

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155322	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/27/2014
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: October 22, 23, 24, 27, 2014.</p> <p>Facility number: 000215 Provider number: 155322 AIM number: 100267600</p> <p>Survey Team: Tim Long, RN-TC Rick Blain, RN Carol Miller, RN Diane Nilson, RN</p> <p>Census bed type: NF: 43 SNF/NF: 15 Total: 58</p> <p>Care Payor type: Medicare: 4 Medicaid: 45 Other: 9 Total: 58</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on October 29,</p>	F000000		
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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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F000223 SS=A	<p>2014 by Randy Fry RN.</p> <p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION 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 substantiated an allegation of abuse regarding a CNA refusing to allow a resident to make a phone call to a family member, and verbal abuse of the resident, for 1 of 3 residents reviewed for the abuse protocol, Resident #3.</p> <p>Findings include:</p> <p>The Administrator provided 3 investigations regarding allegations of abuse, on 10/24/14, at 9:15 A.M. A faxed report to the Indiana State Department of Health(ISDH), dated 2/5/14, was reviewed on 10/24/14, at 11:50 A.M. The report indicated the incident occurred on 2/5/14, and involved Resident #3 and former CNA #3. The description of the incident</p>	F000223	<p>Corrective Action for Affected Resident: Facility substantiated an allegation of abuse and the CNA was terminated.</p> <p>ID/Corrective Action for Potentially Affected Residents: With any allegation of abuse, all potentially affected residents are interviewed as part of the investigative process. Measures for Prevention: Facility has policy in place upholding the regulations of the Indiana State Board of Health and complies with its reporting and investigative requirements. QA for Prevention: Facility is not deficient in this area. We will continue to implement current policy and procedures for any allegations of abuse.</p>	11/10/2014

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F000282 SS=D	<p>indicated CNA #3 reported to Resident #3 that her "spray bottle" was broken, and the resident became upset. The resident indicated CNA #3 refused to take her to the phone to call a family member and that CNA #3 told her, "I'm not putting up with this s--t and took her to her room. Another staff member, LPN #10 validated she heard what CNA #3 had told the resident.</p> <p>A follow-up report, dated 2/7/14, indicated this allegation of abuse was substantiated, and CNA #3 did return the resident to her room and did not allow her to call the family member. CNA #3 indicated the resident began yelling at her when she was taking her to the phone so she returned the resident to her room. CNA #3 was terminated from employment on 2/7/14.</p> <p>3.1-27(b)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>A. Based on record review, and interview, the facility failed to ensure the care plan was followed regarding assessments and vital signs being completed, for 1 of 1 residents reviewed</p>	F000282	Corrective Action for Affected Resident: Resident #37 (assessment) Nurses will assess resident #37 and document properly following the facility policy. A monthly Dialysis Flow	11/26/2014

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	<p>for Dialysis, (Resident #37).</p> <p>B. Based on interviews and record reviews, the facility failed to ensure a Physician's Order was followed in regard to a psychotropic medication increase that was not administered to the resident for 31 days, and failed to ensure an Abnormal Involuntary Movement Scale was accurate for this resident (Resident #10).</p> <p>Findings include:</p> <p>A. The record for Resident #37 was reviewed, on 10/24/14 at 11:56 A.M. Diagnoses included, but were not limited to: Diabetes Mellitus, muscle weakness, edema, hypotension, and chronic kidney disease.</p> <p>A care plan problem, initiated on 1/29/12, most recently updated on 8/14/14, indicated the resident received Dialysis on Mondays, Wednesdays, and Fridays.</p> <p>Nursing interventions for the Dialysis care plan indicated the following: Monitor bruit and thrill at the fistula site; and signs and symptoms of infection and skin integrity; Upon return from dialysis, monitor for signs and symptoms of hematoma, bleeding, or oozing;</p>		<p>Sheet (see Attachment A) has been created to facilitate compliance with assessment and documentation. Corrective Action for Potentially Affected Residents: Policies regarding dialysis services updated with recommendations from DaVita HealthCare regarding resident assessment and monitoring of vital signs for resident receiving dialysis treatment (see Attachment B). At this point Resident #37 is the only one receiving dialysis treatment. Any new residents placed on dialysis will follow the same policy, care plan, and dialysis flow sheet. Measures for Prevention: The IDT reviewed the Care of the Dialysis Resident Policy and updated. A monthly Dialysis Flow Sheet created with pertinent information according to the updated Policy. Other pertinent information will be placed in TAR (Treatment Administration Record). Flow sheet will accompany resident to the Dialysis Center to be completed with pertinent information at each Dialysis visit and returned to the facility in a binder marked with facility and resident's names. The flow sheet will be kept at the nurse's desk for the current month to be completed and then filed in the nurse's notes in Resident's Medical Record. Care plan updated to reflect policy changes (see Attachment C). Direct</p>		

