

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155330	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/11/2014
NAME OF PROVIDER OR SUPPLIER SALEM CROSSING			STREET ADDRESS, CITY, STATE, ZIP CODE 200 CONNIE AVE SALEM, IN 47167		
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F000000	<p>This visit was for Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00129158 and IN00127852.</p> <p>IN00129158-Unsubstantiated due to lack of evidence IN00127852-Substantiated. Federal/state deficiencies related to the allegation are cited at F226.</p> <p>Survey Dates March 4, 5, 6, 7, 10, & 11, 2014</p> <p>Facility Number: 000223 Provider Number: 155330 AIM Number: 100267680</p> <p>Survey Team Gwen Pumphrey, RN-TC Gloria Riesert, MSW Caitlin Lewis, RN</p> <p>Census Payor Type SNF/NF: 87 Total: 87</p> <p>Census Bed Type Medicare: 11 Medicaid: 66 Other: 10</p>	F000000	Please find the enclosed plan of correction for the survey ending March 11, 2014. Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Due to the low scope and severity of the survey finding, please find sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance, feel free to contact me with any questions. Facility respectfully requests a face-to-face IDR for F226, F272, and F520.		

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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	<p>Total: 87</p> <p>Sample: 6</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Report reviewed by Cheryl Fielden RN on March 18, 2014.</p>				

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F000226 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 interview and record review the facility failed to follow their policy with reporting allegations of abuse. An initial nor a follow up report was filed with ISDH. This deficient practice affected 1 of 2 residents reviewed for abuse. (Resident #48).</p> <p>Findings include:</p> <p>On 3/6/14 at 10:13 a.m., Resident #48 indicated a staff person had been rude to her and made her feel rushed while providing care. Resident # 48indicated she reported the incident to a nurse.</p> <p>On 3/7/14 at 11:27 a.m., Resident #48's clinical record was reviewed. She had diagnoses including but not limited to anemia, neuropathy, difficulty in walking, joint pain, heart failure, reflux, and anxiety.</p> <p>The social services progress notes reviewed from January 2013 thru March 2014 lacked documentation of</p>	F000226	<p>The facility respectfully requests a face-to-face IDR to delete this deficiency because the facility believes it was in compliance with deficiency cited. 1. Resident #48 was not harmed. Initial and follow-up allegation of abuse reported to ISDH. Social Service completed a follow-up with resident as needed to make sure psychosocial needs are met. 2. All residents have the potential to be affected. Customer Care Representatives completed QIS abuse interview questions with all interviewable residents. Reviewed resident interviews and there were no concerns that met ISDH reportable guidelines. If any allegations of abuse had been made, the facility would then report these allegations to ISDH per facility policy. 3. Abuse Prohibition, Reporting, and Investigation Policy and Procedures reviewed with no changes made (See Attachment A). All staff in-serviced on the above policy by Clinical Education Coordinator on 4-1-14. Any resident concerns which allege rude behavior by staff will be reported to ISDH per protocol by Executive Director or Designee.</p>	04/10/2014			

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	<p>residents allegations. The notes also lacked documentation of the residents psychosocial status related to the allegations.</p> <p>Nurses notes reviewed from January 2013 thru March 2014 lacked documentation of residents allegations.</p> <p>The Minimum Data Set [MDS] Assessment dated 1/21/14 was reviewed. A Brief Interview of Mental Status [BIMS] was conducted. Resident # scored 10 on a scale of 0-15. This score indicates Resident # 48 had moderate cognitive impairment.</p> <p>On 3/7/14 at 11:15 a.m., the reportables from January 2013 thru March 2014 to ISDH were reviewed. There was no investigative report related to Resident #48's incident.</p> <p>On 3/10/14 at 4:11 p.m., the Director of Nursing Services [DNS] stated regarding Resident #48's allegation,... "The nurse called me at home and I came in immediately to do an investigation. I talked to the resident. The resident pointed out different staff and eventually narrowed it down to [named CNA]. The residents daughter was at bedside and I asked</p>		<p>4. Customer Care Representatives will complete QIS abuse interview questions with all interviewable residents weekly times 4 weeks, then every 2 weeks times 4 weeks, then monthly times 3 months, then quarterly for at least 6 months (See Attachment B). Any allegations of abuse made during these interviews or otherwise will be reported to ISDH per facility policy. To ensure compliance, the ED or designee is responsible for completion of the CQI Reporting Requirements Audit weekly times 4 weeks, then every 2 weeks times 4 weeks, then monthly x 3 months, then quarterly for at least 6 months (See Attachment O). The audits will be reviewed during the facility's CQI meetings and issues will be addressed and the above plan will be altered accordingly as needed.</p>		

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	<p>for permission to [test for a urinary tract infection] because she acts like that she usually has a UTI and she did. I was told that another aide had came into the residents room asking the aide assisting the resident for help. The aide finished care with the resident then left the room to help the other aide. We got statements from the CNA, the Nurse, and the resident. We concluded that it was a misunderstanding between the resident and the aide. The aide works in the cottage mainly and she works on that unit but does not have that resident on her team."</p> <p>On 3/10/14 at 5:05 p.m., the Medical Records clerk provided a copy of investigation for the incident. The incident occurred on 2/7/14 at 8:00 p.m. The investigation lacked documentation that the allegation was reported to ISDH.</p> <p>On 3/11/14 at 2:45 p.m., when asked why a report was not filed with ISDH, the Administrator and Director of Nursing Services indicated they were instructed from the corporate office to not file the report.</p> <p>A copy of the policy titled Abuse Prohibition, Reporting, and Investigation was provided by the</p>						

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	<p>Administrator on 3/4/14 at 10:43a.m. The policy stated, ..."The Executive Director or Director of Nursing is responsible to coordinate all investigation processes, assure an accurate and complete written record of the incident and investigation, and to follow up with a written report to the Indiana State Department of Health within (5) working days..."</p> <p>This federal tag relates to Complaint IN00127852.</p> <p>3.1-28(a)</p>			

