

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155549	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/20/2014
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NAME OF PROVIDER OR SUPPLIER WILLOWBEND LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: February 17, 18, 19 and 20, 2014</p> <p>Facility Number: 000681 Provider Number: 155549 AIM Number: 100286100</p> <p>Survey Team: Tina Smith-Staats, RN, TC Toni Maley, BSW Karen Lewis, RN Ginger McNamee, RN Angela Selleck, RN (February 18, 19 and 20, 2014)</p> <p>Census Bed Type: SNF/NF: 42 Total: 42</p> <p>Census Payor Type: Medicare: 10 Medicaid: 31 Other: 1 Total: 42</p> <p>These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed by Debora</p>	F000000	<p>Submission of the Plan of Correction does not constitute an admission to or an agreement with facts alleged on the survey report. Submission of this Plan of correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. The Plan of Correctio is prepared and submitted because of requirements under State and Federal law. Please accept this Plan of Correction as our credible allegation of compliance.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F000323 SS=D	<p>Barth, RN.</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to ensure interventions identified in the resident's plan of care to prevent falls were in place to help prevent falls for 1 of 3 residents reviewed who met the criteria for accidents. (Resident #22)</p> <p>Findings include: The clinical record for Resident #22 was reviewed on 2/19/14 at 8:39 a.m. Diagnoses for Resident #22 included, but were not limited to, hypoxemia, chronic respiratory failure, hypertension, obstructive sleep apnea, obesity, congestive heart failure, debility, unsteady gait, anemia, osteoarthritis, rheumatoid arthritis, transient ischemic attack, depression, atrial fibrillation, depression, anxiety, Alzheimer's dementia and osteoporosis.</p>	F000323	<p>1. Resident #22 did not experience any negative outcomes from being lowered to the ground. The resident is being assisted as per the individual plan of care. 2. All residents have the potential to be affected. Clinical records were reviewed and if a fall was noted caused by not following the individual resident's plan of care, correcti action was completed. 3. The facility's policy for falls was reviewed with no changes indicated (See Attachment E). The nursing staff was re-educated on the policy with a special focus on providing assistance as per the individual's plan of care (See Attachment F). A Transfer Procedure Observation form has been implemented (See Attachment G). 4. The DON or designee will be responsible for completing the Transfer Procedure Observation form to ensure staff is following the individualized plan of care for the residents related to correct transfer and fall prevention. Five</p>	03/05/2014
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	<p>A review of the Admission Minimum Data Set assessment, dated 12/28/13, indicated the resident was cognitively impaired, and required extensive assistance of 2 staff members for transfers and toileting.</p> <p>A Fall Risk assessment, dated 1/4/14, indicated the resident was at risk for falls.</p> <p>A health care plan problem, dated 1/2/14, indicated Resident #22 was a risk for falls due to multiple health issues including impaired mobility and limited range in bilateral lower extremities. Approaches for this problem included, but were not limited to, "require assist of two with transfer".</p> <p>Review of the Post Fall Investigation report, dated 2/11/14, for the fall indicated the resident was being assisted, in transfer from bed to chair, by one staff member. During the transfer the resident started to slip and went down to one knee. The report further indicated the staff were not performing the skill correctly and did not follow the care plan for an assist of two during transfers.</p>		<p>residents will be monitored on scheduled work days as follows: Daily for two weeks, weekly for two weeks, then monthly thereafter. Should a concern be noted, immediate corrective action will occur. Results of these reviews will be discussed during the facility's quarterly QA meetings for a minimum of 6 months and the plan adjusted accordingly, if indicated.</p>		

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F000329 SS=D	<p>During an interview with the Director of Nursing on 2/20/14 at 1:14 p.m., she indicated staff had not followed the care plan for transferring Resident #22. She further indicated Resident #22 should have had two staff assist during any transfers.</p> <p>3.1-45(a)(2)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, interview and record review, the facility failed to ensure residents with antipsychotic medication had dose reductions or</p>	F000329	1. The psychoactive medications for Resident #43 have been reviewed. Reduction attempts have been initiated or detailed	03/05/2014			