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	<p>Vital signs were to be taken before leaving for dialysis and upon returning from dialysis, and 6 hours after returning to the facility.</p> <p>The nursing notes were reviewed and indicated the following:</p> <p>9/15/14 - Nursing notes timed at 5:30 A.M., indicated vital signs were completed, and bruit and thrill present prior to transport to dialysis, however, there was no documentation of vital signs being completed upon return from dialysis. There was no documentation regarding the fistula site being assessed, until a nursing note, at 10:00 P.M., indicated bruit and thrill present.</p> <p>9/19/14 - Nursing notes, timed at 5:15 A.M., indicated an assessment of the fistula site, alert and oriented times 4, vital signs were completed, and the resident was transported to dialysis. A nursing note, timed at 12 noon indicated the resident complained of pain to the upper back and an assessment revealed a boil was present, however there was no assessment completed regarding the fistula site and no documentation to indicate vital signs were completed upon return from dialysis.</p>		<p>In-Service Training to staff in regards to Overall Changes to the care of a Dialysis Resident. QA for Prevention: DON will monitor Dialysis services binder with every treatment until January 1, 2015 for consistency in documentation. Beginning January 1, 2015, DON will monitor monthly and incorporate in QA system. Policies will be updated and in-services will be completed by November 26, 2014. Corrective Action for Affected Resident: Resident #10 received medications in a timely manner according to physician's orders. Documentation was discovered after the survey was complete (see Attachments D, E, F, G, and H). Corrective Action for Potentially Affected Residents: The policy for checking the physician's orders was reviewed and updated. Nurses to be in-serviced on policy specifically addressing clarification of physician's orders (see Attachment I). Measures for Prevention: Beginning November 1, 2014, all changes in medication orders must be authorized by the DON or designee. Beginning November 1, 2014, short-term monitoring forms are in place for all medication changes (see Attachment J). Nursing staff to be in-serviced on the forms related to accurately following checking physician's orders policy. QA for Prevention: A medical records</p>				

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	<p>9/26/14 - A nursing note, timed at 11:00 A.M., indicated an assessment of the fistula site was completed upon return from dialysis, and the resident's temperature recorded, however, there was no documentation of other vital signs being completed.</p> <p>10/1/14 - A nursing note, timed at 12 P.M., indicated an assessment of the fistula site was completed upon return from dialysis, however there was no documentation of vital signs being completed, until 7:00 P.M.</p> <p>10/3/14 - A nursing note, timed at 5:30 A.M., indicated an assessment with vital signs was completed and the resident was transported to dialysis. A nursing note, timed at 1:00 P.M., indicated the resident had returned from a physician's appointment, however, there was no documentation of an assessment being completed for the fistula site or vital signs being completed upon the resident's return.</p> <p>10/15/14 - A nursing note, timed at 11:00 A.M., indicated the resident returned from dialysis and an assessment of the fistula site was completed, but no vital signs were recorded at this time. A nursing note, timed at 12:45 P.M., indicated the resident was complaining of</p>		<p>QA process will be added for purposes of monitoring filing of physician's orders on resident's medical record. Policies will be updated and in-services will be completed by November 26, 2014. Corrective Action for Affected Resident: Resident #10's AIMS was reviewed and corrected (see Attachment K). ID/Corrective Action for Potentially Affected Residents: AIMS for all residents receiving psychotropic medications reviewed for accuracy and updated accordingly. Measures for Prevention: Nursing staff to be in-serviced by DON and MDS Coordinator on appropriate completion of AIMS. QA for Prevention: MDS Coordinator will monitor AIMS for accuracy at Resident's Quarterly Assessment and Care Plan review. In-services will be completed by November 26, 2014.</p>	