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F000272 SS=D	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on interview, and record review the facility failed to ensure accurate assessments for residents receiving psychotropic medications. This deficient practice affected 1 of 5</p>	F000272	The facility respectfully requests a face-to-face IDR to delete this deficiency because the facility believes it was in compliance with deficiency cited. 1. Resident #43 was not harmed. Nursing	04/10/2014

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	<p>residents reviewed for unnecessary medications. (Resident #43).</p> <p>Findings include:</p> <p>On 3/10/14 at 1:20p.m. Resident #43's medical record was reviewed. He had diagnoses including but not limited to anxiety, depression, and manic depression.</p> <p>The Minimum Data Set Assessment [MDS] dated 2/11/14 indicated the resident exhibited no behaviors during this assessment. The resident received antipsychotic, antianxiety, antidepressant, and diuretic medications for 7 days during the assessment.</p> <p>The care plan listed "track behavior episodes of anxiety, s/sx [sign and symptoms] of depression, side effects of psychotropic meds [medications], and diuretic use as problems.</p> <p>The behavior sheets for signs and symptoms of anxiety, insomnia, and verbally aggressive toward staff were reviewed. The clinical record lacked documentation of residents behavior related to the need for antipsychotic and antidepressant medications.</p>		<p>documentation was initiated with each medication change on 12-10-13, 1-14-14, and 2-11-14. Resident was care planned for depression on 11-12-13 and on both MDS assessments. Depression was indicated (11-19-13 mild depression, 2-11-14 mild depression). Nurses Notes opened 2-27-14 to address the bowel movement issues to rule out potential medical issues before initiating a behavior program. Documentation ended on 3-10-14 and a socially inappropriate care plan was initiated related to resident extracting himself. During psychiatrist visits on 12-10-13, 1-14-14 and 2-11-14. Psychiatrist contacted and after reviewing resident per facility request, discovered software issues in program. Psychiatrist to reissue a corrected note. MDS reviewed and supportive documentation in place and accurate for 7-day look-back period. 2. All other residents have the potential to be affected. Social Services, MDS Coordinator and/or designee completed 100% review of most recent MDS for Sections D, E, and N on all current residents to ensure accuracy. MDS were modified and resubmitted as needed. 3. RAI manual sections D, E and N as well as MDS Supportive Documentation Guidelines reviewed (See</p>				

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	<p>Resident #43 was seen by the psychiatrist on 12/10/13, 1/14/14, and 2/11/14. The progress notes indicated the significant medication changes with each visit to the residents antipsychotic medications. The clinical record lacked documentation of the residents adjustment to the new medication changes.</p> <p>On 3/10/14 at 3:00 p.m., RN # 1 indicated, "Resident #43 gets verbally abusive with staff, he refuses care, and recently we had a behavior of him self extracting himself, and we track his anxiety; The new behavior does not have a sheet yet, the other ones have a sheet."</p> <p>On 3/10/14 at 3:15p.m., LPN #2 indicated, "Its on our MAR [Medication Administration Record] and we mark it at the end of the shift if they have had any side effects. Not everybody gets a behavior sheet. When we get a behavior and open hot charting, if its consistent thing then we care plan for it and do a behavior chart; if its a isolated incidence we just document and notify the doctor."</p> <p>On 3/10/14 at 3:46pm the Director of Nursing Services indicated, ..."We</p>		<p>Attachment C and D). Social Service Staff and MDS Coordinator in-serviced on the reviewed items by Executive Director on 4-1-14. Mood, Behavior, and Medication sections of the most recent MDS assessment will be reviewed during care plan meeting weekly to ensure accuracy. Modification and resubmission will be completed as needed. 4. The Executive Director or designee will audit 5 resident's clinical records weekly times 4 weeks, then every 2 weeks times 4 weeks, then monthly times 3 months then quarterly for at least 6 months for mood, behavior and medication sections of the MDS utilizing the Administrator Monitoring Tool (See Attachment E). The audits will be reviewed during the facility's quality assurance meeting and issues will be addressed and the above plan will be altered accordingly.</p>				

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	<p>have psychotropic flow sheets and side effects worksheets in the MAR. The psychiatrist is in twice a month. When the resident has a new behavior, we document for at least 72 hrs before making sure that it's a "behavior." We have a monthly behavior meeting were we analyze if that medication is working. We are against medicating here. We do a lot of GDR's. I know that the psychiatrist has been trying to work with him to get him stable."</p> <p>CNA #5 indicated on 3/11/14 at 11:30 a.m., "I've not seen any behaviors with Resident #43."</p> <p>CNA #6 indicated on 3/11/14 at 11:40 a.m., "When he first got here he didn't want to take a shower. He's a lot better now. A lot of the behavior things are on second shift. I don't have any problems with him."</p> <p>3.1-31 (d)(1)(3)</p>				

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F000280 SS=E	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on record review and interview, the facility failed to revise the "Behavior" care plan when an intervention for Gradual Dose Reductions of psychotropic medications was considered not applicable. This deficient practice affected 1 of 5 residents reviewed for unnecessary medications. (Resident #57).</p> <p>Finding includes:</p> <p>Review of the clinical record for Resident #57 on 3/10/14 at 3:00 p.m., indicated the resident had</p>	F000280	<p>1. Resident #9, #40, #57, and #69 were not harmed. All care plans have been reviewed and updated as applicable. 2. All other residents have the potential to be affected. All resident's behavior, falls, incontinence, and psychotropic medication care plans have been reviewed and updated as applicable. 3. Care Plan Review and Maintenance Process Policy and Procedures reviewed with no changes made (See Attachment F). IDT in-serviced on the above policy and procedures by Executive Director on 4-1-14. Care plan audit tool will be completed by IDT during weekly care plan meetings to ensure care plan</p>	04/10/2014	

