents with orders for PRN psychoactive medication has the potential to have the unnecessary use of PRN psychoactive medications and the use of PRN medications without documented indication for use or documented evidence of non-pharmaceutical interventions prior to medication use. There</p>	09/07/2012

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	<p>Findings include:</p> <p>The record for Resident #31 was reviewed on 8/8/12 at 2:37 p.m. The resident had diagnoses that included, but were not limited to, diabetes, depression and mood disorder.</p> <p>The quarterly Minimum Data Set (MDS) assessment, dated 8/1/12, indicated the resident had a BIMS (Brief Interview for Mental Status) score of 7, which indicated severe cognitive impairment.</p> <p>The July 2012 and the August 2012 Medication Administration Records (MAR) indicated the resident had a Physician's order for lorazepam (an antianxiety medication) 0.5 mg (milligrams) by mouth every 6 hours prn (as needed) for anxiety.</p> <p>Review of the July 2012 MAR and the August 2012 MAR, indicated lorazepam was administered to the resident on 7/28/12, on 7/29/12 twice, on 8/1/12 and on 8/5/12.</p> <p>Review of July 2012 MAR indicated lorazepam 0.5 mg was administered to the resident on 7/28/12 at 2:10 p.m. for increased anxiety. There was no evidence on the MAR that non-pharmaceutical interventions</p>		<p>was an audit by the DNS of six additional residents who recieved PRN psychoactive medication during the survey month. All six of these records showed supporting documentation of non pharmacological interventions attempted prior to medication, each record had an aopropriate behavior careplan in place with interventions that coorelated with those on the behavior log, and behaviors noted by the administering nurses were also documented on the behavior logs. There were no additional deficiencies noted in these records.(see audit sheets sent)3. To prevent this reoccurrence of unecessary use of medications the following processes will be implemented:All licensed staff will be educated on the implementation and use of the Behavior and Intervention Flow Record and how to accurately document behavioral indications for each resident. In addition, they will be educated on how to appropriately document all non-pharmaceutical interventions attempted to calm or redirect resident who is showing acting out behaviors. There will be a new process of documentation every shift on behavioral logs. Education will include appropriate use of medication only when non-pharmaceutical interventions are not effective and documentation supports this. In addition there will be a new</p>		

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	<p>were attempted prior to the administration of the lorazepam on 7/28/12.</p> <p>Review of the form titled, "Behavior/Intervention Monthly Flow Record" dated July 2012, indicated there was no evidence the resident exhibited behaviors on 7/28/12. There was no evidence that interventions were attempted to decrease behaviors prior to the administration of an antianxiety medication.</p> <p>Review of the nursing progress notes, dated 7/28/12, indicated there was no evidence that non-pharmaceutical interventions were attempted prior to the use of the antianxiety medication.</p> <p>Review of August 2012 MAR, indicated lorazepam 0.5 mg was administered to the resident on 8/5/12 at 9:30 p.m. There was no evidence of an indication for the use of the antianxiety medication on the MAR. There was no evidence that non-pharmaceutical interventions were attempted prior to the administration of the lorazepam on 8/5/12 on the MAR.</p> <p>Review of the "Behavior/Intervention Monthly Flow Record" dated August 2012, indicated there was no</p>		<p>process implemented that any resident with a PRN psychoactive medication upon admission will be reviewed by the case managers and an individualized careplan including non-pharmaceutical interventions for each resident will be completed. If the PRN medication is begun after resident admission then the nurse receiving the PRN order will be responsible to initiate and complete the careplan with interventions. (see education content and new documentation policy forwarded) 4. The appropriate use of PRN psychoactive medication use and it's supporting documentation will be monitored for compliance monthly by case managers who will audit 10% of all residents with PRN psychotropics, pharmacy consultant during monthly visits, and during quarterly psychotropic reduction meetings with care team. (see forwarded audit form)</p>		

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	<p>evidence the resident exhibited behaviors on 8/5/12. There was no evidence that interventions were attempted to decrease behaviors prior to the administration of the lorazepam.</p> <p>Review of the nursing progress notes, dated 8/5/12, indicated there was no evidence of an indication for the use of lorazepam. There was no evidence of non-pharmaceutical interventions used prior to the use of the antianxiety medication.</p> <p>The policy titled, "Medication Monitoring" that was dated October 2011, was provided by the Director of Nursing on 8/9/12. She indicated the policy was current. The policy indicated "Non-pharmaceutical interventions such as behavior modifications or social services and their effects are documented as a part of the care planning process, and are utilized by the prescriber in assessing the continued need for psychoactive medication."</p> <p>Interview with Case Manager #1 on 8/9/12 at 1:10 p.m., indicated there was no evidence that non-pharmaceutical interventions were attempted prior to the use of the antianxiety medication on 7/28/12 and</p>			

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NAME OF PROVIDER OR SUPPLIER CONTINUING CARE CENTER OF LAPORTE HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1007 LINCOLNWAY LA PORTE, IN 46350
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	<p>on 8/5/12. She also indicated there was no evidence of an indication for the use of the antianxiety medication on 8/5/12.</p> <p>3.1-48(a)(4)</p>			

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F0356 SS=C	<p>483.30(e) POSTED NURSE STAFFING INFORMATION</p> <p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation and interview, the facility failed to post the Nursing Staffing information on a daily basis and in a clear and readable format which included the facility address, the total number of hours for</p>	F0356	<p>1. The facility's failure to adequately post the daily staffing data had the potential to affect 43 residents residing in the facility and their visitors. 2. Beginning on 9/10/2012 the facility's unit coordinator will assume the</p>	09/10/2012

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NAME OF PROVIDER OR SUPPLIER CONTINUING CARE CENTER OF LAPORTE HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 1007 LINCOLNWAY LA PORTE, IN 46350		
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	<p>Registered Nurses, Licensed Practical Nurses and Certified Nurse Aides. This had the potential to affect 43 residents residing in the facility and their visitors.</p> <p>Findings include:</p> <p>Observation on 8/6/12 at 9:41 a.m., indicated there was no nurse staffing information posted on the two floors of the facility that included the total number and the actual hours worked by the licensed and unlicensed nursing staff directly responsible for resident care per shift.</p> <p>Continued observations on 8/7/12 at 11:00 a.m. and on 8/8/12 at 9:15 a.m., indicated there was no nurse staffing hours posted.</p> <p>Interview with the Director of Nursing on 8/8/12 at 10:35 a.m., indicated the nursing staffing hours were not posted in the facility on a daily basis. She indicated she was not aware of the need to post the nursing hours.</p> <p>3.1-13(a)</p>		<p>responsibility to post daily the facility name, current date, the total number and the actual hours worked of RNs, LPNs, and CNAs for each shift daily. This will be done on a staffing data form that is large bolded font, and posted in the front of each nurses station reception area at wheelchair visible level inside a clear plastic frame. (see forwarded attachment) Daily copies will be removed from the frame and kept in a three ring binder in the DNS office for 18 consecutive months for viewing upon request. 3. This ongoing posting of staff and facility data will be monitored daily during unit rounds for compliance by the DNS, administrator, case managers, and charge nurses. These rounds will be done each shift by charge nurses for each unit's team, and monitored by administrator, DNS, or case managers once daily during rounds. If there is a deficiency noted in the posting it will be addressed and corrected immediately by the unit coordinator on duty.</p>		