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	<p>statements of contraindication and residents did not have an increase in mood stabilizing medications without adequate indication for the increase for 1 of 5 residents reviewed for unnecessary medication (Resident #43).</p> <p>Findings include:</p> <p>Resident #43's record was reviewed on 2/19/14 at 10:15 a.m. Resident #43's current diagnoses included, but were not limited to, anxiety, Alzheimer's disease with behavioral disturbances and depression. Resident #43 was admitted to the facility on 5/24/13.</p> <p>Resident #43 had current physician's orders for:</p> <p>a.) Seroquel 100 mg (an antipsychotic medication) 1 and 1/2 tablets daily and Seroquel 25 mg 1 tablet daily. The two orders resulted in a total dose of Seroquel 175 mg daily. These two orders originated upon admission on 5/24/13.</p> <p>b.) Depakote 250 mg (a mood stabilizer) 1 tablet two times daily for dementia with agitation. This order originated 2/7/14 and was an increase in medication.</p>		<p>statements of contraindication have been received.2. All other residents receiving psychoactive medications have been reviewed and a reduction attempt has been initiated or detailed statement of contraindication has been received if applicable.3. The facility's policies for Gradual Dose Reductions for psychoactive medication have been reviewed and no changes are indicated at this time (See Attachment H). The facility's care plan team has been re-educated on the policies with a special focus on reduction attempts and detailed statements of contraindication (See Attachment I). A Monthly Mood and Behavior Review form (See Attachment J) and a Psychotropic Medication Monitoring form (See Attachment K) have been implemented.4. The SSD or designee will be responsible for completing the Monthly Mood and Behavior Review form to ensure dose reduction attempts are timely and statements of contraindication are detailed. This monitoring will occur monthly for psychoactive orders already in place on an ongoing basis and the Monthly Mood and Behavior Review form will be completed. The DON or designee will be responsible for completing the Psychotropic Medication Monitoring form. The monitoring will occur daily on scheduled work days for any new psychoactive orders and the Psychotropic</p>		

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	<p>Resident #43's record lacked a gradual dose reduction or a statement of contraindication which included an evaluation of the residents condition and a risk benefit analysis for the use of the antipsychotic medication Seroquel since admission on 5/24/13.</p> <p>Resident #43 had three documented behavioral episodes during the month of January 2014. These events occurred on 1/24/14, 1/16/14 and 1/14/14. Each event involved exit seeking behavior and was documented as calmed or improved after staff intervention. The only documented event in February 2014 prior to the increase of the mood stabilizer Depakote occurred on 2/7/14 (the same date as the increase). A 2/7/14, "Mood and Behavior Communication Memo" indicated the resident's behavior improved after as needed medication use.</p> <p>On 2/17/14 at 11:45 a.m., Resident #43 was observed calmly eating lunch.</p> <p>On 2/19/14 at 10:35 a.m., Resident #43 was observed napping in his recliner.</p> <p>On 2/19/14 at 1:25 p.m., Resident</p>		Medication Monitoring form will be completed on an ongoing basis. Should a concern be found with any of the monitoring, immediate corrective action will occur. Results of these reviews will be discussed during the facility's quarterly QA meetings and the plan adjusted, if indicated.				

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	<p>#43 was observed playing checkers. He was calm, conversational and laughing.</p> <p>During a 2/20/14, 1:10 p.m., interview, the Director of Nursing indicated Resident #43 did not have any additional behavioral concerns prior to the increase of the Depakote on 2/7/14. The mood stabilizer was increased following the 2/7/14 event and not based on a series of events. Resident #43 did not have a gradual dose reduction or statement of contraindication with a risk benefit analysis for the use of Seroquel.</p> <p>A current, 5/09, facility policy titled "Antipsychotic Drug Use Policy", which was provided by the Director of Nursing" indicated the following: "Gradual dose reduction will be attempted, unless clinically contraindicated, in an effort to discontinue these drugs."</p> <p>3.1-48(a)(6)</p>				