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	<p>diagnoses which included, but were not limited to: anxiety, depression, Alzheimer's disease, and dementia with behavior disturbance and psychosis.</p> <p>On 3/10/14 at 4:00 p.m, a request was made to the Medical Records Clerk for a copy of the current version of the Psychotropic Drug Use care plan. At 5:30 p.m., she presented a copy of a 1/10/2013 Care Plan titled "Psychotropic Drug Use - Resident is at risk for adverse side effects related to use of psychotropic medication." Approaches included, but were not limited to: "IDT [Interdisciplinary Team] to review routinely to attempt gradual dose reductions, unless contraindicated by MD."</p> <p>During an interview with the Memory Care Unit Coordinator on 3/10/14 at 3:20 p.m., she indicated the family usually refused any Gradual Dose Reductions [GDRs] be done, so GDRs were not being done. Documentation by the physician was also lacking of the GDRs being contraindicated.</p> <p>3.1-35(d)(2)(B)</p>		<p>meets current needs. 4. The Executive Director or designee will audit 5 resident's charts weekly times 4 weeks, then every 2 weeks times 1 month, then monthly times 3 months then quarterly for at least 6 months utilizing the Administrator Monitoring Tool (See Attachment E). The audits will be reviewed during the facility's quality assurance meeting and issues will be addressed and the above plan will be altered accordingly.</p>		

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F000280 SS=E	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on observation, interview and record review the facility failed to update the care plans to reflect the residents current physical and mental status. This deficient practice affected 3 out of 22 resident's reviewed for care planning. (Resident #9, 40, and 69),</p> <p>Findings include:</p> <p>a. During an observation on 03/10/2014 at 11:26 a.m., Resident #9 was sitting in a recliner in her room. There was no sensor pad</p>	F000280	<p>1. Resident #9, #40, #57, and #69 were not harmed. All care plans have been reviewed and updated as applicable. 2. All other residents have the potential to be affected. All resident's behavior, falls, incontinence, and psychotropic medication care plans have been reviewed and updated as applicable. 3. Care Plan Review and Maintenance Process Policy and Procedures reviewed with no changes made (See Attachment F). IDT in-serviced on the above policy and procedures by Executive Director on 4-1-14. Care plan audit tool will be completed by IDT during weekly care plan meetings to ensure care plan</p>	04/10/2014			

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	<p>alarm noted in the room. The call light was observed without having any neon tape attached to it.</p> <p>During an observation on 3/10/2014 at 2:35 p.m., Resident #9 was sitting in her recliner in her room. There was no sensor pad alarm noted in the room. The call light was observed without having any neon tape attached to it.</p> <p>During an observation on 3/11/2014 at 9:53 a.m., Resident #9 was transferring from wheel chair to chair in room with staff assistance. There was no sensor pad alarm noted in the room. The call light was observed out of reach and without having any neon tape attached to it.</p> <p>During an observation on 3/11/2014 at 11:53 a.m., the resident was sitting in a chair in her room. There was no sensor pad alarm noted in the room. The call light was observed without having any neon tape attached to it. A staff member was in the room with the resident.</p> <p>During an interview on 03/10/2014 at 11:30 a.m., Resident #9 indicated she had recently fell while in her room coming out of the bathroom. She had an X-ray done, but she was</p>		<p>meets current needs. 4. The Executive Director or designee will audit 5 resident's charts weekly times 4 weeks, then every 2 weeks times 1 month, then monthly times 3 months then quarterly for at least 6 months utilizing the Administrator Monitoring Tool (See Attachment E). The audits will be reviewed during the facility's quality assurance meeting and issues will be addressed and the above plan will be altered accordingly.</p>		

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	<p>"just bruised up" and "wasn't hurt." She did not use her call light to call for assistance from the bathroom to her bed. She needs assistance with ambulation.</p> <p>During an interview on 3/11/2014 at 9:57 a.m., CNA #1 indicated the resident does not have a sensor pad at this time.</p> <p>During an interview on 3/11/2014 at 11:14 a.m., LPN #1 indicated the alarm was discontinued on 2/24/2014. The resident did not tolerate the alarm well. She would get really upset and would turn it off herself. Her fall interventions included therapy, a urinalysis and education on using her call light.</p> <p>During record review on 3/10/2014 at 2:30 p.m., Resident # 9 had the diagnosis of, but not limited to, generalized anxiety disorder, depressive disorder, neuropathy, esophageal reflux, diverticulosis, osteoarthritis, hypertension and atrial fibrillation.</p> <p>An "ASC Fall Event" dated 2/26/2014, indicated Resident #9 had an unwitnessed fall at 8:30 a.m. The resident was sitting on the toilet at the time of the fall. She was found, by</p>				

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	<p>staff, on her back in the doorway of the bathroom. The resident had proper footwear on. The resident had some pain in her hips and back. She also had "head weakness." The resident had hit her head. Neurological checks were initiated at the time of the assessment. There were no injuries noted. The resident indicated she was rising from the toilet and the high rise was not secure. The resident lost balance. There had been no medication changes at the time of the fall. The resident's vital signs were taken and were within normal limits. The intervention put into place was to adjust the high rise on the toilet seat. The physician and family were notified on 2/26/2014. The care plan was updated on 2/26/2014.</p> <p>The care plan dated 2/28/2014, indicated the resident had "disregard for safety devices: resident does not use call light, ask for assistance, not allow staff to assist with transfer, due to limited ability to understand safety needs due to BIMS (Brief Interview for Mental Status) score 10 which indicated moderately impaired cognition." The goal indicated the "resident will have no significant injury from non compliance." The approaches indicated "Assure call</p>			
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	<p>light in reach. Counsel resident regarding need for safety devices."</p> <p>The care plan dated 11/01/2012, indicated the resident is a "Fall risk related to: General weakness." The goal indicated, "Resident will have no injury related to falls." The approaches indicated, "Neon Tape [sic.] to call light, sensor pad at all times, Encourage and remind resident to use call light, Provide assistance as needed" and "Refer to therapies for screening."</p> <p>The Physician's Orders for Resident # 9 indicated the resident had an order dated 02/06/2014, for a sensor pad alarm at all times and to check for placement and functioning. This order was discontinued on 2/24/2014.</p> <p>The March 2014 treatment record indicated the resident had a sensor pad alarm at all times with the functioning and placement being checked every shift. This was initialed on every shift daily from 03/01/2014 until the current date.</p> <p>b. During an observation on 3/10/2014 at 11:54 a.m., Resident #40 was incontinent of bowel and bladder.</p>				