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	<p>chest pain, and pain radiating down the left arm, vital signs indicated the blood pressure was 95/49, pulse was 109, and respirations 24. The physician was at the facility, assessed the resident, and the resident was transported to the emergency room via ambulance, at 1:30 P.M.</p> <p>10/17/14 - A nursing note, timed at 11:00 A.M., indicated the resident returned from dialysis, an assessment of the fistula site was completed, however no vital signs were recorded at this time. A nursing note, timed at 12 noon indicated the resident had completed an antibiotic and a temperature was recorded, but no other vital signs. There was no documentation of an assessment of the fistula site being completed or vital signs completed prior to the resident being transported to dialysis on 10/17/14.</p> <p>LPN #2 was interviewed, on 10/27/14, at 10:15 A.M., and indicated vital signs were supposed to be completed prior to going to dialysis and upon return from dialysis, and were supposed to be recorded in the nursing notes. She indicated vital signs were taken routinely at 8:00 P.M., every evening, and recorded on the treatment record.</p> <p>The Care of the Dialysis Resident policy,</p>			

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	<p>dated June, 2011, was provided by the Social Service Designee, on 10/27/14, at 11:00 A.M.</p> <p>The policy was reviewed, on 10/27/14, at 11:05 A.M., and indicated the following: Assess the resident including vital signs, neurological status and assessment of access site; Upon return from dialysis, assess the condition of the resident including vital signs, neurological status, and any changes in condition upon return and six hours later. Assessment of the access site and vital signs were to be recorded in the nurses' notes and on the Treatment record.</p> <p>The DNS was interviewed, on 10/27/14, at 2:35 P.M., regarding the missing documentation. She confirmed there were missing vital signs and documentation regarding the dialysis assessments.</p> <p>B. Resident #10's clinical record was reviewed on 10/24/14 at 9:00 a.m. Resident #10's diagnosis included, but were not limited to, paranoia with atypical psychosis.</p> <p>The Physician's Order Sheet dated 4/2014 indicated Resident #10 had an order for Quetiapine (psychotropic medication) 25 milligrams (mg) once a day since</p>						

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	<p>10/28/13.</p> <p>The Behavioral Medicine Evaluation and Management Note dated 5/1/14 indicated the Family Nurse Practitioner had documented the resident had behaviors of being very irritable, yelling and making rude comments about her room-mate, and was somewhat anxious.</p> <p>The Treatment Plan indicated will increase Quetiapine 25 mg to twice a day for "increased behaviors as documented above".</p> <p>The Medication Administration Record (MAR) dated 5/1/14 through 5/31/14 indicated Resident #10 had received Quetiapine 25 mg once a day for 31 days. The MAR dated 6/1/14 indicated the resident had received Quetiapine 25 mg twice a day in June 2014.</p> <p>The Nurse's Notes dated 5/1/14 at 1:40 p.m. indicated the "...Psych NP (Psychiatric Nurse Practitioner) here N.O. (new order) received..."</p> <p>The Physician's Order Sheet dated 6/2014 indicated on 5/3/14 the resident had an order for Quetiapine 25 mg twice a day.</p> <p>An interview with the Minimum Data Set (MDS) Coordinator LPN on 10/27/14 at 11:00 a.m. indicated on the Physician's</p>			