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F000514 SS=D	<p>483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on observation, interview and record review, the facility failed to ensure as needed medication was documented on the medication record when administered to ensure proper assessment and treatment of the resident's condition and in accordance with facility policy for 1 of 5 resident reviewed for unnecessary medication use. (Resident #43).</p> <p>Findings include:</p> <p>Resident #43's record was reviewed on 2/19/14 at 10:15 a.m. Resident #43's current diagnoses included, but were not limited to, anxiety, Alzheimer's disease with behavioral disturbances and depression. Resident #43 was admitted to the</p>	F000514	<p>1. The clinical record for Resident #43 has been reviewed and PRN medications are being documented as given when indicated. 2. All other residents with PRN medication orders have the potential to be affected. Their clinical records have been reviewed and PRN medications are being documented as given when indicated. 3. The facility's policy for Medication Administration (See Attachment A) has been reviewed and no changes are indicated at this time. The nurses and QMAs have been re-educated on the policy with a special focus on signing out of PRN medications (See Attachment B). A PRN Monitoring form has been implemented (See Attachment C). A Behavior Memo Review form has been initiated (See Attachment D). 4. SSD will be</p>	03/05/2014	

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	<p>facility on 5/24/13.</p> <p>Resident #43 had current physician's orders for:</p> <p>a.) Haloperidal Lac 5 mg/ml (an antipsychotic medication) inject 1 ml (5 mg) IM (intra muscular) as needed every 8 hours for agitation. This order originated 8/30/13.</p> <p>b.) Haloperidal 5 mg tablet (an antipsychotic medication) give one tablet as needed every 8 hours for agitation. This order originated 8/30/13.</p> <p>Review on Resident #43's behavior monitoring record for October, November, December 2013 and January, February 2014 indicated the resident had four "Mood and Behavior Communication Memos," dated 10/19/13, 10/20/13, 11/2/13, 11/28/13 which indicated the resident received as needed psychoactive medication on these dates.</p> <p>Resident #43's medication records and as needed medication flow sheets for October and November 2014 lacked any documentation or indication that the 10/19/13, 10/20/13, 11/2/13, 11/28/13 doses</p>		<p>responsible for completing the Behavior Memo Review form on scheduled work days on an ongoing basis. Should a PRN medication be noted as given, the DON will be notified. The DON or designee will be responsible for completing the PRN Monitoring form to ensure all PRN medications are being documented as given, including rationale for administration and efficacy of the PRN medication. This monitoring will take place on scheduled work days as follows: Daily for two weeks, weekly for two weeks, then monthly thereafter. Should concerns be found, immediate corrective action will occur. Results of these reviews will be discussed during the facility's quarterly QA reviews for a minimum of 6 months and the plan adjusted accordingly, if indicated.</p>				

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	<p>of as needed medications had been administered, the time, the staff involved or the effectiveness the medication.</p> <p>Resident #43 had a current, 1/2/14, care plan problem regarding the use of the as needed psychoactive medication. Approaches to this plan included, refer of psychological evaluation as indicated, refer to pharmacist consultant as needed, follow up with psychiatrist.</p> <p>On 2/17/14 at 11:45 a.m., Resident #43 was observed calmly eating lunch.</p> <p>On 2/19/14 at 10:35 a.m., Resident #43 was observed napping in his recliner.</p> <p>On 2/19/14 at 1:25 p.m., Resident #43 was observed playing checkers. He was calm, conversational and laughing.</p> <p>During a 2/20/14, 10:15 a.m., interview, the Director of Nursing indicated all as needed medication must be documented on the PRN flow sheet section of the medication administration record.</p> <p>During a 2/20/14, 1:10 p.m., interview, the Director of Nursing indicated the four events which were</p>				

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	<p>documented on the behavior memo with as needed medication being administered were not documented on the medication administration record as required. She additionally indicated the facility could not assess and evaluate the use of as needed medication if it was not documented on the correct form for review.</p> <p>A current, 9/05, facility policy titled "Medication Administration Policy and Procedure", which was provided by the Director of Nursing indicated the following: "21. Medication Administration will be recorded on the MAR [medication administration record] or TAR [treatment administration record] after given."</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>				