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	<p>During an interview on 3/10/2014 at 11:50 a.m., CNA #2 indicated Resident #40 is "always incontinent." She has been incontinent since she was admitted to the facility. The resident will not use her call light if she needs changed. Resident #40 will not tell anyone when she is wet.</p> <p>During an interview on 3/11/2014 at 9:29 a.m., LPN #2 indicated Resident #40 has always been incontinent since she has been admitted to the facility. She refuses to get out of bed.</p> <p>During an interview on 3/10/2014 at 2:08 p.m., the DON indicated she and the MDS coordinator share the responsibility of updating care plans. Care plans are updated when there is a significant change, change in condition and quarterly. She indicated Resident #40 will not use a bed pan. Whenever the staff attempt she refuses the bed pan. The care plan indicating the resident should be toileted upon rising, before and after meals, at bedtime and as needed "should be revised." The staff would change the care plan with her next quarterly assessment when they review hydration.</p> <p>During an interview on 3/11/2014 at</p>						

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	<p>10:47 a.m., the MDS coordinator indicated her and the DON review care plans quarterly with the MDS according to a schedule. When Resident # 40's care plan was updated on 2/13/2014 she had a continent episode in the quarterly look back period. There is no reason to remove the approach if she is having continent episodes. She had a continent episode on 1/14/2014 and 1/18/2014. She had 2 continent episodes noted on 2/15/2014. This approach is set to encourage her to get up and toilet. If she has any continent episodes the staff want to encourage her to get up and toilet. The approach would be revised if she continuously refuses, or she voices to someone that she does not want to get up and toilet.</p> <p>During record review on 03/10/2014 at 12:45 p.m., the resident had the diagnosis of, but not limited to, chronic pain, anemia, anxiety disorder, depressive disorder, hypertension, esophageal reflux, impaired renal function and osteoarthritis.</p> <p>The MDS assessment dated 11/19/2013 indicated the resident had a trial of a toileting program with no improvement. The resident was</p>			
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	<p>"frequently incontinent" of bowel and bladder.</p> <p>The MDS assessment dated 2/11/2014 indicated the resident was "always incontinent" of bowel and bladder. A toileting program was not being used at that time.</p> <p>The care plan dated 11/13/2013, indicated Resident # 40 "is incontinent due to: weakness/chronic dysuria." The goal indicated the "Resident will be free from adverse effects of incontinence." The approaches included, "Assess and document skin condition weekly and as needed. Assist with elimination. Assist with incontinent care as needed. Check every 2 hours for incontinence. Document any abnormal findings and notify MD. Observe for signs of urinary tract infection: decreased output, concentrated urine, abdominal/flank pain, difficult/painful urination, frequency, change in mental status, fever, increase in incontinence. Toilet upon rising before and after meals at bedtime and PRN (as needed)."</p> <p>A progress note dated 11/12/2013 at 11:15 a.m., indicated Resident #40 was continent of bowel and bladder with episodes of incontinence.</p>						

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	<p>A progress note dated 11/13/2013 at 12:52 a.m., indicated Resident #40 was continent of bowel and bladder with episodes of incontinence.</p> <p>A progress note dated 11/13/2013 at 10:13 a.m., indicated Resident #40 was incontinent of bowel and bladder.</p> <p>A progress note dated 11/13/2013 at 10:30 p.m., indicated Resident #40 was incontinent of bowel and bladder.</p> <p>A progress note dated 11/16/2013 at 1:19 p.m., indicated Resident #40 was incontinent of bowel and bladder.</p> <p>A progress note dated 12/12/2013 at 1:33 a.m., indicated Resident #40 is incontinent of bowel and bladder.</p> <p>A progress note dated 2/14/2014 at 10:08 p.m., indicated Resident #40 is incontinent of bowel and bladder.</p> <p>A progress note dated 3/1/2014 at 2:58 a.m., indicated Resident #40 is incontinent of bowel and bladder.</p> <p>A bowel and bladder flowsheet for Resident # 40 indicated she was continent of bladder during 2 occasions on 1/14/2014, during 2 occasions on 1/18/2014 and during 1 occasion on 2/15/2014. The resident was continent of bowels during 1 occasion on 1/18/2014 and during 1 occasion on 2/15/2014. At all other times the resident was incontinent.</p> <p>c. Resident #69's clinical record was</p>						

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	<p>reviewed on 3/10/14 at 10:35a.m. He was admitted to the facility on 12/9/11. He had diagnoses including but not limited to, altered mental status, anxiety, depressive disorder, and congestive heart failure.</p> <p>Behavior flow sheets were reviewed indicated the facility was tracking episodes of anxiety. There were no behavior flow sheets for episodes of depression.</p> <p>Social services notes dated 10/18/13 and 1/15/14 indicated resident was depressed. The notes also indicated the resident and family denied psychiatric services and medications were managed by the primary care provider.</p> <p>The care plan listed problems including but not limited to, ..."side effects of psychotropic medications, behavior track for anxiety..." The care plan lacked documentatio of tracking depression or the residents refusal of gradual dose reductions.</p> <p>MDS dated 1/14/14 indicated the resident recieved diruetic, antianxiety and antidepressant medications for 7 of 7 days during the assement time frame. A mood interview was also conducted. The resident's total</p>						