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	<p>Order Sheet dated 10/2014 the Quetiapine 25 mg had been increased from once a day to twice a day on 5/3/14. The MDS Coordinator LPN indicated she was not able to find the original Physician's Orders dated 5/3/14 to increase the Quetiapine 25 mg from once a day to twice a day and also was unable to find an order for 6/1/2014 when the Quetiapine was increased to twice a day. The MDS Coordinator LPN indicated she thinks the nurse got the verbal order dated 5/1/14 from the Family Nurse Practitioner to increase the Quetiapine 25 mg from once a day to twice a day but the order did not get written by the nurse. The MDS Coordinator LPN indicated Resident #10's behaviors did increase in May 2014 and felt the increase in Quetiapine 25 mg twice a day would have helped the resident's behaviors. The MDS Coordinator LPN indicated the facility policy is a Physician's Order should had been written by the nurse on 5/1/14 when she spoke with the Family Nurse Practitioner in regard to the increase of Quetiapine 25 mg once a day to twice a day.</p> <p>The policy "Checking physicians' orders received from the MDS Coordinator LPN on 10/27/14 at 1:15 p.m. revised January 2012, indicated "A. All physicians' orders are to be</p>			

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	<p>written on a telephone order form... B. The professional nurse taking the order is responsible for checking the order for accuracy, transcribing the order to the appropriate administration record..."</p> <p>The Physician's Order Sheet dated 4/2014 indicated since 10/28/13 Resident #10 had been receiving Quetiapine 25 mg (Psychotropic medication) for paranoia with atypical psychosis.</p> <p>The AIMS (Abnormal Involuntary Movement Scale) was last done on 7/31/14, for Resident #10 and indicated abnormal results when compared to the 2 previous AIMS done on 5/3/14 and 1/27/14 which were both normal.</p> <p>The AIMS done on 7/31/14 indicated the resident had a mild to moderate increase in facial and oral movements of puckering and smacking of the lips and movements of the forehead, eyebrows including frowning and blinking. The AIMS also indicated a mild severity of abnormal movements.</p> <p>On 10/27/14 at 10:00 a.m. an interview with the MDS Coordinator LPN indicated the AIMS done on 7/31/14 was done by a nurse who no longer worked at the facility, and she questioned the</p>				

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	<p>accuracy of the AIMS results done on 7/31/14. The MDS Coordinator LPN indicated there were no observations of Resident #10 with any of these signs or symptoms of an abnormal AIMS.</p> <p>An interview with RN #2 on 10/27/14 at 10:15 a.m. indicated she had not observed Resident #10 with any signs or symptoms such as muscle or facial expressions, no puckering, pouting or smacking, and no biting. RN #2 had witnessed no abnormal of movements at all for the resident.</p> <p>An interview with the Director Of Nursing (DON) on 10/27/14 at 10:30 a.m. indicated the AIMS dated 7/31/14 was done by the nurse who is no longer employed at the facility, and was not accurate because Resident #10 did not have any signs or symptoms that would trigger an abnormal AIMS. The DON further indicated she feels the nurse who did the AIMS dated 7/31/14 had done the wrong resident at that time, because there was one resident who had an AIMS consistent with the AIMS that was done for Resident #10.</p> <p>The policy received from the MDS Coordinator LPN on 10/27/14 at 1:15 p.m. Nursing Documentation MDS 3.0 revised 1/2012 indicated the "Purpose:</p>				

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	<p>To provide complete, accurate supportive documentation during the MDS assessment period.</p> <p>Procedure: A. During the MDS assessment period, the nurse on each shift is responsible for documenting</p> <p>F. Complete the following screens for all MDS assessments: "...AIMS Scale...."</p> <p>3.1-35(g)(1) 3.1-35(g)(2)</p>				