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	<p>severity score of 14 indicated moderate depression.</p> <p>On 3/11/14 at 2:35p.m., Resident #69 was interviewed. He was observed to have a flat affect. When asked if the staff provided education about his medications he indicated no. When asked how things were going he indicated some things were good and some were bad.</p> <p>On 3/10/14 at 3:00p.m., RN#1 indicated, "He yells out, instead of using the call light we track that on the behavior sheet. I'm not sure about tracking depression. When I first started taking care of him, he was getting tearful but he doesn't do that anymore.</p> <p>On 3/10/14 at 4:00p.m., the Director of Nursing Services, indicated, "He is very anxious most of the time, and it depends on which staff goes in there with him. He can be tearful at times and he has some ocd tendencies that can send him into a frenzy. He was going group therapy for socialization and he started to get so anxious that he refused to go. In October 2013, the resident and family declined any changes to psychotropic medications. He has been stable since then."</p>				

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	<p>A policy and procedure titled, "Care Plan Review and Maintenance Process" revised 08/2011, indicated "Care plan, problems, goals and interventions will be updated based on changes in resident assessment/condition, resident preferences or family input." "Care pan interventions/changes impacting care provided by CNA's will be communicated to CNA via verbal report and/or CNA assignment sheet." "Care Plans will be maintained and updated within Matrix."</p> <p>3.1-35(d)(2)(B)</p>			

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F000329 SS=D	<p>483.25(l) 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 gradual dose reductions were completed in an effort to reduce and/or discontinue the anti-anxiety, anti-depressant and psychotropic medications for 1 of 5 residents reviewed for unnecessary medications. (Resident #57).</p> <p>Finding includes:</p> <p>Review of the clinical record for</p>	F000329	<p>1. Resident #57 was not harmed. The physicians have been addressed in regard to potential GDRs and alerted to possible side effects and the same documented. Mood and behavior care plans were reviewed and modifications completed as necessary. 2. All residents have the potential to be affected. Those residents with ordered psychotropic medications have been identified and records were reviewed for who could be candidates for a GDR. The physicians of candidates</p>	04/10/2014

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	<p>Resident #57 on 3/10/14 at 3:00 p.m., indicated the resident had diagnoses which included, but were not limited to: anxiety, depression, Alzheimer's disease, and dementia with behavior disturbance and psychosis.</p> <p>Review of the March 2014 Monthly Physician Orders indicated the resident was on the following medications:</p> <ul style="list-style-type: none"> - Xanax [an anti-anxiety medication] 0.25 mg [milligrams] 1 tab TID [3 times a day] for anxiety state ordered 3/12/13. - Zoloft [an anti-depressant] 100 mg 1 tab QD[every day] for depressive disorder ordered 8/21/12. - Seroquel [an anti-psychotic] 25 mg - 1 tab Q [every] HS [night] for dementia with psychosis ordered 12/6/10. <p>Documentation was lacking of Gradual Dose Reductions [GDRs] having been implemented since the medications were first ordered</p> <p>Review of a 4/5/13 note written by the Memory Care Facilitator and signed by the family, indicated no more GDRs were to be done due to the resident being stable and having had 2 prior failed attempts.</p>		<p>identified were contacted relative to potential GDR or the obtaining of appropriate documentation should a gradual dose reduction be medically contraindicated. Mood and behavior care plans were reviewed and modifications made as necessary. An event will be opened in clinical record for nursing to document for at least 72 hours on medication adjustment with an IDT note completed at the end to discuss adjustment to medication change.</p> <p>3. ASC Psychotropic Medication Management Program reviewed with no changes made (See Attachment G). Interdisciplinary team in-serviced on the above policies. Licensed nurses and IDT in-serviced on the ASC Psychotropic Medication Management Program by Social Service Consultant and Clinical Education Coordinator on 4-1-14. Psychotropic medications will be reviewed on a monthly basis to evaluate if a gradual dose reduction would be beneficial. Physician or psychiatrist will be notified for gradual dose reduction recommendations.</p> <p>4. The Executive Director or designee shall conduct Administrator Monitoring Tool on 5 residents weekly times 4 weeks, then every two weeks x 4 weeks, then monthly times 3 months, and then quarterly for at least 6 months (See Attachment E). The audits will be reviewed during the facilities quality</p>				

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	<p>Documentation was lacking of when these 2 failed dose reductions had been performed.</p> <p>On 3/10/14 at 5:30 p.m., the Medical Records Clerk presented a copy of a 1/10/2013 Care Plan titled "Psychotropic Drug Use - Resident is at risk for adverse side effects related to use of psychotropic medication." Approaches included, but were not limited to: "IDT [Interdisciplinary Team] to review routinely to attempt gradual dose reductions, unless contraindicated by MD."</p> <p>During an interview with the Memory Care Unit Coordinator on 3/10/14 at 3:20 p.m., she indicated the family usually refused any Gradual Dose Reductions [GDRs] be done, so GDRs were not being done. She also indicated that the physician would be the one who documented in his notes that the family refuses GDRs.</p> <p>Review of the physician progress notes between 3/8/13 and 1/8/14 failed to locate documentation of the family having been spoken to and having refused GDRs or that GDR of the 3 medications were contraindicated.</p> <p>Review of the Behavior Symptom</p>		assurance meeting and issues will be addressed and the above plan will be altered accordingly.				

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	<p>Monthly Summary Forms between 5/8/13 and 2/3/14 completed by the Social Worker and/or the Memory Care Facilitator, indicated GDRs for the Xanax, Zoloft and Seroquel as well as documentation by the physician of clinical contraindications were not applicable.</p> <p>Review of the Behavior Flow Records for August 2013 to March 2014 indicated the resident was being tracked for anxiety issues and rejection of care. The Flow Records indicated the resident had moderate to frequent episodes of anxiety at different times of the days, but had no episodes of rejection of care.</p> <p>Review of the 1/15/14 Significant Change MDS [Minimum Data Set] Assessment, 11/13/13, 8/22/13 and 6/4/13 Quarterly MDS Assessments, all indicated the resident had no mood or behavior symptoms - including rejection of care.</p> <p>On 3/10/14 at 5:30 p.m., the Medical Records Clerk presented a copy of the facility's current policy titled "ASC [American Senior Communities] Psychotropic Medication Management Program." Review of this policy at this time included, but was not limited to: "...Procedure:...2.</p>						

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	<p>The facility will initiate a request for a Gradual Dose Reduction at least on the following schedule for each drug: For residents who use antipsychotic, anxiolytic, and antidepressant medications, a GDR must be initiated per the following guidelines: During the first year that the facility has initiated an antipsychotic, A GDR must be attempted in two separate quarters with a month in between attempts, unless clinically contraindicated by the physician. After the first year, a GDR must be initiated annually unless clinically contraindicated by the physician..."</p> <p>3.1-48(a)(3) 3.1-48(a)(4)</p>			

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F000428 SS=D	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on record review and interview, the facility failed to ensure Consultant Pharmacy recommendations were acted upon by the physician by indicating whether he agreed/disagreed with the recommendation and by giving "Patient-specific information" for refusing to reduce or change a resident's anti-anxiety, anti-depressant and psychotropic medications. This deficient practice affected 1 of 3 residents reviewed for Pharmacy recommendations.</p> <p>Finding included:</p> <p>Review of the clinical record for Resident #57 on 3/10/14 at 3:00 p.m., indicated the resident had diagnoses which included, but were not limited to: anxiety, depression, Alzheimer's disease, and dementia with behavior disturbance and psychosis.</p>	F000428	<p>1. Resident #57 was not harmed. IDT reviewed psychotropic medications with gradual dose reduction recommended to physician for review. Physician ordered a gradual dose reduction. 2. All resident have the potential to be affected. All residents on psychotropic medications reviewed by IDT with recommendations for gradual dose reductions made as appropriate for physician to review. 3. Pharmacist Consulting Services Policy and Procedures reviewed with no changes made (See Attachment H). IDT educated on the above policy by Social Service Consultant on 4-1-14. Psychotropic medications will be reviewed on a monthly basis to evaluate if a gradual dose reduction would be beneficial. Physician or psychiatrist will be notified for gradual dose reduction recommendations. 4. The Executive Director or designee will utilize the Administrator Monitoring Tool</p>	04/10/2014			

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	<p>On 3/28/13, the Consultant Pharmacist made the following recommendations:</p> <ul style="list-style-type: none"> - "Resident has been taking Sertraline [Zoloff] 100 mg [milligrams] Q [every] AM [morning] since 8/12. Please evaluate for a gradual dose reduction at this time, while monitoring for re-emergence and/or withdrawal symptoms." - "Resident has been taking Alprazolam [Xanax] 0.25 mg TID [23 times a day] for anxiety since 3/12." - "Rationale for recommendation: Federal nursing regulations require that a gradual dose reduction GDR be attempted twice in two separate quarters in the first year and annually unless clinically contraindicated." <p>On 4/2/13, the Director of Nursing [DoN] signed the recommendation for the physician indicating the resident was receiving optimal dose that benefits the resident's function and activities of daily living. The AGREE/DISAGREE/OTHER categories were not checked as to whether or not he wanted to follow the recommendations.</p> <p>On 8/26/13, the Consultant Pharmacist again made a recommendation for "Resident has been taking Sertraline [Zoloff] 100 mg</p>		<p>review 5 residents from Consultant Pharmacy Report every month times 3 months, then every other month times 4 months, then quarterly for at least 6 months (See Attachment E). The audits will be reviewed during the facilities quality assurance meeting and issues will be addressed and the above plan will be altered accordingly.</p>		

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	<p>Q AM for Depression since 8/12. Rationale for recommendation: Federal nursing regulations require that a gradual dose reduction GDR be attempted twice in two separate quarters in the first year and annually unless clinically contraindicated."</p> <p>No date or signature by the physician was present on the form, but a check mark was placed next to the statement indicating the resident was receiving optimal dose that benefits the resident's function and activities of daily living. The DISAGREE box was checked and "Currently stable with 2 failed GDRs" was written on the form, but no specific examples of of the failed GDRs were given.</p> <p>On 9/24/13, the Consultant Pharmacist made a recommendation for "Resident had been taking Quetiapine [Seroquel] 25 mg Q HS [at night] for dementia with psychosis since 12/10. On 9/30/13, the physician signed the form and only marked "Disagree" with no resident-specific examples as to why he disagreed with the recommendation.</p> <p>During a discussion with the DON on 3/11/14 at 1:30 p.m., she indicated the protocol after receiving pharmacy</p>			
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	<p>recommendations was: once received, she would call the individual doctors and report the recommendations and write orders for any changes. She indicated she didn't know they had to write an explanation about it being contraindicated or reason for no change and that she just checked the "Optimal benefit" notation only."</p> <p>On 3/11/14 at 1:30 p.m., the Staff Development Coordinator presented a copy of the facility's current policy titled "Drug Regimen Review and Reporting". Review of this policy included, but was not limited to: "...The prescriber may disagree with a recommendation however it is not acceptable for a physician to document only that he/she disagrees with the report, without some basis for disagreeing..."</p> <p>3.1-25(h) 3.1-25(j)</p>				

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F000431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation and interview the facility failed to ensure medications were stored and labeled properly. This deficient practice</p>	F000431	<p>1. Medications were destroyed and all carts cleaned. Placed overflow medications in medication storage room per medication storage policy. 2. All</p>	04/10/2014	

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	<p>affected 1 of 2 medication rooms observed and 3 of 4 medication carts observed. This deficient practice had the potential to the affect 1 of 6 resident receiving insulin on the locked unit (Resident #84)</p> <p>Findings include:</p> <p>a. On 3/10/14 at 4:30p.m., the refrigerator in the medication room was found to have one vial of Novolin insulin to be opened. The vial did not have an open date. The vial belonged to Resident #84.</p> <p>On 3/10/14 at 5:00p.m., RN # 3 was unable to provide an explanation of when the vial was opened and discarded the medication. She indicated that the vial should have a date to indicate when it was opened.</p> <p>On 3/11/14 at 11:00a.m., Resident #84's clinical record was reviewed. The resident had not received a dose of insulin from November 2013 thru March 2014.</p> <p>On 3/11/14 at 11:45a.m., LPN #3 stated, " I don't know how that vial was opened. I haven't given Resident #84 any insulin since she's been on it. I think we need to make sure the vials aren't open when they</p>		<p>medication storage areas have the potential to be affected. All medication carts, treatment carts, and medication rooms were inspected and cleaned with no further issues noted. Deep cleaning schedule initiated and to be completed weekly and as needed. 3. Storage and Maintenance of Medications Policy and Procedure and Guide for Storage of Insulin Policy and Procedures were reviewed with no changes made (See Attachment I and J). All licensed nursing staff in-serviced on the above policies by Clinical Education Coordinator. Medication overflow will be maintained in medication storage room per medication storage policy. Medication Cart will be cleaned weekly per scheduled. 4. Clinical Education Coordinator or designee will complete Medication Storage Review (See Attachment K) weekly times for 4 weeks, then every other week times 4 weeks, then monthly times 3 months, then quarterly for at least 6 months. The audits will be reviewed during the facility's CQI meetings and issues will be addressed and the above plan will be altered accordingly as needed.</p>		

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	<p>come from the pharmacy."</p> <p>The policy for insulin storage was provided by the Staff Development Coordinator on 3/11/14 at 1:21p.m. The policy indicated unopened, not-in-use insulin should be stored in the refrigerator. The policy indicated opened, in-use insulin may be stored at room temperature.</p> <p>b. On 3/10/14, 3 of 4 medication carts was observed to have sediment and loose pills in the drawers.</p> <p>In an interview, on 3/10/14 at 5:00p.m., RN #3 indicated the medication carts are cleaned on a weekly basis. She indicated the carts were audited on Friday March 7, 2014. The RN indicated the loose pills must have happened over the weekend.</p> <p>Review of the policy titled, "Medication Carts" was provided by the Staff Development Coordinator on 3/11/14 at 1:21p.m. The policy indicated the medicine preparation area is to maintained by nursing staff in the clean and organized manner.</p> <p>3.1-25(o)</p>						

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F000441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview and</p>	F000441	1. Resident #40 and #43 were not harmed. Follow hand	04/10/2014	

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	<p>record review the facility failed to follow the policies and procedures on handwashing and perineal care. This had the potential to affect 2 out of 3 residents observed for perineal care. (Resident #40 and Resident #43). Findings include:</p> <p>During an observation on 3/10/2014 at 11:40 a.m., CNA # 2 provided perineal care to Resident #43. CNA #2 hand washed for 20 seconds and donned gloves before preparing supplies for perineal care. CNA #2 explained the procedure to the resident and provided privacy for the resident. CNA #2 dipped a clean wash cloth into a basin of water and poured soap over the washcloth. The CNA then washed the creases of the resident's perineal area. The CNA put the wash cloth into a bag and wet a new washcloth. She washed the resident's testicles. She placed the washcloth into a bag and retrieved another washcloth. She again washed the creases of the resident's perineal area. She used the same washcloth to wipe the outer part of the resident's penis. She then pulled the foreskin down and washed the</p>		<p>washing policy and procedures for perineal care. 2. All residents have the potential to be affected. All CNAs will have hand washing and perineal care validation checklist to ensure protocol is being followed. 3. ASC Perineal Care Skills Validation for CNA and Hand Hygiene policy and procedures reviewed with no changes made (See Attachment L and M). All nursing staff in-serviced on Perineal Care and Hand Hygiene by Clinical Education Coordinator on 4-1-14. DNS and/or designee will make direct observations to ensure hand washing and perineal care is being conducted properly. 4. Clinical Education Coordinator or designee will complete Perineal Care and Hand Hygiene skills validations with 3 CNAs and/or nurses five times a week for 4 weeks, then weekly times 4 weeks, then monthly times 3 months, then quarterly for at least 6 months (See Attachment L and M). The audits will be reviewed during the facility's CQI meetings and issues will be addressed and the above plan will be altered accordingly as needed.</p>		

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	<p>urethral area. There was no handwashing or glove change noted inbetween washing the resident's creases of his thighs, his penis or his urethral area. She then rinsed the cleansed areas. She changed gloves and washed the resident's bottom from front to back. The CNA removed her gloves to retrieve a washcloth from the hallway. Upon her return she performed a 5 second handwash before donning a new pair of gloves and rinsing and drying the resident. The CNA removed her gloves and handwashed for 15 seconds. During an observation on 3/10/2014 at 11:54 a.m., CNA #2 and CNA #3 provided perineal care to resident #40. CNA # 2 handwashed for 20 seconds and donned gloves. CNA #3 handwashed for 20 seconds and donned gloves. CNA #2 dipped wash cloth in basin of water and applied soap to washcloth. She washed the resident's thigh creases and then used the same wash cloth to wash the resident's urethral area. CNA #2 then changed gloves and got a new washcloth. She washed the resident's outer labia front to back. She then</p>			
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	<p>dried the resident. CNA #2 then changed gloves. She used a wet wipe to remove bowel movement from the resident's bottom. As CNA #2 changed gloves she indicated, "just because of her being impatient you would hand sanitize or wash in between glove change because of BM (bowel movement). The resident was noted to be speaking in a mumbled tone at the time. The resident was not moving uncontrollably and CNA #3 was beside the resident for assistance. CNA #2 then rinsed and dried the resident and changed her brief. She removed gloves and handwashed for 12 seconds. CNA #3 removed gloves and handwashed for 6 seconds.</p> <p>During an interview on 3/11/2014 at 11:26 a.m., the SDC indicated the policy on handwashing is to wash for 20 seconds. She just did an inservice on handwashing. She inservices on handwashing monthly.</p> <p>During record review on 3/10/2014 at 2:20 p.m., the policy and procedure dated 02/2010 titled, "Hand Hygiene" and dated indicated, "Turn on water. Adjust temperature (Water should be warm not hot). Angle arms down,</p>			

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	<p>holding hands lower than your elbows. Apply soap, rub hand [sic.] together, between fingers to create a lather. Lather all surfaces of fingers and hands including wrists. Use friction for at least 20 seconds. Clean nails by rubbing palms on other hand. Rinse hands, fingers, and wrists thoroughly holding downward. Use a clean paper towel to pat dry all hands, fingers and wrists. Turn off faucet with paper towel and discard paper towel immediately." The policy indicated to use hand hygiene before patient contact, before an aseptic task, after body fluid exposure risk, after patient contact and after contact with patient surroundings.</p> <p>The policy and procedure dated 02/2010 titled, "Perineal Care" indicated, "Verify resident and explain procedure. Provide for privacy. Wash hands. Put on gloves. Assist resident to supine position. Drape resident as needed. Fill wash basin with warm water and have resident check temperature. Assist resident to spread legs and lift knees if possible. Wet and soap folded wash cloth. Obtain clean wash cloth. Wet, soap and fold wash cloth. Females: Separate labia and wash urethral area first. Wash between and outside labia in downward strokes. Alternate</p>			
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	<p>from side to side- wipe from front to back and from center of perineum outward. Use a clean area of the wash cloth with each wipe. Change wash cloth as needed. Males: Pull back foreskin (if male is uncircumcised). Wash and rinse tip of penis in circular motion, starting at wrethra moving outward. Use a clean area of the wash cloth with each wipe. Do not rewipe area, unless using clean area of the wash cloth. Continue washing down the penis to the scrotum outward. Change water in basin. With a clean wash cloth, rinse area, thoroughly in the same direction as when washing. Gently pat area dry in same direction as when washing. Assist resident to turn onto side away. Wet and soap wash cloth. Clean anal area from front to back, using a clean area of wash cloth with each wipe. Do not rewipe area, unless using a clean area of the wash cloth. Change washcloth as needed. Change water in basin. With a clean wash cloth, rinse area, thoroughly in the same direction as when washing. Gently pat dry in same direction as when washing. Assist resident to run onto back and undrape resident. Remove gloves. Wash hands..."</p> <p>3.1-18(l)</p>			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155330	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/11/2014
NAME OF PROVIDER OR SUPPLIER SALEM CROSSING			STREET ADDRESS, CITY, STATE, ZIP CODE 200 CONNIE AVE SALEM, IN 47167		
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F000520 SS=F	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on interview and record review, the facility Quality Assurance and Assessment Committee failed to develop and implement appropriate plans of action to address deficiencies regarding Infection Control issues related to peri-care and handwashing/glove use, unnecessary psychoactive drug administration and gradual dose reductions, and updating Care Plans to reflect current interventions This</p>	F000520	<p>The facility respectfully requests a face-to-face IDR to delete this deficiency because the facility believes it was in compliance with deficiency cited.</p> <p>1.No residents were harmed. A copy of the facility CQI Log of Activity for February 2014 was provided to ISDH during interview. The Log included hand washing, infection control, psychotropics, and care plans. Surveyor informed all are part of the CQI program. Surveyor did not request a copy of the actual</p>	04/10/2014	

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	<p>had the potential to effect all residents residing in the facility.</p> <p>Findings Include:</p> <p>The administrator was interviewed on 3/11/14 at 3:30 p.m. The administrator was queried regarding the facility QAA (Quality Assurance and Assessment) and the identified concerns of the Annual Survey as follows:</p> <ol style="list-style-type: none"> 1. Infection Control practices related to peri care and handwashing/glove use. 2. The appropriate use of and Gradual Dose Reductions of psychoactive medications. 3. Updating Care Plans to reflect current interventions. <p>The administrator indicated these concerns had not been included in the facility QAA Program.</p> <p>The Director of Nursing was also present during this meeting and indicated that care plan issues had been identified back in June 2013 and that a 100% audit of the residents' clinical records had been completed. She also indicated that monitoring of the problem had been discontinued in January 2014 as the matter was deemed resolved.</p>		<p>action plans. CQI action plans for infection control, psychotropic medications, and care plans are conducted on a monthly basis.</p> <p>2.All residents have the potential to be affected. CQI Action Plans reviewed and updated as needed. Deficient practices discussed during morning meetings with all department heads present and action plans to be initiated.</p> <p>3.CQI Program policy and procedures reviewed with no changes made (See Attachment N). All department heads in-serviced on policy by Executive Director on 4-1-14. CQI program includes monthly review of infection control, psychotropic medications and care plans. Executive Director and/or designee will ensure that hand washing, infection control, psychotropic medications and care plan audit tools will be completed on a monthly basis and the Executive Director will make sure it is reviewed during monthly CQI meeting.</p> <p>4.Executive Director or designee will utilize the Administrator Monitoring Tool to review deficient practices discussed during morning meeting to ensure action plan in place weekly times 4 weeks, then every other week times 4 weeks, then monthly times 3 months, then quarterly times 6 months (See Attachment E). The audits will be reviewed during the</p>				

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	3.1-52(b)(2)		facility's CQI meetings and issues will be addressed and the above plan will be altered accordingly as needed.		